

STATE OF NEW YORK

700

2017-2018 Regular Sessions

IN ASSEMBLY

January 9, 2017

Introduced by M. of A. RODRIGUEZ -- read once and referred to the Committee on Health

AN ACT to amend the social services law and the public health law, in relation to prescription drugs in Medicaid managed care programs; and to repeal certain provisions of the social services law, relating to payments for prescription drugs

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The social services law is amended by adding a new section 365-i to read as follows:

§ 365-i. Prescription drugs in Medicaid managed care programs. 1. Definitions. As used in this section, unless the context clearly requires otherwise:

(a) "Article" means title eleven of article five of this chapter with respect to the medical assistance program, title eleven-D of article five of this chapter with respect to the family health plus program, and title one-A of article twenty-five of the public health law with respect to the child health insurance program.

(b) "Clinical drug review program" means the clinical drug review program under section two hundred seventy-four of the public health law.

(c) "Emergency condition" means a medical or behavioral condition as determined by the prescriber or pharmacist, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, and for which delay in beginning treatment prescribed by the patient's health care practitioner would result in:

(i) placing the health or safety of the person afflicted with such condition or other person or persons in serious jeopardy;

(ii) serious impairment to such person's bodily functions;

(iii) serious dysfunction of any bodily organ or part of such person;

(iv) serious disfigurement of such person; or

(v) severe discomfort.

(d) "Managed care provider" means a managed care provider under section three hundred sixty-four-j of this title, a managed long term care plan or other care coordination model under section forty-four

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [-] is old law to be omitted.

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1 hundred three-f of the public health law, a family health insurance plan
2 under section three hundred sixty-nine-ee of this article (family health
3 plus program), an approved organization under title one-A of article
4 twenty-five of the public health law (child health insurance program),
5 or any other entity that provides or arranges for the provision of
6 medical assistance services and supplies to participants directly or
7 indirectly (including by referral), including case management, including
8 the managed care provider's authorized agents.

9 (e) "Non-preferred drug" means a prescription drug that requires prior
10 authorization under the participant's managed care provider.

11 (f) "Participant" means a medical assistance recipient who receives,
12 is required to receive or elects to receive his or her medical assist-
13 ance services from a managed care provider.

14 (g) "Preferred drug" means a prescription drug that is not a non-pre-
15 ferred drug under the patient's managed care provider. "Preferred drug
16 list" means a list of a managed care provider's preferred drugs.

17 (h) "Preferred drug program" means the preferred drug program estab-
18 lished under section two hundred seventy-two of the public health law.

19 (i) "Prescriber" means a health care professional authorized to
20 prescribe prescription drugs for a participant of the managed care
21 provider, acting within his or her lawful scope of practice.

22 (j) "Prescription drug" or "drug" means a drug defined in subdivision
23 seven of section sixty-eight hundred two of the education law, for which
24 a prescription is required under the federal food, drug and cosmetic
25 act. Any drug that does not require a prescription under such act, but
26 which would otherwise be eligible for reimbursement under this article
27 when ordered by a prescriber and the prescription is subject to the
28 applicable provisions of this article and paragraph (a) of subdivision
29 four of section three hundred sixty-five-a of this title.

30 (k) "Prior authorization" means a process requiring the prescriber or
31 the dispenser to verify with the participant's managed care provider
32 that the drug is appropriate for the needs of the specific patient.

33 (l) "Qualified prescription drug system" or "system" means a process
34 under this section, approved by the commissioner, through which a
35 managed care provider approves payment for a non-preferred drug for a
36 participant based on prior authorization.

37 2. Payment for prescription drugs under capitation. (a) Payment for
38 prescription drugs shall be included in the capitation payments for
39 services or supplies provided to a managed care provider's participants,
40 provided that the managed care provider pays for prescription drugs
41 under a qualified prescription drug system. Every prescription drug
42 eligible for reimbursement under this article prescribed in relation to
43 a service provided by the managed care provider shall be either a
44 preferred or non-preferred drug under the qualified prescription drug
45 system. The commissioner shall approve a managed care provider's quali-
46 fied prescription drug system if it conforms to the provisions of this
47 section.

48 (b) If the managed care provider does not pay for prescription drugs
49 under a qualified prescription drug system, then payment for
50 prescription drugs for the managed care provider's patients shall not be
51 included in such capitation payments and prescription drugs shall be
52 provided for the managed care provider's participants under the
53 preferred drug program.

54 3. Qualified prescription drug system; criteria. (a) A qualified
55 prescription drug system shall promote access to the most effective
56 prescription drugs while reducing the cost of prescription drugs under

1 this article. This subdivision and subdivision four of this section
2 apply to qualified prescription drug systems.

3 (b) When a prescriber prescribes a non-preferred drug for a partic-
4 ipant, reimbursement may be denied unless prior authorization is
5 obtained, unless no prior authorization is required under this section.
6 When a prescriber prescribes a preferred drug for a participant, no
7 prior authorization shall be required for reimbursement, unless prior
8 authorization is required under the clinical drug review program.

9 (c) The commissioner shall establish performance standards for systems
10 that, at a minimum, ensure that systems provide sufficient technical
11 support and timely responses to consumers, prescribers and pharmacists.

12 (d) The commissioner shall adopt criteria for qualified prescription
13 drug systems after considering recommendations and comments received
14 from prescribers, pharmacists, participants, and organizations repres-
15 enting them.

16 (e) The managed care provider shall develop its preferred drug list
17 based initially on an evaluation of the clinical effectiveness, safety,
18 and patient outcomes, followed by consideration of the cost-effective-
19 ness of the drugs. In each therapeutic class, the managed care provider
20 shall determine whether there is one drug that is significantly more
21 clinically effective and safe, and that drug shall be included on the
22 preferred drug list without consideration of cost. If, among two or more
23 drugs in a therapeutic class, the difference in clinical effectiveness
24 and safety is not clinically significant, then cost-effectiveness may
25 also be considered in determining which drug or drugs shall be included
26 on the preferred drug list.

27 4. Prior authorization. (a) A qualified prescription drug system shall
28 make available a twenty-four hour per day, seven days per week telephone
29 call center that includes a tollfree telephone line and dedicated
30 facsimile line to respond to requests for prior authorization. The call
31 center shall include qualified health care professionals who shall be
32 available to consult with prescribers concerning prescription drugs that
33 are non-preferred drugs. A prescriber seeking prior authorization shall
34 consult with the program call line to reasonably present his or her
35 justification for the prescription and give the program's qualified
36 health care professional a reasonable opportunity to respond.

37 (b) When a patient's health care provider prescribes a non-preferred
38 drug, the prescriber shall consult with the system to confirm that in
39 his or her reasonable professional judgment, the patient's clinical
40 condition is consistent with the criteria for approval of the non-pre-
41 ferred drug. Such criteria shall include:

42 (i) the preferred drug has been tried by the patient and has failed to
43 produce the desired health outcomes;

44 (ii) the patient has tried the preferred drug and has experienced
45 unacceptable side effects;

46 (iii) the patient has been stabilized on a non-preferred drug and
47 transition to the preferred drug would be medically contraindicated; or

48 (iv) other clinical indications identified by the commissioner or the
49 managed care provider for the patient's use of the non-preferred drug,
50 which shall include consideration of the medical needs of special popu-
51 lations, including children, elderly, chronically ill, persons with
52 mental health conditions, and persons affected by HIV/AIDS or Hepatitis
53 C.

54 (c) In the event that the patient does not meet the criteria in para-
55 graph (b) of this subdivision, the prescriber may provide additional
56 information to the managed care provider to justify the use of a non-

1 preferred drug. The system shall provide a reasonable opportunity for a
2 prescriber to reasonably present his or her justification of prior
3 authorization. If, after consultation with the managed care provider,
4 the prescriber, in his or her reasonable professional judgment, deter-
5 mines that the use of a non-preferred drug is warranted, the
6 prescriber's determination shall be final.

7 (d) If a prescriber meets the requirements of paragraph (b) or (c) of
8 this subdivision, the prescriber shall be granted prior authorization
9 under this section.

10 (e) In the instance where a prior authorization determination is not
11 completed within twenty-four hours of the original request, solely as
12 the result of a failure of the system (whether by action or inaction),
13 prior authorization shall be immediately and automatically granted with
14 no further action by the prescriber and the prescriber shall be notified
15 of this determination. In the instance where a prior authorization
16 determination is not completed within twenty-four hours of the original
17 request for any other reason, a seventy-two hour supply of the medica-
18 tion shall be approved by the system and the prescriber shall be noti-
19 fied of this determination.

20 (f) When, in the judgment of the prescriber or the pharmacist, an
21 emergency condition exists, and the prescriber or pharmacist notifies
22 the managed care provider that an emergency condition exists, a seven-
23 ty-two hour emergency supply of the drug prescribed shall be immediately
24 authorized by the managed care provider.

25 (g) In the event that a patient presents a prescription to a pharma-
26 cist for a prescription drug that is a non-preferred drug and for which
27 the prescriber has not obtained a prior authorization, the pharmacist
28 shall, within a prompt period based on professional judgment, notify the
29 prescriber. The prescriber shall, within a prompt period based on
30 professional judgment, either seek prior authorization or shall contact
31 the pharmacist and amend or cancel the prescription. The pharmacist
32 shall, within a prompt period based on professional judgment, notify the
33 patient when prior authorization has been obtained or denied or when the
34 prescription has been amended or cancelled.

35 (h) Once prior authorization of a prescription for a drug that is not
36 on the preferred drug list is obtained, prior authorization shall not be
37 required for any refill of the prescription.

38 (i) No prior authorization under a qualified prescription drug system
39 shall be required for: (i) atypical anti-psychotics; (ii) anti-depres-
40 sants; (iii) anti-retrovirals used in the treatment of HIV/AIDS or Hepa-
41 titis C; (iv) anti-rejection drugs used in the treatment of organ and
42 tissue transplants; and (v) any other therapeutic class for the treat-
43 ment of mental illness, HIV/AIDS or Hepatitis C, approved by the commis-
44 sioner.

45 5. Clinical drug review program. In the case of a drug for which prior
46 authorization is required under the clinical drug review program, prior
47 authorization shall be obtained under the clinical drug review program
48 and not under this section.

49 6. Prescriber conduct. The managed care provider and the department
50 shall monitor the prior authorization process under a qualified
51 prescription drug system for prescribing patterns which are suspected of
52 endangering the health and safety of the patient or which demonstrate a
53 likelihood of fraud or abuse. The managed care provider and the depart-
54 ment shall take any and all actions otherwise permitted by law to inves-
55 tigate such prescribing patterns, to take remedial action and to enforce
56 applicable federal and state laws.

1 7. Use of preferred drug program. The commissioner may contract with a
2 managed care provider for the provider to use the preferred drug program
3 to provide prior authorization under the managed care provider's quali-
4 fied prescription drug system. The contract shall include terms required
5 by the commissioner to maximize savings to the Medicaid program and
6 protect the health and interests of the managed care provider's partic-
7 ipants. The contract shall provide whether the preferred drug program
8 shall use the managed care provider's lists of preferred and non-pre-
9 ferred drugs or the preferred drug list under the preferred drug
10 program, with respect to whether prior authorization is required.

11 § 2. Subdivisions 25 and 25-a of section 364-j of the social services
12 law are REPEALED.

13 § 3. Section 2511 of the public health law is amended by adding a new
14 subdivision 22 to read as follows:

15 22. Payment for prescription drugs. Payment for prescription drugs
16 shall be included in the payments for services or supplies provided by
17 the approved organization, provided that the plan pays for prescription
18 drugs under a qualified prescription drug system under section three
19 hundred sixty-five-i of the social services law. Every prescription drug
20 eligible for reimbursement under this article prescribed in relation to
21 a service provided by the approved organization shall be either a
22 preferred or non-preferred drug under the qualified prescription drug
23 system. If the approved organization does not pay for prescription drugs
24 under a qualified prescription drug system, then payment for
25 prescription drugs for the approved organization's patients shall not be
26 included in such payments and prescription drugs shall be provided for
27 the approved organization's participants under the preferred drug
28 program.

29 § 4. Subdivision 11 of section 270 of the public health law, as
30 amended by section 2-a of part C of chapter 58 of the laws of 2008, is
31 amended to read as follows:

32 11. "State public health plan" means the medical assistance program
33 established by title eleven of article five of the social services law
34 (referred to in this article as "Medicaid"), the elderly pharmaceutical
35 insurance coverage program established by title three of article two of
36 the elder law (referred to in this article as "EPIC"), ~~[and]~~ the family
37 health plus program established by section three hundred sixty-nine-ee
38 of the social services law ~~[to the extent that section provides that the~~
39 ~~program shall be subject to this article]~~, and the child health insur-
40 ance program under title one-A of article twenty-five of this chapter.

41 § 5. Section 272 of the public health law is amended by adding a new
42 subdivision 12 to read as follows:

43 12. No prior authorization shall be required under the preferred drug
44 program for:

45 (a) atypical anti-psychotics; (b) anti-depressants; (c) anti-retrovi-
46 als used in the treatment of HIV/AIDS or Hepatitis C; (d) anti-rejec-
47 tion drugs used in the treatment of organ and tissue transplants; and
48 (e) any other therapeutic class for the treatment of mental illness,
49 HIV/AIDS or Hepatitis C, recommended by the board and approved by the
50 commissioner under this section.

51 § 6. This act shall take effect on the one hundred eightieth day after
52 it shall become a law; provided, however, that section two of this act
53 shall take effect one year after this act shall become a law; and
54 provided further, that the commissioner of health is immediately author-
55 ized and directed to take actions necessary to implement this act when
56 it takes effect.