SENATE BILL NO. 177–SENATORS DONDERO LOOP, SPEARMAN; CANNIZZARO, FLORES, LANGE, NEAL, NGUYEN, OHRENSCHALL AND PAZINA

FEBRUARY 20, 2023

JOINT SPONSOR: ASSEMBLYWOMAN THOMAS

Referred to Committee on Health and Human Services

SUMMARY—Imposes requirements governing Medicaid coverage of certain antipsychotic or anticonvulsant drugs. (BDR 38-82)

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

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

AN ACT relating to Medicaid; requiring Medicaid and health maintenance organizations and other managed care organizations providing coverage to recipients of Medicaid to cover certain antipsychotic or anticonvulsant drugs under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to develop a list of preferred prescription drugs to be used for the Medicaid program. (NRS 422.4025) The policies of the Department currently provide for the coverage of any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid. (*Medicaid Services Manual* 1203.1(B)(1)(h)) **Section 1** of this bill codifies this requirement in law, and **sections 2 and 4** of this bill clarify that the requirement applies to health maintenance organizations and other managed care organizations providing coverage to recipients of Medicaid. **Section 3** of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of authority of a health maintenance organization that fails to comply with the requirement of **section 2** to cover any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid. The Commissioner would also be

authorized to take such action against other managed care organizations who fail to comply with the requirements of **section 4**. (NRS 680A.200)

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

Section 1. NRS 422.4025 is hereby amended to read as follows:

422.4025 1. The Department shall:

(a) By regulation, develop a list of preferred prescription drugs to be used for the Medicaid program and the Children's Health Insurance Program, and each public or nonprofit health benefit plan that elects to use the list of preferred prescription drugs as its formulary pursuant to NRS 287.012, 287.0433 or 687B.407; and

(b) Negotiate and enter into agreements to purchase the drugs included on the list of preferred prescription drugs on behalf of the health benefit plans described in paragraph (a) or enter into a contract pursuant to NRS 422.4053 with a pharmacy benefit manager, health maintenance organization or one or more public or private entities in this State, the District of Columbia or other states or territories of the United States, as appropriate, to negotiate such agreements.

2. The Department shall, by regulation, establish a list of prescription drugs which must be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs established pursuant to subsection 1. The list established pursuant to this subsection must include, without limitation:

(a) Prescription drugs that are prescribed for the treatment of the human immunodeficiency virus, including, without limitation, antiretroviral medications;

(b) Antirejection medications for organ transplants;

(c) Antihemophilic medications; and

(d) Any prescription drug which the Board identifies as appropriate for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs.

3. The regulations must provide that the Board makes the final determination of:

(a) Whether a class of therapeutic prescription drugs is included on the list of preferred prescription drugs and is excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs;

(b) Which therapeutically equivalent prescription drugs will be reviewed for inclusion on the list of preferred prescription drugs and

for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs; and

(c) Which prescription drugs should be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs based on continuity of care concerning a specific diagnosis, condition, class of therapeutic prescription drugs or medical specialty.

4. The list of preferred prescription drugs established pursuant to subsection 1 must include, without limitation:

(a) Any prescription drug determined by the Board to be essential for treating sickle cell disease and its variants; and

(b) Prescription drugs to prevent the acquisition of human immunodeficiency virus.

5. The regulations must provide that each new pharmaceutical product and each existing pharmaceutical product for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs must be made available pursuant to the Medicaid program with prior authorization until the Board reviews the product or the evidence.

6. ***The Medicaid program must automatically cover any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid.***

7. On or before February 1 of each year, the Department shall:

(a) Compile a report concerning the agreements negotiated pursuant to paragraph (b) of subsection 1 and contracts entered into pursuant to NRS 422.4053 which must include, without limitation, the financial effects of obtaining prescription drugs through those agreements and contracts, in total and aggregated separately for agreements negotiated by the Department, contracts with a pharmacy benefit manager, contracts with a health maintenance organization and contracts with public and private entities from this State, the District of Columbia and other states and territories of the United States; and

(b) Post the report on an Internet website maintained by the Department and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In odd-numbered years, the Legislature; or

(2) In even-numbered years, the Legislative Commission.

Sec. 2. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

A health maintenance organization that provides health care services to recipients of Medicaid under the State Plan for

Medicaid pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall automatically cover any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs developed pursuant to NRS 422.4025 upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid.

Sec. 3. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 2 of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 4. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

A managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services shall automatically cover any typical or atypical antipsychotic medication or anticonvulsant medication that is not on the list of preferred prescription drugs developed pursuant to NRS 422.4025 upon the demonstrated therapeutic failure of one drug on that list to adequately treat the condition of a recipient of Medicaid.

Sec. 5. This act becomes effective on July 1, 2023.