Am. Sub. H.B. 166
As Passed by the Senate
MCDCD52; DASCD37;
MCDCD72; MCDCD73;
MCDCD64; MCDCD76

_____ moved to amend as follows:

In line 66 of the title, after "3953.231," insert "3959.01,"

In line 149 of the title, after "122.84," insert "125.95,"

In line 178 of the title, after "5126.053," insert "5162.137,"

In line 179 of the title, after "5162.72," insert "5164.7515,"

In line 180 of the title, delete "5167.122, 5167.123,"

In line 181 of the title, after "5167.22," insert "5167.24, 5167.241, 5167.242, 5167.243, 5167.244, 5167.245, 5167.246,"

In line 270, after "3953.231," insert "3959.01,"

In line 330, after "122.84," insert "125.95,"

In line 353, after "5126.053," insert "5162.137,"; after "5162.72," insert "5164.7515,"

In line 354, delete "5167.122, 5167.123,"

In line 355, after "5167.22," insert "5167.24, 5167.241, 5167.242, 5167.243, 5167.244, 5167.245, 5167.246,"

After line 7038, insert:

"**Sec. 125.95.** (A) There is hereby created within the department of administrative services the prescription drug transparency and affordability advisory council. The department shall provide administrative support to the advisory council as necessary for the advisory council to carry out its duties under this section.

(1) Members of the advisory council shall include the following:

(a) The director of administrative services;

(b) The director of health;

(c) The medicaid director;

(d) The director of mental health and addiction services;

(e) The administrator of workers' compensation.

(2) Members of the advisory council shall also include individuals who are working to address prescription drug availability and affordability in any of the following areas:

(a) Insurance;

(b) Local, state, and federal government service;

(c) Private industry;

(d) Organizations of faith;

(e) Health care providers;

(f) Consumer organizations;

(g) Prescription drug manufacturers;

(h) Prescription drug wholesale distributors;

(i) Pharmacists;

(j) Business organizations;

(k) Individuals concerned about mental health or substance abuse matters;

(l) Advocates for individuals struggling to afford prescription drugs.

The governor, the senate president, and the speaker of the house of representatives shall each appoint three members, each of whom represents at least one of the categories listed in divisions (A)(2)(a) to (l) of this section.

(B) Members shall serve without compensation. Initial appointments shall be made not later than sixty days after the effective date of this section. Vacancies shall be filled in the manner provided for original appointments.

(C) Not later than six months after the date of initial appointments under division (B) of this section, the advisory council shall submit a report to the governor, the general assembly, and the chairperson of the joint medicaid oversight committee in accordance with section 101.68 of the Revised Code. The report shall include recommendations on all of the following:

(1) How this state can best achieve prescription drug price transparency;

(2) New payment models or other avenues to create the most affordable environment for purchasing prescription drugs;

(3) Leveraging this state's purchasing power across all state agencies, boards, commissions, and similar entities;

(4) Creating efficiencies across different health care systems, such as hospitals, the criminal justice system, treatment

and recovery support programs, and employer-sponsored health insurance, to reduce duplicative service delivery across these systems, ensure that patients receive high quality and affordable prescription drugs, and support quality care and outcomes;

(5) Which critical outcomes can be measured and used to improve this state's system of purchasing affordable prescribed drugs;

(6) How federal, state, and local resources are being used to optimize these outcomes and identify where the resources can be better coordinated or redirected to meet the needs of consumers in this state.

(D) State agencies, boards, commissions, and similar entities shall cooperate with and provide assistance to the advisory council as necessary for the advisory council to carry out its duties under this section.

(E) Upon completion of the report described in division (C) of this section, the advisory council shall meet not less than quarterly to provide assistance and guidance relating to the recommendations in the report."

After line 44774, insert:

"**Sec. 3959.01.** (A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy

benefit manager. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a

pharmacy services administration organization, group purchasing organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(G) "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

(H) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(I) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

(J) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code.

(K) "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source

drugs that are listed in the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(M) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

(N) "Pharmacy benefit manager" means an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

(O) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

(P) "Plan sponsor" means the person who establishes the plan.

(Q) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

(R) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or

trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

(S) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

(T) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code."

After line 65680, insert:

"**Sec. 5162.137.** The department of medicaid shall develop findings based on the quarterly reports provided to the department by pharmacy benefit managers under section 5167.243 of the Revised Code. The department shall complete a report detailing the findings not later than sixty days after receiving each quarterly report. The report shall be submitted to the general assembly in accordance with section 101.68 of the Revised Code. On request, the department also shall testify about its findings before either chamber of the general assembly or the joint medicaid oversight committee. The department shall keep as confidential any document or information marked "confidential" or "proprietary" and shall redact any information as necessary before it becomes public, except that the department may share the document or information with other state agencies or entities."

After line 66500, insert:

"**Sec. 5164.7515.** (A) Not later than July 1, 2020, the medicaid director shall establish an annual benchmark for prescribed drug spending growth under the medicaid program. If the

director determines that prescribed drug spending in a given year is projected to exceed the benchmark for that year, the director shall identify specific prescribed drugs that significantly contribute to exceeding the benchmark.

(B) For a prescribed drug identified by the director under division (A) of this section, the director shall determine if there is a current supplemental rebate for that drug between the drug's manufacturer and the department or its designee. If there is a current supplemental rebate for the drug, the director may renegotiate the supplemental rebate agreement. If there is not a supplemental rebate for the drug, the director shall evaluate whether to pursue a supplemental rebate agreement for the drug with the drug manufacturer. In making that evaluation, the director may consider any of the following:

(1) The prescribed drug's actual cost to the state;

(2) Whether the drug's manufacturer is providing significant discounts or rebates for other prescribed drugs under the medicaid program;

(3) Any other information the director considers relevant.

(C)(1) If the director determines that a prescribed drug rebate agreement renegotiation is warranted under division (B) of this section, the director shall establish a target rebate amount. In determining the target rebate amount, the director may consider any of the following:

(a) Publicly available information relevant to pricing the prescribed drug;

(b) Information the department has that is relevant to the pricing of the drug;

(c) Information relating to value-based pricing of the drug for medicaid recipients;

(d) The seriousness and prevalence of the conditions for which the drug is prescribed;

(e) The drug's volume of use among medicaid recipients;

(f) The effectiveness of the drug in treating conditions for which it is prescribed or improving a patient's health, quality of life, or overall health outcomes;

(g) The likelihood that use of the drug will reduce the need for other medical care, including hospitalization;

(h) The average wholesale price, wholesale acquisition cost, and retail price of the drug, and the cost of the drug under the medicaid program, not including any rebates received for the drug under the program;

(i) In the case of generic drugs, the number of manufacturers that produce the drug;

(j) Whether there are pharmaceutical equivalents to the drug;

(k) Any other information the director considers relevant.

(2) In negotiating a new rebate agreement under division (B) of this section, the director shall seek to negotiate an amount that is equal to the target rebate amount under division (C)(1) of this section. The director shall not enter into a rebate agreement that is less than sixty per cent of the target rebate amount. If no rebate agreement is established or renegotiated under this section, the director may consider removing the drug from the medicaid program's preferred drug list and imposing a prior authorization requirement on the drug in accordance with section 5160.34 of the Revised Code.

(D) The director shall publish a list of the prescribed drugs it identifies as being responsible for increasing spending above the annual benchmark for prescribed drug spending growth."

In line 67065, after "(A)" insert ""Affiliated company" means an entity, including a third-party payer or specialty pharmacy, with common ownership, members of a board of directors, or managers, or that is a parent company, subsidiary company, jointly held company, or holding company with respect to the other entity.

(B)"

In line 67067, delete "(B)" and insert "(C)"

In line 67069, delete "(C)" and insert "(D)"

In line 67071, delete "(D)" and insert "(E)"

In line 67074, delete "(E)" and insert "(F)"

In line 67076, delete "(F)" and insert "(G)"

In line 67078, delete "(G)" and insert "(H)"

In line 67081, delete "(H)" and insert "(I)"

In line 67086, delete "(I)" and insert "(J)"

In line 67088, delete "(J)" and insert "(K)"

After line 67089, insert:

"(L) "Part B drug" means a drug or biological described in section 1842(o)(1)(C) of the "Social Security Act," 42 U.S.C. 1395u(o)(1)(C)."

In line 67090, delete "(K)" and insert "(M)"

After line 67091, insert:

"(N) "Practice of pharmacy" has the same meaning as in section 4729.01 of the Revised Code."

In line 67092, delete "(L)" and insert "(O)"

In line 67094, delete "(M)" and insert "(P)"

In line 67096, delete "(N)" and insert "(Q)"

In line 67100, delete "(O)" and insert "(R)"

After line 67101, insert:

"(S) "State pharmacy benefit manager" means the pharmacy benefit manager selected by and under contract with the medicaid director under section 5167.24 of the Revised Code.

(T) "Third-party administrator" means any person who adjusts or settles claims on behalf of an insuring entity in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs and includes a pharmacy benefit manager."

Delete lines 67268 through 67298

In line 67299, delete everything after "(A)"

Delete lines 67300 through 67302

In line 67303, delete "(1) Upon" and insert "The state pharmacy benefit manager shall, on"

Delete lines 67309 through 67334, and insert:

"(B) Each medicaid managed care organization shall disclose to the department of medicaid in the format specified by the department the organization's administrative costs associated with providing pharmacy services under the care management system."

After line 67513, insert:

"**Sec. 5167.24.** (A) If the department of medicaid includes prescribed drugs in the care management system as authorized under

section 5167.05 of the Revised Code, the medicaid director, through a procurement process, shall select a third-party administrator to serve as the single pharmacy benefit manager used by medicaid managed care organizations under the care management system. The state pharmacy benefit manager shall be responsible for processing all pharmacy claims under the care management system. The department of medicaid is responsible for enforcing the contract after the procurement process.

(B) As part of the procurement process, the director shall do all of the following:

(1) Accept applications from entities seeking to become the state pharmacy benefit manager;

(2) Establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager;

(3) Select and contract with a single state pharmacy benefit manager;

(4) Develop a master contract to be used by the director when contracting with the state pharmacy benefit manager, which shall prohibit the state pharmacy benefit manager from requiring a medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state pharmacy benefit manager.

(C) A prospective state pharmacy benefit manager shall disclose to the director all of the following during the procurement process:

(1) Any activity, policy, practice, contract or arrangement of the state pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the

department or a medicaid managed care organization;

(2) All common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager (or any of the pharmacy benefit manager's affiliated companies) with any of the following:

(a) A medicaid managed care organization and its affiliated companies;

(b) An entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies;

(c) A drug wholesaler or distributor and its affiliated companies;

(d) A third-party payer and its affiliated companies;

(e) A pharmacy and its affiliated companies.

(3) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control; or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state that operate more than eleven locations;

(5) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state that operate eleven or fewer locations.

(6) Any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler,

including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

(D) The director shall select a provisional state pharmacy benefit manager not later than July 1, 2020.

(1) Once a provisional state pharmacy benefit manager has been selected, full implementation of the entity as the state pharmacy benefit manager shall be subject to that entity's demonstrated ability to fulfill the duties and obligations of the state pharmacy benefit manager as illustrated through a readiness review process established by the director. Any entity failing to complete the readiness review process shall be deemed as having not met the criteria of the review process. The selected entity shall not enter into contracts with the department or medicaid managed care organizations as the state pharmacy benefit manager before the date on which the entity has satisfactorily completed the readiness review process.

(2) If the director determines that, for reasons beyond the director's control, selection of a provisional state pharmacy benefit manager cannot occur before July 1, 2020, the director shall notify the joint medicaid oversight committee of the reasons for the delay and identify the steps the director is taking to complete the selection as expeditiously as possible.

(E) The director shall review the state pharmacy benefit manager contract every six months and shall effect any changes by contract amendment or renewal.

(F) Every four years, the director shall reprocure the state pharmacy benefit manager contract under division (B) of this section.

(G) The affiliated companies of the state pharmacy benefit

manager selected under this section may conduct pharmacy benefit manager business in their own names with medicaid managed care organizations.

Sec. 5167.241. (A)(1) Medicaid managed care organizations shall use the state pharmacy benefit manager selected under section 5167.24 of the Revised Code pursuant to the terms of the master contract entered into under that section. The state pharmacy benefit manager shall be responsible for processing all pharmacy claims under the care management system.

(2) All contracts between the state pharmacy benefit manager and a medicaid managed care organization shall specify that all pharmacy claims information shared between the parties is confidential and proprietary.

(B)(1) The medicaid director shall determine the rate the state pharmacy benefit manager is paid for its services. All payments relating to claims adjudication shall be made to the state pharmacy benefit manager from a medicaid managed care organization. All payments relating to other administrative matters, such as formulary management and prescribed drug supplemental rebate negotiation, shall be made to the state pharmacy benefit manager directly from the department.

All payment arrangements between the department of medicaid, medicaid managed care organizations, and the state pharmacy benefit manager shall comply with state and federal statutes, regulations adopted by the centers for medicare and medicaid services, and any other agreement between the department and the centers for medicare and medicaid services. The director may change a payment arrangement in order to comply with state and federal statutes, regulations adopted by the centers for medicare

and medicaid services, or any other agreement between the department and the centers for medicare and medicaid services.

(2) The director shall establish a dispensing fee to be paid to the pharmacy for each prescribed drug it dispenses under the care management system.

(C) Notwithstanding division (A) of this section, a medicaid managed care organization may contract directly with a pharmacy regarding the practice of pharmacy.

Sec. 5167.242. (A) In consultation with the medicaid director, the state pharmacy benefit manager shall develop a medicaid prescribed drug formulary that it will use when administering prescribed drug benefits on behalf of a medicaid managed care organization under the care management system. At minimum, the medicaid prescribed drug formulary shall list prescribed drugs and shall specify the per unit price for each drug. The formulary price is the total price ceiling, including any supplemental rebates or discounts received for the prescribed drug. The formulary shall not become effective until the medicaid director approves it.

(B) The state pharmacy benefit manager shall disclose immediately and in writing to the department of medicaid any changes to the medicaid prescribed drug formulary. The medicaid director may disapprove any changes to the formulary.

(C) The state pharmacy benefit manager shall not make any payment for a prescribed drug included in the medicaid prescribed drug formulary in an amount that exceeds the per unit price for the drug as described in division (A) of this section.

(D) In developing the medicaid prescribed drug formulary under this section in consultation with the director, the state

pharmacy benefit manager shall negotiate prices for and price each prescribed drug at the lowest price that also maximizes the health of medicaid recipients and promotes the efficiency of the medicaid program.

Sec. 5167.243. (A) The state pharmacy benefit manager shall provide to the medicaid director a written quarterly report containing the following information from the immediately preceding quarter:

(1) The prices that the state pharmacy benefit manager negotiated for prescribed drugs under the care management system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) The prices the state pharmacy benefit manager paid to pharmacies for prescribed drugs;

(3) Any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) The percentage of savings in drug prices that are passed on to participants in the care management system;

(5) The information described in division (C) of section 5167.24 of the Revised Code;

(6) Any other information required by the director.

(B) The director may ask the state pharmacy benefit manager to provide additional information as necessary and shall collect other clinical data from the state pharmacy benefit manager as the director sees fit.

(C) At the time of contract execution, renewal, or modification, the department shall modify the reporting requirements under its medicaid managed care organization

contracts as necessary to meet the requirements of this section.

Sec. 5167.244. No person shall violate the terms of the master state pharmacy benefit manager contract under section 5167.24 of the Revised Code or section 5167.241 or 5167.242 of the Revised Code. Whoever violates those sections is subject to a civil penalty in an amount to be determined by the medicaid director.

Sec. 5167.245. The medicaid director shall establish an appeals process by which pharmacies may appeal to the department of medicaid any disputes relating to the maximum allowable cost set by the state pharmacy benefit manager for a prescribed drug. All pharmacies participating in the care management system shall use the appeals process to resolve any disputes relating to the maximum allowable cost set by the state pharmacy benefit manager.

Sec. 5167.246. The medicaid director shall adopt rules under section 5167.02 of the Revised Code as necessary to implement and enforce sections 5167.24 to 5167.245 of the Revised Code, including rules that do all of the following:

(A) Specify the information that must be disclosed to the director by the state pharmacy benefit manager under section 5167.243 of the Revised Code;

(B) Establish the amount of the civil penalties under section 5167.244 of the Revised Code;

(C) Adjust the capitation payments to medicaid managed care organizations as necessary as a result of the state pharmacy benefit manager processing all pharmacy claims under the care management system as provided under section 5167.241 of the

Revised Code;

(D) Prohibit the state pharmacy benefit manager from requiring a medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state pharmacy benefit manager;

(E) Define "specialty drug" and "specialty pharmacy" for the purpose of division (D) of this section;

(F) Establish a dispensing fee to be paid to the state pharmacy benefit manager for claims adjudication, as authorized under division (B)(2) of section 5167.241 of the Revised Code;

(G) Specify procedures for conducting the appeals process established under section 5167.245 of the Revised Code."

In line 82860, after "3953.231," insert "3959.01,"

In line 89582, delete "$4,095,440,909" and insert "$4,095,940,909"

In line 89584, delete "$13,850,847,393" and insert "$13,851,347,393"

In line 89588, add $500,000 to fiscal year 2020

In line 89590, add $500,000 to fiscal year 2020

In line 89615, add $500,000 to fiscal year 2020

After line 90212, insert:

"**Section 333.230.** RE-PROCUREMENT OF MEDICAID MCO CONTRACTS

(A) As used in this section, "care management system" and "Medicaid managed care organization" have the same meanings as in section 5167.01 of the Revised Code.

(B) Not later than July 1, 2020, the Medicaid Director shall

complete a procurement process for Medicaid managed care organizations under the care management system.

Section 333.240. REVIEW OF PRESCRIBED DRUG REFORM SAVINGS

Not later than January 1, 2021, the Department of Medicaid shall conduct a review of all of the savings to the state from prescribed drug reforms included in this act. The Department shall complete a report detailing its findings not later than sixty days after its review. The report shall be submitted to the Governor and to the General Assembly in accordance with section 101.68 of the Revised Code. The Department shall testify about its findings before the Joint Medicaid Oversight Committee. Upon request, the Department also shall testify about its findings before the General Assembly as requested by the Speaker of the House of Representatives, the President of the Senate, or both."

Delete lines 90213 through 90243

After line 90265, insert:

"**Section 333.___.** PRESCRIBED DRUG CLAIMS PROCESSING PILOT PROGRAM

(A) As used in this section, "Medicaid managed care organization," "Medicaid MCO plan," "pharmacy benefit manager," and "prescribed drug" have the same meanings as in section 5167.01 of the Revised Code.

(B) The Department of Medicaid shall establish and administer a pilot program for the pre-audit processing of prescribed drug claims submitted to Medicaid managed care organizations or their pharmacy benefit managers by pharmacies that meet the requirements of division (C) of this section. A pharmacy's participation in the pilot program is voluntary.

(C) In order for a claim to be processed under the program, both of the following apply:

(1) The claim must relate to a prescription filled in Adams, Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Tuscarawas, Vinton, or Washington County.

(2) The pharmacy submitting the claim must serve a significant share of Medicaid recipients in the county who are enrolled in Medicaid MCO plans as determined by the Medicaid Director.

(D) Under the pilot program, the Department shall do all of the following:

(1) Approve individuals or entities to serve as claims processors;

(2) Ensure that claims are adjudicated by approved claims processors and that information relating to each claim is submitted to the Department for evaluation and review;

(3) Authorize approved claims processors to accept and adjudicate claims from the payment amounts submitted by patients;

(4) Utilize a coordination of benefits process to determine the respective payment responsibilities of different payors.

(E) The Department shall ensure that the pilot program is fully operational beginning January 1, 2020, and shall conclude the program on December 31, 2020. At the conclusion of the program, the Department shall evaluate and review all of the following data relating to each prescribed drug claim: the usual and customary drug cost, the contracted drug ingredient cost, the dispensing fee, and any applicable taxes. If a claims processor is unable to provide claims data to the Department, the participating

pharmacies shall, to the extent permissible under state and federal law, cooperate with the Department in providing any information missing from the claim.

(F) Not later than September 1, 2021, the Department shall prepare and submit to the Governor, Speaker of the House of Representatives, Senate President, and Chairperson of the Joint Medicaid Oversight Committee a report outlining both of the following:

(1) Any costs, savings, trends, and utilization rates realized under the program;

(2) Any policy recommendations, including whether to reinstate the program, and if further implementation will decrease prescribed drug costs and spending levels.

The report shall be submitted in accordance with section 101.68 of the Revised Code.

(G) Of the foregoing appropriation item 651525, Medicaid Health Care Services, $500,000 in fiscal year 2020 shall be used to establish and administer the pilot program."

The motion was _____ agreed to.

SYNOPSIS

Medicaid prescribed drug spending

R.C. 5164.7515

Adds new provisions as follows:

-Requires the Medicaid Director, not later than July 1, 2020, to establish an annual benchmark for prescribed drug spending

growth under the Medicaid program.

-Requires the Director to identify specific prescribed drugs that significantly contribute to the spending in excess of the benchmark in years it is exceeded and to publish a list of those drugs.

-For identified prescribed drugs, requires the Director to determine if there is a current supplemental rebate agreement for those drugs with the drug manufacturer and to evaluate if a supplemental rebate agreement should be entered into or if an existing supplemental rebate agreement should be renegotiated.

-If the Director determines a supplemental rebate agreement for an identified prescribed drug should be renegotiated, requires the Director to establish a target rebate amount for that drug.

-Requires the Director to, in negotiating a new supplemental rebate agreement, (1) seek to negotiate an amount equal to the target rebate amount and (2) not enter into an agreement that is less than 60% of the target rebate amount.

-Provides that if no rebate agreement is established or renegotiated for an identified prescribed drug, the Director can consider removing the prescribed drug from the Medicaid program's preferred drug list and imposing a prior authorization requirement on the drug.

State pharmacy benefit manager

R.C. 3959.01, 5162.137, 5167.01, 5167.24, 5167.241, 5167.242, 5167.243, 5167.244, and 5167.245

Restores House-added provisions, with described changes, to do all of the following:

-Require the Medicaid Director (instead of the Director of

Administrative Services) to select a single state pharmacy benefit manager (PBM) to administer pharmacy benefits under the care management system;

-Require prospective state PBMs to disclose certain information to the Director;

-Require the Director to reprocure the state PBM contract every four years;

-Require Medicaid managed care organizations (MCOs) to use the selected state PBM to administer their pharmacy benefits under the care management system;

-Require the state PBM to process all pharmacy claims under the care management system;

-Require the state PBM to make quarterly reports to the Department of Medicaid and require the Department to develop findings based on those quarterly reports and submit those findings to the General Assembly;

-Require the state PBM, in consultation with the Director, to establish a prescribed drugs formulary for the care management system;

-Prohibit violations of these provisions and task the Director with adopting rules specifying civil penalties for violations.

-Provide that instead of selecting the state PBM by July 1, 2020, the Director must select a provisional state PBM by that date, and that entity will not be fully implemented as the state PBM until it demonstrates its ability to fulfill the duties of the state PBM, as evidenced through successful completion of a readiness review process developed by the Director.

Adds new provisions as follows:

-Imposes a civil penalty, in an amount to be determined by the Director, on a person for violating the terms of the master PBM contract.

-Requires the Director, as part of the data the state PBM must disclose to the Director, to collect from the state PBM clinical data as the Director sees fit.

-Requires all contracts between the state PBM and a Medicaid MCO to specify that all pharmacy claims information shared between the parties is confidential and proprietary.

-Requires the Director to define "specialty drug" and "specialty pharmacy" for purposes of the state PBM provisions.

-Requires the Director to establish a dispensing fee to be paid to the pharmacy for dispensing prescribed drugs.

-Requires the Director to determine the state PBM's payment rate, and require that payments for claims adjudication must be made by a Medicaid MCO, while payment for other administrative services, such as formulary management and prescription drug supplemental rebate agreement negotiation, must be made directly from the Department to the state PBM.

-Requires all payment arrangements between the Department, Medicaid MCOs, and the state PBM to comply with state and federal statutes and regulations, and any other agreement between the Department and the Centers for Medicare and Medicaid Services (CMS).

-Permits the Director to change a payment arrangement in order to comply with state or federal statutes or regulations or other agreement between the Department and CMS.

Appeals process for prescription drugs maximum allowable cost

R.C. 5167.245 (renumbered and new enact) and 5167.246 (renumbered)

-Requires the Medicaid Director to establish an appeals process that pharmacies can use to bring to the Department of Medicaid disputes about the maximum allowable cost set by the state pharmacy benefit manager for a prescription drug.

-Requires pharmacies that participate in the care management system to use the appeals process to resolve maximum allowable cost disputes.

Medicaid PBM prescribed drugs data disclosure

R.C. 5167.124

Modifies Senate-added provisions relating to PBM cost disclosures as follows:

-Specifies that the state PBM must comply with the cost disclosures, instead of a PBM under contract with a Medicaid MCO;

-Removes the requirement that a PBM under contract with a Medicaid MCO annually contract with an independent third party to conduct a Service Organization Controls Report (SOC-1) audit and disclose that report to the Medicaid MCO.

-Removes the requirement that the contracted PBM and Medicaid MCO cooperate with any other compliance audits of the PBM.

-Removes the authority of the Medicaid Director to, in the event of violations of the provisions about PBM cost disclosures, impose a financial penalty on a Medicaid MCO as permitted in the MCO contract and recommend to the Superintendent of Insurance that the PBM's administrator license be suspended.

Re-procurement of Medicaid managed care organizations

Section 333.230

Restores a House-added provision that, by July 1, 2020, requires the Medicaid Director to re-procure its contracts with Medicaid managed care organizations.

Review prescribed drug reforms savings

Section 333.240

Restores a House-added provision that requires the Department to review all of the savings to the state from the bill's prescribed drug reforms and issue a report.

Care management single preferred drug list

R.C. 5167.122

Removes Senate-added provisions that would have:

-Required the Department of Medicaid to establish a single preferred drug list for the care management system and required Medicaid managed care organizations (MCOs) and their contracted pharmacy benefit managers (PBMs) to follow the list.

-Required the list to do certain things, including ease the administrative burden for prescribers, reduce confusion and the burden on the Medicaid recipients, and ensure that prescribed drug rebates are sent directly to the Department instead of to a Medicaid MCO or its PBM.

Specialty pharmacies

R.C. 5167.123

Removes Senate-added provisions that would have required, beginning January 1, 2020, a Medicaid MCO to contract with a specialty pharmacy as a participating provider if the pharmacy (1) meets the Medicaid MCO's standards for participating providers,

(2) can provide pharmacy services at the same or lower cost than other participating provider specialty pharmacies, and (3) seeks to be a participating provider.

340B Drug Pricing Program compliance report

Section 333.260 (removed from bill)

Removes a Senate-added provision that would have required the Medicaid Director, not later than January 1, 2021, to submit the report to the General Assembly detailing the processes and methods employed by the Department that:

-Ensure that utilization data used to invoice prescribed drug manufacturers does not include data on claims representing drugs purchased under the 340B Drug Pricing Program;

-Identify a Medicaid provider that is a 340B covered entity and any pharmacy that has a contract to dispense on that provider's behalf drugs purchased under the 340B Drug Pricing Program.

Prescription Drug Transparency and Affordability Advisory Council

R.C. 125.95

Adds new provisions as follows:

-Creates within the Department of Administrative Services the Prescription Drug Transparency and Affordability Advisory Council consisting of 14 individuals from specified state agency directors and individuals who are presently working to address prescription drug availability and affordability.

-Requires the advisory council to submit a written report including recommendations on prescription drug issues, including (1) ways to increase prescription drug price transparency, (2)

leveraging Ohio's purchasing power for the drugs, (3) creating efficiencies across different health care delivery systems, and (4) identifying how federal, state, and local resources can be better used to improve health outcomes for Ohioans.

-Requires the report to be submitted to the Governor, the General Assembly, and the chairperson of the Joint Medicaid Oversight Committee not later than six months after initial appointments have been made.

-Provides that after submitting the report, the advisory council must meet not less than quarterly to provide assistance and guidance relating to the recommendations in the report.

Prescribed drug claims processing pilot program

Section 333.___

Adds new provisions as follows:

-Requires the Department of Medicaid to establish a pilot program for pre-audit processing of Medicaid managed care organization (MCO) and pharmacy benefit manager prescribed drug claims.

-Provides that in order for a claim to be processed under the program, the prescription must be filled in a county in southeastern Ohio and the dispensing pharmacy must serve a significant share of Medicaid patients in the county.

-Requires the Department under the program to approve claims processors and ensure that claims are adjudicated by approved claims processors that submit claims information to the Department for review.

-Requires the pilot program to be fully operational by January 1, 2020, and conclude on December 31, 2020.

-At the conclusion of the program, requires the Department to evaluate and review certain data relating to each prescribed drug claim.

-Requires the Department, not later than September 1, 2021, to submit a report to the Governor, Speaker of the House, Senate President, and Chairperson of the Joint Medicaid Oversight Committee.

-Specifies that the report must include any cost savings trends and utilization rates under the program and any policy recommendations, including whether to reinstate the program.

Department of Medicaid

Section 333.10

Increases GRF appropriation item 651525, Medicaid Health Care Services, by $500,000 state share in FY 2020 and requires funds to be used to support the Prescribed Drug Claims Processing Pilot Program.