HOUSE BILL No. 1249

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

Synopsis: Medicaid prescription drug program. Requires the office of the secretary of family and social services to provide a prescription drug benefit for a Medicaid recipient under: (1) the risk based managed care program; and (2) the healthy Indiana plan. (Current law allows the office or the managed care organization to provide the prescription drug benefit.)

Effective: July 1, 2019.

Davisson

January 10, 2019, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 121st General Assembly (2019)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2018 Regular and Special Session of the General Assembly.

HOUSE BILL No. 1249

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-5-5, AS AMENDED BY P.L.152-2017, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 5. (a) The office ~~may~~ **shall** provide a prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program.

(b) ~~If~~ The office ~~provides a prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program:~~

~~(1)~~ ~~the office~~ shall develop a procedure and provide the recipient's risk based managed care provider with information concerning the recipient's prescription drug utilization for the risk based managed care provider's case management program. ~~and~~

~~(2)~~ **(c)** The provisions of IC 12-15-35.5 apply **to a prescription drug benefit under this section.**

~~(c) If the office does not provide a prescription drug benefit to a Medicaid recipient in a Medicaid risk based managed care program, a managed care organization shall provide coverage and reimbursement for outpatient single source legend drugs subject to IC 12-15-35-46,~~

~~IC 12-15-35-47, and IC 12-15-35.5.~~

SECTION 2. IC 12-15-5-8, AS ADDED BY P.L.246-2005, SECTION 105, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 8. (a) As used in this section, "maintenance drug" means a medication that is dispensed under a single prescription for a period of not less than one hundred eighty (180) days, excluding authorized refills, for the ongoing treatment of a chronic medical condition or disease or congenital condition or disorder.

(b) The office may designate:

(1) a mail order pharmacy;

(2) an Internet based pharmacy (as defined in IC 25-26-18-1);

(3) a pharmacy that agrees to sell a maintenance drug at the same price as a mail order or an Internet based pharmacy; or

(4) all the pharmacies listed in subdivisions (1) through (3);

through which a recipient may obtain a maintenance drug.

~~(c) If the office makes a designation under subsection (b), a managed care organization that has a contract with the office under IC 12-15-12 is not required to use a pharmacy that is designated under subsection (b).~~

~~(d)~~ **(c)** If a Medicaid recipient's physician prescribes a maintenance prescription drug, the Medicaid recipient may purchase the maintenance prescription drug from a pharmacy that is designated under subsection (b).

~~(e)~~ **(d)** The office shall apply to amend the state Medicaid plan if the office determines that an amendment is necessary to carry out this section.

~~(f)~~ **(e)** The office may require a recipient to pay the maximum copayment allowable under federal law if the recipient obtains a maintenance drug from a pharmacy other than a pharmacy described in subsection (b).

SECTION 3. IC 12-15-12-4.5, AS ADDED BY P.L.101-2005, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4.5. A managed care provider's contract or provider agreement with the office may **not** include a prescription drug program. ~~subject to IC 12-15-5-5, IC 12-15-35, and IC 12-15-35.5.~~ **The office shall provide the prescription drug benefit for a risk based care Medicaid recipient.**

SECTION 4. IC 12-15-35-28, AS AMENDED BY P.L.130-2018, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 28. (a) The board has the following duties:

(1) The implementation of a Medicaid retrospective and

prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(2) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria and standards for appropriate prescribing are based on the compendia and developed with professional input with provisions for timely revisions and assessments as necessary.

(3) The development, selection, application, and assessment of interventions for physicians, pharmacists, and patients that are educational and not punitive in nature.

(4) The publication of an annual report that must be subject to public comment before issuance to the federal Department of Health and Human Services and to the Indiana legislative council by December 1 of each year. The report issued to the legislative council must be in an electronic format under IC 5-14-6.

(5) The development of a working agreement for the board to clarify the areas of responsibility with related boards or agencies, including the following:

(A) The Indiana board of pharmacy.

(B) The medical licensing board of Indiana.

(C) The SURS staff.

(6) The establishment of a grievance and appeals process for physicians or pharmacists under this chapter.

(7) The publication and dissemination of educational information to physicians and pharmacists regarding the board and the DUR program, including information on the following:

(A) Identifying and reducing the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and recipients.

(B) Potential or actual severe or adverse reactions to drugs.

(C) Therapeutic appropriateness.

(D) Overutilization or underutilization.

(E) Appropriate use of generic drugs.

(F) Therapeutic duplication.

(G) Drug-disease contraindications.

(H) Drug-drug interactions.

(I) Incorrect drug dosage and duration of drug treatment.

(J) Drug allergy interactions.

(K) Clinical abuse and misuse.

(8) The adoption and implementation of procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program that identifies individual physicians, pharmacists, or recipients.

(9) The implementation of additional drug utilization review with respect to drugs dispensed to residents of nursing facilities shall not be required if the nursing facility is in compliance with the drug regimen procedures under 410 IAC 16.2-3.1 and 42 CFR 483.60.

(10) The research, development, and approval of a preferred drug list for:

(A) Medicaid's fee for service program;

(B) ~~a~~ **Medicaid's** risk based managed care program; ~~if the office provides a prescription drug benefit and subject to IC 12-15-5;~~ and

(C) the children's health insurance program under IC 12-17.6;

in consultation with the therapeutics committee.

(11) The approval of the review and maintenance of the preferred drug list at least two (2) times per year.

(12) The preparation and submission of a report concerning the preferred drug list at least one (1) time per year to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(13) The collection of data reflecting prescribing patterns related to treatment of children diagnosed with attention deficit disorder or attention deficit hyperactivity disorder.

(14) Advising the Indiana comprehensive health insurance association established by IC 27-8-10-2.1 concerning implementation of chronic disease management and pharmaceutical management programs under IC 27-8-10-3.5.

(b) The board shall use the clinical expertise of the therapeutics committee in developing a preferred drug list. The board shall also consider expert testimony in the development of a preferred drug list.

(c) In researching and developing a preferred drug list under subsection (a)(10), the board shall do the following:

(1) Use literature abstracting technology.

(2) Use commonly accepted guidance principles of disease

management.

(3) Develop therapeutic classifications for the preferred drug list.

(4) Give primary consideration to the clinical efficacy or appropriateness of a particular drug in treating a specific medical condition.

(5) Include in any cost effectiveness considerations the cost implications of other components of the state's Medicaid program and other state funded programs.

(d) Prior authorization is required for coverage under a program described in subsection (a)(10) of a drug that is not included on the preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date on which the manufacturer notifies the board in writing of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration, and that is:

(1) in a therapeutic classification:

(A) that has not been reviewed by the board; and

(B) for which prior authorization is not required; or

(2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list developed under subsection (a)(10):

(1) Except as provided by IC 12-15-35.5-3(b) and IC 12-15-35.5-3(c), the office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:

(A) To override a prospective drug utilization review alert.

(B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.

(C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

(D) To permit implementation of a disease management

program.

(E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

(h) At least one (1) time each year, the board shall provide a report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6. The report must contain the following information:

(1) The cost of administering the preferred drug list.

(2) Any increase in Medicaid physician, laboratory, or hospital costs or in other state funded programs as a result of the preferred drug list.

(3) The impact of the preferred drug list on the ability of a Medicaid recipient to obtain prescription drugs.

(4) The number of times prior authorization was requested, and the number of times prior authorization was:

(A) approved; and

(B) disapproved.

(5) Any recommendations received from the mental health Medicaid quality advisory committee under section 51(h) of this chapter.

(i) The board shall provide the first report required under subsection (h) not later than six (6) months after the board submits an initial preferred drug list to the office.

SECTION 5. IC 12-15-35-45, AS AMENDED BY P.L.152-2017, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 45. (a) The chairman of the board, subject to the approval of the board members, may appoint an advisory committee to make recommendations to the board on the development of a Medicaid outpatient drug formulary.

(b) If the office decides to establish a Medicaid outpatient drug formulary, the formulary shall be developed by the board.

~~(c) A formulary, preferred drug list, or prescription drug benefit used by a managed care organization is subject to IC 12-15-5-5, IC 12-15-35.5, and sections 46 and 47 of this chapter.~~

SECTION 6. IC 12-15-35-48 IS REPEALED [EFFECTIVE JULY

1, 2019]. ~~Sec. 48. (a) The board shall review the prescription drug program of a managed care organization that participates in a risk based managed care program at least one (1) time per year. The board's review of a prescription drug program must include the following:~~

~~(1) An analysis of the single source drugs requiring prior authorization, including the number of drugs requiring prior authorization in comparison to other managed care organizations' prescription drug programs that participate in the state's Medicaid program.~~

~~(2) A determination and analysis of the number and the type of drugs subject to a restriction.~~

~~(3) A review of the rationale for:~~

~~(A) the prior authorization of a drug described in subdivision (1); and~~

~~(B) a restriction on a drug.~~

~~(4) A review of the number of requests a managed care organization received for prior authorization, including the number of times prior authorization was approved and the number of times prior authorization was disapproved.~~

~~(5) A review of:~~

~~(A) patient and provider satisfaction survey reports; and~~

~~(B) pharmacy-related grievance data for a twelve (12) month period.~~

~~(b) A managed care organization described in subsection (a) shall provide the board with the information necessary for the board to conduct its review under subsection (a).~~

SECTION 7. IC 12-15-44.5-3.5, AS ADDED BY P.L.30-2016, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage:

(A) administered by the office; and

(B) including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.
(10) Urgent care center services.
(11) Preventative care services.
(12) Family planning services:
(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and
(B) not including abortion or abortifacients.
(13) Hospice services.
(14) Substance abuse services.
(15) Pregnancy services.
(16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(c) The plan may provide vision services and dental services only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.

(d) The benefit package offered in the plan:
(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and
(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars ($500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.