AN ACT relating to pharmacy benefits in the Medicaid program.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) (a) Notwithstanding KRS 205.647 or any other state law, and except as provided pursuant to subsection (6) of this section, after the effective date of this Act the Department for Medicaid Services shall directly administer all outpatient pharmacy benefits for all Medicaid members.

(b) For the purposes of this section, "directly administer" includes a requirement that the Department for Medicaid Services by administrative regulation shall create an outpatient pharmacy benefits program that includes:

1. A formulary;

2. Reimbursement methodologies that may include the maximum allowable cost as defined in KRS 304.17A-161(3) for drugs dispensed for outpatient services for managed care; and

3. A dispensing fee as provided in subsection (2) of this section;

that shall be used by any third-party administrator performing services on behalf of the Department for Medicaid Services pursuant to this section.

(2) The Department for Medicaid Services shall promulgate an administrative regulation establishing reasonable dispensing fees pursuant to guidance or guidelines from the federal Centers for Medicare and Medicaid Services.

(3) (a) The Department for Medicaid Services may contract with a third party on a fee-for-service reimbursement model for the purpose of administration of pharmacy benefits; however, these services shall be approved by the department. The Department for Medicaid Services shall ensure coordination of care between the third-party administrator or the outpatient

pharmacy benefits program and managed care organizations as a consideration in any contracts established pursuant to this section. Any managed care techniques, principles, or administration of benefits utilized pursuant to this subsection shall comply with Kentucky law.

(b) The following shall apply to contracts between entities contracting relating to third-party administrators and pharmacies:

1. The Department for Medicaid Services shall approve any contract between a third-party administrator and a pharmacy;

2. A third-party administrator shall not change the terms of a contract between a third-party administrator and a pharmacy without written approval by the Department for Medicaid Services; and

3. A third-party administrator shall not create, modify, implement, or indirectly establish any fee on a pharmacy, pharmacist, or a Medicaid recipient without written approval by the Department for Medicaid Services.

(4) A contract to provide managed care shall not be renewed or negotiated if it provides for the administration of outpatient pharmacy benefits for Medicaid members by an entity other than the Department for Medicaid Services, except as provided pursuant to subsections (3) and (6) of this section.

(5) All Medicaid managed care contracts with Medicaid managed care organizations or pharmacy benefit managers that are entered into or negotiated after the effective date of this Act shall be reduced in amount by at least the cost of all outpatient pharmacy benefits, except those benefits described pursuant to subsection (6) of this Act, within the contract or master agreement to administer the Medicaid program that was in operation as of January 1, 2017.

(6) The provisions of this section shall not apply to outpatient pharmacy services provided by a health care facility registered as a covered entity pursuant to 42

U.S.C. sec. 256b or any pharmacy owned by or contracted with the covered entity. A Medicaid managed care organization, either directly or through a pharmacy benefit manager, shall administer and reimburse outpatient pharmacy claims submitted by a health care facility registered as a covered entity pursuant to 42 U.S.C. sec. 256b, its owned pharmacies and contracted pharmacies in accordance with the contractual agreements the Medicaid managed care organization or its pharmacy benefit manager has with such facilities and pharmacies. A Medicaid managed care organization or its pharmacy benefit manager shall not exclude any health care facility registered as a covered entity pursuant to 42 U.S.C. sec. 256b from its pharmacy network.

(7) On at least an annual basis, the Medicaid commissioner shall update the Interim Joint Committee on Health and Welfare and Family Services and the Interim Joint Committee on Banking and Insurance, relating to any contract, contract issues, formulary, dispensing fees, and maximum allowable cost concerns regarding a third-party administrator and managed care.

➔Section 2. KRS 205.647 is amended to read as follows:

(1) As used in this section, "pharmacy benefit manager" has the same meaning as in KRS 304.9-020.

(2) A pharmacy benefit manager contracted with a managed care organization that provides Medicaid benefits pursuant to this chapter shall comply with the provisions of this section and KRS 304.9-053, 304.9-054, 304.9-055, and 304.17A-162.

(3) KRS 304.17A-162(10), (11), (12), and (13) shall not apply to a pharmacy benefit manager contracted directly with the cabinet to provide Medicaid benefits.

(4) A pharmacy benefit manager shall notify the cabinet in writing of any activity, policy, or practice of the pharmacy benefit manager that directly or indirectly presents a conflict of interest that interferes with the discharge of the pharmacy

benefit manager's duty to a managed care organization to exercise its contractual duties.

(5) A pharmacy benefit manager shall, upon request, disclose to the cabinet the following information:

(a) Whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a pharmaceutical manufacturer to exclusively dispense or provide a drug to a managed care organization's enrollees, and the application of all consideration or economic benefits collected or received pursuant to that arrangement;

(b) The percentage of claims payments made by the pharmacy benefit manager to pharmacies owned, managed, or controlled by the pharmacy benefit manager, or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company for the previous year;

(c) The aggregate amount of the fees or assessments imposed on, or collected from, pharmacy providers; and

(d) The average annualized percentage of revenue collected by the pharmacy benefit manager as a result of each contract it has executed with a managed care organization contracted by the cabinet to provide Medicaid benefits which is not paid by the pharmacy benefit manager to pharmacy providers and pharmaceutical manufacturers or labelers, or in order to perform administrative functions pursuant to its contracts with managed care organizations.

(6) The information disclosed pursuant to subsection (5) of this section shall include all retail, mail order, specialty, and compounded prescription products. This information shall be excluded from the application of KRS 61.870 to 61.884 in

accordance with KRS 61.878(1)(c).

(7) A pharmacy benefit manager shall disclose directly in writing to a pharmacy provider contracting with the pharmacy benefit manager of any material change to a contract provision that affects the terms of the reimbursement, the process for verifying benefits and eligibility, dispute resolution, procedures for verifying drugs included on the formulary, and contract termination at least thirty (30) days prior to the date of the change to the provision.

(8) A pharmacy benefit manager shall not include the following in a contract with a pharmacy provider:

(a) A provision prohibiting the provider from informing a patient of a less costly alternative to a prescribed medication; or

(b) A provision that prohibits the provider from dispensing a particular amount of a prescribed medication, if the pharmacy benefit manager allows that amount to be dispensed through a pharmacy owned or controlled by the pharmacy benefit manager, unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration, or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(9) Nothing in this section shall be construed to prohibit a pharmacy benefit manager from requiring the same reimbursement and terms and conditions for a pharmacy provider as for a pharmacy owned, controlled, or otherwise associated with the pharmacy benefit manager.

(10) A pharmacy benefit manager shall establish and implement a process for the resolution of disputes arising out of this section, which shall be approved by the cabinet.

➔Section 3. Section 1 of this Act takes effect January 1, 2019.