SENATE BILL NO. 118–SENATOR STONE

PREFILED JANUARY 27, 2025

Referred to Committee on Health and Human Services

SUMMARY—Revises requirements relating to coverage under Medicaid for certain services provided by pharmacists. (BDR 38-218)

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 to include coverage for certain services provided by a pharmacist; imposing requirements relating to the rate of reimbursement that a pharmacist must receive for services covered under Medicaid; prohibiting Medicaid or a managed care organization that provides health care services to recipients of Medicaid from requiring prior authorization for the services of a pharmacist 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 administer Medicaid. (NRS 422.270) **Section 1** of this bill requires the Director of the Department to include under Medicaid: (1) coverage for services provided by a pharmacist within his or her scope of practice if such services are covered when performed by another provider of health care; and (2) reimbursement for such services at an amount equal to or greater than the amount reimbursed to a physician, physician assistant or advanced practice registered nurse for similar services. **Sections 1 and 5** of this bill prohibit Medicaid or a managed care organization that provides health care services to recipients of Medicaid from requiring prior authorization for such a service if prior authorization is not required when the service is performed by another provider of health care. **Sections 2, 3 and 6** of this bill remove requirements related to coverage under Medicaid for specific services provided by pharmacists because **section 1** would provide for the coverage of such services. **Section 4** of this bill makes a conforming change to indicate that the provisions of **section 1** will be administered in the same manner as other provisions of existing law governing Medicaid.

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 a new section to read as follows:

1. To the extent that federal financial participation is available, the Director shall include under Medicaid coverage for services provided by a pharmacist that are:

(a) Within the authorized scope of practice of the pharmacist; and

(b) Covered when provided by another provider of health care.

2. Medicaid must not limit:

(a) Coverage for services provided by a pharmacist to a number of occasions less than for such services when provided by another provider of health care.

(b) Reimbursement for services provided by a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

3. Medicaid or a managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid shall not require a recipient of Medicaid to obtain prior authorization for any service provided by a pharmacist that is not required for the service when provided by another provider of health care.

4. As used in this section:

(a) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(b) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 2. NRS 422.27172 is hereby amended to read as follows:

422.27172 1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

(d) Insertion or removal of a device for contraception, including, without limitation, the insertion of such a device at a hospital immediately after a person gives birth;

(e) A contraceptive injection, including, without limitation, such an injection immediately after a person gives birth.

(f) Education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use;

(g) Management of side effects relating to contraception; and

(h) Voluntary sterilization for women.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. The Director shall ensure that the provisions of this section are carried out in a manner which complies with the requirements established by the Drug Use Review Board and set forth in the list of preferred prescription drugs established by the Department pursuant to NRS 422.4025.

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

5. For each method of contraception which is approved by the Food and Drug Administration, the Plan must include at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the person enrolled in Medicaid, but the Plan may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception. If the Plan requires a person enrolled in Medicaid to pay a copayment or coinsurance for a drug for contraception, the Plan may only require the person to pay the copayment or coinsurance:

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

6. ~~[The Plan must provide for the reimbursement of a pharmacist for providing services described in subsection 1 that are within the scope of practice of the pharmacist to the same extent as if the services were provided by another provider of health care. The Plan must not limit:~~

~~(a) Coverage for such services provided by a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.~~

~~(b) Reimbursement for such services provided by a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.~~

~~7.~~**]** The Plan must not require a recipient of Medicaid to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

[~~8.~~**]** ***7.*** As used in this section:

(a) "Drug Use Review Board" has the meaning ascribed to it in NRS 422.402.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(c) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 3. NRS 422.27235 is hereby amended to read as follows:

422.27235 1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Any laboratory testing that is necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus.

(b) ~~**[**The services of a pharmacist described in NRS 639.28085. The State must provide reimbursement for such services at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.~~

~~(c)~~**]** Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. The Director shall include in the State Plan for Medicaid a requirement that the State reimburse an advanced practice registered nurse or a physician assistant for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. As used in this section, "primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

Sec. 4. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 1 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 5. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437, 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177 ~~[,]~~ ***and section 1 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 6. NRS 422.27237 is hereby repealed.

Sec. 7. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 6, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act;

(b) On January 1, 2026, for all other purposes.

TEXT OF REPEALED SECTION

422.27237 State Plan for Medicaid: Inclusion of requirement for payment of certain costs for services of pharmacist; rate of reimbursement.

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for the services of a pharmacist described in NRS 639.28079.

2. The State must provide reimbursement for the services of a pharmacist described in NRS 639.28079 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.