HB1536

LRB10304823KTG49833b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB1536

Introduced 1/31/2023, by Rep. Hoan Huynh

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5.12 from Ch. 23, par. 5-5.12

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides the no appropriation may be expended to a managed care organization under contract with the Department of Healthcare and Family Services unless the managed care organization, and its pharmacy benefits manager, allows prescription drug benefits to be provided by specialty pharmacies that are certified in the Business Enterprise Program and accredited by at least 2 different accreditation entities for specialty pharmacy services on the same terms and conditions by any willing provider that is qualified for network participation and authorized to dispense prescription drugs. Prescription drug benefits include those that are managed both as a part of the overall healthcare benefits package, medical and pharmacy benefits that are integrated into one package through a managed care organization, and pharmacy benefits that are separately administered or subcontracted through a pharmacy benefits manager. Defines "specialty pharmacy". Effective July 1, 2023.

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A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Public Aid Code is amended by changing Section 5-5.12 as follows:

(305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

Sec. 5-5.12. Pharmacy payments.

(a) Every request submitted by a pharmacy for reimbursement under this Article for prescription drugs provided to a recipient of aid under this Article shall include the name of the prescriber or an acceptable identification number as established by the Department.

(b) Pharmacies providing prescription drugs under this Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall review utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors including the gender of the person taking the medication.

(f) The Department shall cooperate with the Department of Public Health and the Department of Human Services Division of Mental Health in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency (including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services Division of Mental Health in developing a protocol and criteria for deciding whether to

grant such prior approval.

(g) The Department may by rule provide for reimbursement of the dispensing of a 90-day supply of a generic or brand name, non-narcotic maintenance medication in circumstances where it is cost effective.

(g-5) On and after July 1, 2012, the Department may require the dispensing of drugs to nursing home residents be in a 7-day supply or other amount less than a 31-day supply. The Department shall pay only one dispensing fee per 31-day supply.

(h) Effective July 1, 2011, the Department shall discontinue coverage of select over-the-counter drugs, including analgesics and cough and cold and allergy medications.

(h-5) On and after July 1, 2012, the Department shall impose utilization controls, including, but not limited to, prior approval on specialty drugs, oncolytic drugs, drugs for the treatment of HIV or AIDS, immunosuppressant drugs, and biological products in order to maximize savings on these drugs. The Department may adjust payment methodologies for non-pharmacy billed drugs in order to incentivize the selection of lower-cost drugs. For drugs for the treatment of AIDS, the Department shall take into consideration the potential for non-adherence by certain populations, and shall develop protocols with organizations or providers primarily serving those with HIV/AIDS, as long as such measures intend

to maintain cost neutrality with other utilization management controls such as prior approval. For hemophilia, the Department shall develop a program of utilization review and control which may include, in the discretion of the Department, prior approvals. The Department may impose special standards on providers that dispense blood factors which shall include, in the discretion of the Department, staff training and education; patient outreach and education; case management; in-home patient assessments; assay management; maintenance of stock; emergency dispensing timeframes; data collection and reporting; dispensing of supplies related to blood factor infusions; cold chain management and packaging practices; care coordination; product recalls; and emergency clinical consultation. The Department may require patients to receive a comprehensive examination annually at an appropriate provider in order to be eligible to continue to receive blood factor.

(i) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(j) On and after July 1, 2012, the Department shall impose limitations on prescription drugs such that the Department shall not provide reimbursement for more than 4 prescriptions, including 3 brand name prescriptions, for distinct drugs in a

30-day period, unless prior approval is received for all prescriptions in excess of the 4-prescription limit. Drugs in the following therapeutic classes shall not be subject to prior approval as a result of the 4-prescription limit: immunosuppressant drugs, oncolytic drugs, anti-retroviral drugs, and, on or after July 1, 2014, antipsychotic drugs. On or after July 1, 2014, the Department may exempt children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program.

(k) No medication therapy management program implemented by the Department shall be contrary to the provisions of the Pharmacy Practice Act.

(l) Any provider enrolled with the Department that bills the Department for outpatient drugs and is eligible to enroll in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act may exclude fee-for-service Medicaid from their participation in that program, however, entities defined in Section 1905(l)(2)(B) of the Social Security Act are excluded from this requirement. This subsection does not apply to outpatient drugs billed to Medicaid managed care organizations.

(m) No appropriation may be expended to a managed care organization under contract with the Department unless the managed care organization, and its pharmacy benefits manager, allows prescription drug benefits to be provided by specialty pharmacies that are:

(1) certified in the Business Enterprise Program as defined in the Business Enterprise for Minorities, Women, and Persons with Disabilities Act; and

(2) accredited by at least 2 different accreditation entities for specialty pharmacy services,

on the same terms and conditions by any willing provider that is qualified for network participation and authorized to dispense prescription drugs. Prescription drug benefits include those that are managed both as a part of the overall healthcare benefits package, medical and pharmacy benefits that are integrated into one package through a managed care organization, and pharmacy benefits that are separately administered or subcontracted through a pharmacy benefits manager. As used in this subsection, "specialty pharmacy" means a licensed pharmacy in Illinois that solely or largely provides only medications that are oral, infusion, or injectable for individuals with serious health conditions requiring complex therapies that include, but are not limited to, the following: cancer, hepatitis C, rheumatoid arthritis, HIV/Aids, multiple sclerosis, cystic fibrosis, organ transplantation, human growth hormone deficiencies, and

bleeding disorders.

(Source: P.A. 102-558, eff. 8-20-21; 102-778, eff. 7-1-22.)

Section 99. Effective date. This Act takes effect July 1, 2023.