SENATE BILL NO. 374–SENATOR SCHNEIDER

MARCH 17, 2003

Referred to Committee on Human Resources and Facilities

SUMMARY—Makes various changes concerning coverage of prescription drugs by Medicaid fee-for-service program. (BDR 38-764)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

~

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to public welfare; prohibiting a Medicaid fee-for-service program that provides coverage for prescription drugs from taking certain actions concerning the provision or coverage of prescription drugs; requiring the Department of Human Resources to submit a biennial report to the Legislature concerning the provision of coverage for prescription drugs by a Medicaid fee-for-service program; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

**Section 1.** Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

**Sec. 2.** ***1. To the extent permitted by federal law, a Medicaid fee-for-service program established in the State of Nevada that provides coverage for prescription drugs may not request or require, directly or indirectly, a physician who treats patients receiving benefits pursuant to Medicaid to change a prescription for a drug that has previously been prescribed to and used by a recipient of Medicaid for a specific condition to a prescription for another drug based primarily on economic***

*considerations as a condition of the recipient of Medicaid receiving:*

*(a) Coverage for the prescription drug;*

*(b) A favorable cost-sharing arrangement for the prescription drug; or*

*(c) A prompt refill or renewal of a prescription for the prescription drug.*

*2. If a recipient of Medicaid files an action against the Department for a violation of the provisions of this section and the court finds that the Medicaid fee-for-service program acted with disregard for the views of a physician treating the recipient in violating the provisions of this section, the recipient may:*

*(a) Obtain compensation of up to $100,000 as liquidated damages; and*

*(b) Recover all reasonable costs and expenses incurred in the action, including the cost of expert witnesses, court fees and attorney's fees.*

**Sec. 3.** *1. A Medicaid fee-for-service program established in the State of Nevada that provides coverage for prescription drugs shall not use a management technique for the care of patients receiving prescription drugs pursuant to the program unless the program assures that the clinical foundation of the management technique is consistent with the provisions of quality patient care. For the purposes of this section, a "management technique for the care of patients receiving prescription drugs" includes, without limitation, the use of a formulary, a preferred drug list, treatment protocols or guidelines, or step therapy, or the requirement of prior authorization for prescription drugs.*

*2. The assurance required pursuant to subsection 1 must include, without limitation:*

*(a) Evidence of a clinically based definition for each therapeutic class of prescription drugs covered by the program;*

*(b) Reliance on scientific and clinical data in updating formularies, preferred drug lists, treatment protocols or guidelines, and step therapy requirements; and*

*(c) For any prescription drug that is included within a program that requires prior authorization, the use of a specific set of clinical criteria that specifies when that drug is authorized for coverage and that is made available to providers of health care who provide services to patients receiving benefits pursuant to the Medicaid fee-for-service program and to such patients.*

*3. If a recipient of Medicaid files an action against the Department for a denial of coverage for a prescription drug that is based on the use of a management technique in violation of the provisions of this section and the court finds that the Medicaid*

*fee-for-service program acted with disregard for the views of a physician treating the recipient in using the management technique the recipient may:*

*(a) Obtain compensation of up to $100,000 as liquidated damages; and*

*(b) Recover all reasonable costs and expenses incurred in the action, including the cost of expert witnesses, court fees and attorney's fees.*

**Sec. 4.** *1. Any program that requires prior authorization for a prescription drug within a Medicaid fee-for-service program established in the State of Nevada must:*

*(a) Provide for the receipt of requests for prior authorization 24 hours a day, 7 days a week, via telephone, facsimile or electronic transmission;*

*(b) Provide a response to a request for prior authorization:*

*(1) Within 10 minutes after the submission of the request, in a situation in which a physician treating the patient for whom authorization for the prescription drug is being requested indicates that a delay of care in the treatment of the patient exclusively to fulfill administrative requirements would be medically inappropriate;*

*(2) Within 4 hours after the submission of the request, in a situation in which the physician who prescribed the prescription drug for which authorization is being requested indicates that the prescription drug is for an acute condition; or*

*(3) Within 24 hours after the submission of the request, in a situation in which the physician who prescribed the prescription drug for which authorization is being requested indicates that the prescription drug is for a chronic or nonacute condition;*

*(c) Provide that in a situation described in subparagraph (1) or (2) of paragraph (b), if the program of prior authorization denies a request for prior authorization, the physician appeals that denial in a timely manner and a response to the appeal is not received within 24 hours after the initial request for prior authorization was made, the program of prior authorization will provide for the approval of:*

*(1) An initial course of therapy of the prescription drug for an acute condition; or*

*(2) A 7-day supply of the prescription drug for a chronic condition; and*

*(d) Not require prior authorization for the renewal or refill of a prescription for a prescription drug that is authorized by the same person who initially prescribed the prescription drug.*

*2. As used in this section:*

*(a) "Acute condition" means:*

*(1) A symptom, condition or disease that is expected to last two weeks or less; or*

*(2) A condition which requires prompt receipt of medication for pain, for the treatment of an infection or an exposure that requires antibiotics, or for symptoms which threaten the life of a person.*

*(b) "Chronic condition" means a symptom, condition or disease that is expected to last longer than two weeks.*

**Sec. 5.** *1. A Medicaid fee-for-service program established in the State of Nevada that provides coverage for prescription drugs shall not discriminate against recipients of Medicaid by using either a cost-sharing requirement that is based on an incentive to use a prescription drug or a tiered copayment for a prescription drug that is based solely on:*

*(a) The relative cost of the prescription drug;*

*(b) The form of dosage of the prescription drug;*

*(c) Technology relating to the prescription drug;*

*(d) The regulatory status of the prescription drug; or*

*(e) The status of the patent for the prescription drug.*

*2. Each cost-sharing requirement that is based on an incentive to use a prescription drug and each tiered copayment for a prescription drug used by a Medicaid fee-for-service program established in the State of Nevada for the provision of prescription drugs to recipients of Medicaid must be based on providing choices to recipients of Medicaid so that in making decisions concerning prescription drugs recipients can take cost into account without sacrificing the quality of care they receive pursuant to Medicaid, including, without limitation, cost-sharing requirements and tiered copayments that are based on providing choices in the form of a dosage and the substitution of a generic pharmaceutical drug, and choices related to the convenience of a product.*

*3. If a recipient of Medicaid files an action against the Department based on payments made over the previous 5 years by the recipient that were required by the Medicaid fee-for-service program in violation of the provisions of this section the recipient may, if the court finds that the Medicaid fee-for-service program required payments in violation of the provisions of this section:*

*(a) Obtain the difference between the payments actually made by the recipient and the payments the recipient would have been required to make if the Medicaid fee-for-service program did not require payments in violation of the provisions of this section, and interest on that difference;*

*(b) Obtain compensation for the discriminatory treatment in an amount the court determines is appropriate to deter the*

*Medicaid fee-for-service program from violating the provisions of this section in the future; and*

*(c) Recover all reasonable costs and expenses incurred in the action, including the cost of expert witnesses, court fees and attorney's fees.*

**Sec. 6.** *1. If a Medicaid fee-for-service program established in the State of Nevada that provides coverage for prescription drugs denies coverage for a prescription drug which was prescribed to a recipient of Medicaid for a medical condition which is covered under the Medicaid fee-for-service program, the recipient, or a provider of health care or other person acting on behalf of the recipient, may request a review of the decision to deny coverage before appealing to the Department in the manner set forth in NRS 422.276 to 422.279, inclusive. The Medicaid fee-for-service program must:*

*(a) Complete a review requested pursuant to this subsection within 4 weeks after the date on which the review was requested; and*

*(b) Notify the recipient or person acting on behalf of the recipient in writing of the results of its review within 7 days after it completes the review.*

*2. A recipient of Medicaid, or a provider of health care or other person acting on behalf of the recipient, may, pursuant to NRS 422.276 to 422.279, inclusive, appeal the results of a review conducted pursuant to subsection 1 to the Department if:*

*(a) The prescription drug is not excluded from the benefits available to the recipient and the person who prescribed the prescription drug to the recipient states that the denial of coverage for the recipient is a denial of medically necessary care; or*

*(b) The Medicaid fee-for-service program fails to comply with the requirements of paragraph (a) or (b) of subsection 1.*

*3. Until the time that an appeal filed pursuant to subsection 2 is final, the Medicaid fee-for-service program shall pay for the provision of the prescription drug for which coverage was denied to the recipient of Medicaid.*

*4. A recipient of Medicaid who succeeds in an appeal filed pursuant to subsection 2 may:*

*(a) If the court finds that the Medicaid fee-for-service program failed to pay for the provision of the prescription drug during the appeal as required pursuant to subsection 3, obtain payment retroactively for the provision of the prescription drug, and interest on the amount paid by the recipient for the prescription drug;*

*(b) If the court finds that the Medicaid fee-for-service program acted with disregard for the views of a physician treating the*

*recipient in denying coverage of the prescription drug, obtain compensation of up to $100,000 as liquidated damages; and*

*(c) Recover all reasonable costs and expenses incurred in the appeal, including the cost of expert witnesses, court fees and attorney's fees.*

**Sec. 7.** *1. In addition to any other remedy provided by law, a person aggrieved by a violation or threatened violation of the provisions of sections 2 to 6, inclusive, of this act may seek injunctive relief as provided by law.*

*2. If a person prevails in any proceeding to seek injunctive relief for a violation or threatened violation of the provisions of sections 2 to 6, inclusive, of this act, he may recover all reasonable costs and expenses incurred in the proceeding, including the cost of expert witnesses, court fees and attorney's fees.*

*3. A contractor, administrator or fiscal agent of the Medicaid fee-for-service program who is responsible for a violation which results in a person obtaining injunctive relief pursuant to this section is ineligible to provide services to recipients of the Medicaid fee-for-service program until one year after the date on which it establishes to the satisfaction of the court that the services it intends to provide to recipients of the Medicaid fee-for-service program will comply with sections 2 to 6, inclusive, of this act.*

**Sec. 8.** *1. If a Medicaid fee-for-service program violates the provisions of section 2, 3 or 4 of this act, a physician who treats patients receiving benefits pursuant to the program may bring an action against the Department for impermissibly interfering with the relationship between the physician and the patient.*

*2. In an action brought pursuant to subsection 1, if the court finds that the Medicaid fee-for-service program acted with intentional disregard for the views of the physician in treating the patient, the physician may:*

*(a) Obtain compensation in an amount the court determines is appropriate to deter the Medicaid fee-for-service program from violating the provisions of this section in the future; and*

*(b) Recover all reasonable costs and expenses incurred in the action, including the cost of expert witnesses, court fees and attorney's fees.*

**Sec. 9.** *1. The Department shall, on or before January 15 of each odd-numbered year, submit to the Director of the Legislative Counsel Bureau for transmittal to the Legislature a report concerning the provision of coverage for prescription drugs by any Medicaid fee-for-service program established in the State of Nevada which, for a significant number of prescription drugs, uses a formulary or preferred drug list, or requires prior*

***authorization for prescription drugs. The report must include, without limitation, information regarding:***

***(a) The direct cost of using the formulary or preferred drug list, or of requiring prior authorization, including, without limitation, any costs, fees and incentives paid to contractors or administrators;***

***(b) Any cost that is shifted to physicians who treat patients receiving benefits pursuant to Medicaid for the time spent in obtaining authorization for a prescription drug; and***

***(c) Any shifting of costs within the Department that are associated with the use of any formulary or preferred drug list or the requirement of obtaining prior authorization, including, without limitation, costs related to additional prescriptions, laboratory tests, visits to a physician, hospitalization and skilled nursing care.***

***2. The report required pursuant to this section must include a list of all therapeutic classes of prescription drugs that are included in a formulary or preferred drug list, or that require prior authorization.***

***3. The Department shall not contract with a person for the preparation of the report required pursuant to this section related to any person who develops or implements a formulary, a preferred drug list, or a program for prior authorization for the Medicaid fee-for-service program.***

**Sec. 10.** NRS 422.240 is hereby amended to read as follows:

422.240 1. Money to carry out the provisions of NRS 422.001 to 422.410, inclusive, ***and sections 2 to 9, inclusive, of this act*** and 422.580, including, without limitation, any federal money allotted to the State of Nevada pursuant to the program to provide Temporary Assistance for Needy Families and the Program for Child Care and Development, must be provided by appropriation by the Legislature from the State General Fund.

2. Disbursements for the purposes of NRS 422.001 to 422.410, inclusive, ***and sections 2 to 9, inclusive, of this act*** and 422.580 must be made upon claims duly filed, audited and allowed in the same manner as other money in the State Treasury is disbursed.

**Sec. 11.** This act becomes effective on July 1, 2003.

㉚