SENATE BILL NO. 149–SENATOR STONE

PREFILED JANUARY 30, 2025

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions governing the administration of pharmacy benefits under Medicaid. (BDR 38-224)

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 the Department of Health and Human Services to select and contract with a state pharmacy benefit manager to manage pharmacy benefits for Medicaid and certain other health benefit plans; prescribing certain duties of the state pharmacy benefit manager; requiring that the Department approve certain contracts entered into by the state pharmacy benefit manager; prohibiting the state pharmacy benefit manager from engaging in certain activities; providing monetary penalties for certain violations; requiring a Medicaid managed care organization to contract with and utilize the state pharmacy benefit manager to manage pharmacy benefits; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Department of Health and Human Services to enter into a contract with a pharmacy benefit manager or a health maintenance organization to manage coverage of prescription drugs under the State Plan for Medicaid, the Children's Health Insurance Program and certain other health benefit plans that elect to use the list of preferred prescription drugs established for Medicaid as their formulary. (NRS 422.4025, 422.4053)

Section 13 of this bill instead requires the Department to enter into a contract with one pharmacy benefit manager, known as the state pharmacy benefit manager, to manage all such coverage of prescription drugs. **Sections 13 and 14** of this bill prescribe certain required terms of such a contract. **Section 4** of this bill prescribes the required contents of an application to serve as the state pharmacy benefit manager. **Section 5** of this bill requires the Department to adopt regulations establishing: (1) the criteria that a pharmacy benefit manager must meet in order to

serve as the state pharmacy benefit manager; and (2) certain requirements relating to the payment of pharmacies for services rendered under the contract between the Department and the state pharmacy benefit manager. **Section 9** of this bill requires a Medicaid managed care organization to contract with and utilize the state pharmacy benefit manager to administer all pharmacy benefits for recipients of Medicaid who receive such benefits through the Medicaid managed care organization.

Section 6 of this bill requires that the Department approve any contract between the state pharmacy benefit manager and a pharmacy or an entity that contracts on behalf of a pharmacy if the contract is for the provision of benefits under the contract between the state pharmacy benefit manager and the Department, or any revision, suspension or termination of such a contract, in order for the contract, revision, suspension or termination to become effective. **Section 6** also authorizes the Department to change certain payment arrangements as necessary to comply with federal requirements. Finally, **section 6** prohibits the state pharmacy benefit manager from entering into, renewing or amending a contract that conflicts with the obligations of the state pharmacy benefit manager under the provisions of this bill. **Section 7** of this bill: (1) prohibits the state pharmacy benefit manager from taking certain actions to avoid paying reimbursement owed to pharmacies; and (2) authorizes the Department to impose a monetary penalty on the state pharmacy benefit manager for violating that prohibition.

Sections 2 and 3 of this bill define certain terms, and **section 8** of this bill establishes the applicability of those definitions. **Section 10** of this bill applies certain other definitions in existing law to **sections 4-7**. **Sections 11, 12 and 15** of this bill make conforming changes to transfer certain duties to the state pharmacy benefit manager and revise certain references in accordance with the provisions of this bill.

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 7, inclusive, of this act.

Sec. 2. ***"Medicaid managed care organization" means a health maintenance organization with which the Department enters into a contract pursuant to NRS 422.273 to provide health care services through managed care to recipients of Medicaid.***

Sec. 3. ***"State pharmacy benefit manager" means the pharmacy benefit manager that enters into a contract with the Department pursuant to NRS 422.4053.***

Sec. 4. ***1. A pharmacy benefit manager that meets the eligibility requirements established pursuant to section 5 of this act may apply to become the state pharmacy benefit manager by submitting an application to the Department on a form prescribed by the Department. The application must include, without limitation:***

(a) Any activity, policy, practice, contract or agreement of the applicant that may directly or indirectly present a conflict of

interest in the relationship between the applicant and the Department or a Medicaid managed care organization, including, without limitation, any such activity, policy, practice, contract or agreement that operates solely or partially outside this State;

(b) Any direct or indirect fees, charges or assessments that the applicant imposes on any pharmacy in this State:

(1) With which the applicant shares common ownership, management or control;

(2) Which is owned, managed or controlled by any management, parent or subsidiary of the applicant, any company jointly held by the applicant or any company otherwise affiliated with the applicant by a common owner, manager or holding company;

(3) For which the board of directors of the pharmacy shares any members in common with the board of directors of the applicant; or

(4) Which shares any manager in common with the applicant;

(c) Any direct or indirect fees, charges or assessments that the applicant imposes on pharmacies and pharmacists in this State; and

(d) All common ownership, common management, common members of a board of directors, shared managers or shared control between:

(1) The applicant, or any management, parent, subsidiary or jointly held company of the applicant or any company otherwise affiliated by a common owner, manager or holding company with the applicant; and

(2) Any of the following entities:

(I) A managed care organization or a company affiliated with a managed care organization;

(II) A pharmacy services administrative organization, any other entity that contracts on behalf of a pharmacy or any company affiliated with a pharmacy services administrative organization or such an entity;

(III) A wholesaler, as defined in NRS 639.016, or any company affiliated with a wholesaler;

(IV) A third party or any company affiliated with a third party; and

(V) A pharmacy or any company affiliated with a pharmacy.

2. As used in this section, "third party" means any insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 5. ***1. The Department shall adopt regulations establishing:***

(a) The criteria that a pharmacy benefit manager must meet in order to be eligible to enter into a contract with the Department pursuant to NRS 422.4053 to serve as the state pharmacy benefit manager.

(b) The methodology for reimbursement to the pharmacies for providing benefits under the contract entered into pursuant to NRS 422.4053. The methodology for reimbursement must not discriminate against pharmacies owned or contracted by a health care facility that is registered as a covered entity pursuant to 42 U.S.C. § 256b, except where required by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(c) Dispensing fees paid to pharmacies and pharmacists for providing benefits under the contract entered into pursuant to NRS 422.4053. In establishing those dispensing fees, the Department may consider applicable guidance promulgated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

2. To the extent authorized by federal law, the dispensing fees established pursuant to paragraph (c) of subsection 1 may vary by pharmacy type, including, without limitation, rural and independently owned pharmacies, pharmacies owned by a corporation operating in multiple states and pharmacies owned and contracted by a health care facility that is registered as a covered entity pursuant to 42 U.S.C. § 256b.

Sec. 6. ***1. The state pharmacy benefit manager shall submit to the Department for review:***

(a) Each contract for the provision of benefits under the contract entered into pursuant to NRS 422.4053 between the state pharmacy benefit manager and a pharmacy or an entity that contracts on behalf of such a pharmacy;

(b) Each revision to the terms and conditions of a contract described in paragraph (a); and

(c) Each suspension or termination of a contract described in paragraph (a).

2. The Department shall review each submission received pursuant to subsection 1 and approve or deny the contract, revision, suspension or termination, as applicable. A contract, revision, suspension or termination is not effective until the contract, revision, suspension or termination, as applicable, is approved by the Department.

3. The Department may change a payment arrangement between the Department and a Medicaid managed care

organization, the Department and the state pharmacy benefit manager or a Medicaid managed care organization and the state pharmacy benefit manager in order to comply with federal or state law or regulations or any other agreement between the Department and the Federal Government.

4. The state pharmacy benefit manager shall not enter into, renew or amend any contract that is inconsistent with:

(a) The terms and conditions of the contract between the state pharmacy benefit manager and the Department; or

(b) The reimbursement methodologies and dispensing fees established by the Department pursuant to subsection 1 of section 5 of this act.

5. Any contract entered into by the state pharmacy benefit manager in violation of subsection 4 is void and unenforceable.

Sec. 7. ***1. In the course of providing benefits under the contract entered into pursuant to NRS 422.4053, the state pharmacy benefit manager:***

(a) Shall not enter into a contract with a pharmacy that authorizes the release of the state pharmacy benefit manager from any payment owed to the pharmacy or remove the pharmacy from a network after the pharmacy has rendered services;

(b) Must not be released from an obligation to make a payment owed to a pharmacy for services performed before the termination of a contract between the state pharmacy benefit manager and a Medicaid managed care organization or pharmacy, as applicable; and

(c) Shall administer, adjudicate and, when appropriate, reimburse any claim for services performed before the termination of the contract between the state pharmacy benefit manager and a Medicaid managed care organization in accordance with the contract between the state pharmacy benefit manager and the Medicaid managed care organization.

2. The Department may impose a fine of $25,000 per day that a violation occurs for any violation of subsection 1.

Sec. 8. NRS 422.001 is hereby amended to read as follows:

422.001 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 422.003 to 422.054, inclusive, ***and sections 2 and 3 of this act*** have the meanings ascribed to them in those sections.

Sec. 9. NRS 422.273 is hereby amended to read as follows:

422.273 1. To the extent that money is available, the Department shall:

(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to

recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.

(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).

2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid;

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid; and

(d) Complied with the provisions of subsection 2 of NRS 695K.220.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

3. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

4. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

5. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

6. To the extent that money is available, a Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural health clinic affiliated with a critical access hospital for covered services at a rate that is equal to or greater than

the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis.

7. ***A Medicaid managed care program must require each health maintenance organization that enters into a contract with the Department pursuant to this section to contract with and utilize the state pharmacy benefit manager for the purpose of administering all pharmacy benefits for recipients of Medicaid who receive pharmacy benefits through the health maintenance organization.***

8. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~[8.]~~ ***9.*** As used in this section, unless the context otherwise requires:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

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

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

(e) "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

Sec. 10. NRS 422.401 is hereby amended to read as follows:

422.401 As used in NRS 422.401 to 422.406, inclusive, ***and sections 4 to 7, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 422.4015 to 422.4024, inclusive, have the meanings ascribed to them in those sections.

Sec. 11. NRS 422.4025 is hereby amended to read as follows:

422.4025 1. The Department shall ~~[:~~

~~(a) By]~~ ***, 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 cover a prescription drug that is not included on the list of preferred prescription drugs as if the drug were included on that list if:

(a) The drug is:

(1) Used to treat hepatitis C;

(2) Used to provide medication-assisted treatment for opioid use disorder;

(3) Used to support safe withdrawal from substance use disorder; or

(4) In the same class as a drug on the list of preferred prescription drugs; and

(b) All preferred prescription drugs within the same class as the drug are unsuitable for a recipient of Medicaid because:

(1) The recipient is allergic to all preferred prescription drugs within the same class as the drug;

(2) All preferred prescription drugs within the same class as the drug are contraindicated for the recipient or are likely to interact in a harmful manner with another drug that the recipient is taking;

(3) The recipient has a history of adverse reactions to all preferred prescription drugs within the same class as the drug; or

(4) The drug has a unique indication that is supported by peer-reviewed clinical evidence or approved by the United States Food and Drug Administration.

7. 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.

8. 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]~~ ***contract*** entered into pursuant to ***subsection 1 of*** NRS 422.4053 ***with the state pharmacy benefit manager and any contracts entered into pursuant to subsection 2 of 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;]~~ ***each such contract;*** 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. 12. NRS 422.4032 is hereby amended to read as follows:

422.4032 1. The ~~[Department or a]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization with which the Department contracts pursuant to NRS 422.4053 to manage prescription drug benefits]~~ shall allow a recipient of Medicaid who has been diagnosed with stage 3 or 4 cancer or the attending practitioner of the recipient to apply for an exemption from step therapy that would otherwise be required pursuant to NRS 422.403 to instead use a prescription drug prescribed by the attending practitioner to treat the cancer or any symptom thereof of the recipient of Medicaid. The application process must:

(a) Allow the recipient or attending practitioner, or a designated advocate for the recipient or attending practitioner, to present to the ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ the clinical rationale for the exemption and any relevant medical information.

(b) Clearly prescribe the information and supporting documents that must be submitted with the application, the criteria that will be used to evaluate the request and the conditions under which an expedited determination pursuant to subsection 4 is warranted.

(c) Require the review of each application by at least one physician, registered nurse or pharmacist.

2. The information and supporting documentation required pursuant to paragraph (b) of subsection 1:

(a) May include, without limitation:

(1) The medical history or other health records of the recipient demonstrating that the recipient has:

(I) Tried other drugs included in the pharmacological class of drugs for which the exemption is requested without success; or

(II) Taken the requested drug for a clinically appropriate amount of time to establish stability in relation to the cancer and the guidelines of the prescribing practitioner; and

(2) Any other relevant clinical information.

(b) Must not include any information or supporting documentation that is not necessary to make a determination about the application.

3. Except as otherwise provided in subsection 4, the ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable, that receives]~~ ***, upon receiving*** an application for an exemption pursuant to subsection 1 ***,*** shall:

(a) Make a determination concerning the application if the application is complete, or request additional information or documentation necessary to complete the application not later than 72 hours after receiving the application; and

(b) If ~~[it]~~ ***the state pharmacy benefit manager*** requests additional information or documentation, make a determination concerning the application not later than 72 hours after receiving the requested information or documentation.

4. If, in the opinion of the attending practitioner, step therapy may seriously jeopardize the life or health of the recipient, the ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization that receives an application for an exemption pursuant to subsection 1, as applicable,]~~ must make a determination concerning the application as expeditiously as necessary to avoid serious jeopardy to the life or health of the recipient.

5. The ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ shall disclose to a recipient or attending practitioner who submits an application for an exemption from step therapy pursuant to subsection 1 the qualifications of each person who will review the application.

6. The ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ must grant an exemption from step therapy in response to an application submitted pursuant to subsection 1 if:

(a) Any treatment otherwise required under the step therapy or any drug in the same pharmacological class or having the same mechanism of action as the drug for which the exemption is requested has not been effective at treating the cancer or symptom of the recipient when prescribed in accordance with clinical indications, clinical guidelines or other peer-reviewed evidence;

(b) Delay of effective treatment would have severe or irreversible consequences for the recipient and the treatment otherwise required under the step therapy is not reasonably expected to be effective based on the physical or mental characteristics of the recipient and the known characteristics of the treatment;

(c) Each treatment otherwise required under the step therapy:

(1) Is contraindicated for the recipient or has caused or is likely, based on peer-reviewed clinical evidence, to cause an adverse reaction or other physical harm to the recipient; or

(2) Has prevented or is likely to prevent the recipient from performing the responsibilities of his or her occupation or engaging in activities of daily living, as defined in 42 C.F.R. § 441.505; or

(d) The condition of the recipient is stable while being treated with the prescription drug for which the exemption is requested and the recipient has previously received approval for coverage of that drug.

7. If the ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ approves an application for an exemption from step therapy pursuant to this section, the State must pay the nonfederal share of the cost of the prescription drug to which the exemption applies. The ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization]~~ may initially limit the coverage to a 1-week supply of the drug for which the exemption is granted. If the attending practitioner determines after 1 week that the drug is effective at treating the cancer or symptom for which it was prescribed, the State must continue to pay the nonfederal share of the cost of the drug for as long as it is necessary to treat the recipient for the cancer or symptom. The ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ may conduct a review not more frequently than once each quarter to determine, in accordance with available medical evidence, whether the drug remains necessary to treat the recipient for the cancer or symptom. The ~~[Department,]~~ ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ shall provide a report of the review to the recipient.

8. The Department and ~~[any]~~ ***the state*** pharmacy benefit manager ~~[or health maintenance organization with which the Department contracts pursuant to NRS 422.4053 to manage prescription drug benefits]~~ shall post in an easily accessible location on an Internet website maintained by the Department ~~[,]~~ ***or state*** pharmacy benefit manager ***,*** ~~[or health maintenance organization,]~~ as applicable, a form for requesting an exemption pursuant to this section.

9. As used in this section, "attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the cancer or any symptom of such cancer of a recipient.

Sec. 13. NRS 422.4053 is hereby amended to read as follows:

422.4053 1. ~~[Except as otherwise provided in subsection 2, the]~~ ***The*** Department shall ~~[directly]~~ ***:***

(a) Evaluate applications received pursuant to section 4 of this act and choose an applicant to serve as the state pharmacy benefit manager; and

(b) Enter into a contract with the state pharmacy benefit manager chosen pursuant to paragraph (a) to, except as otherwise provided in subsection 2, manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid ***,*** ~~[and]~~ the Children's Health Insurance Program ~~[.]~~ ***and the other health benefit plans described in subsection 1 of NRS 422.4025.***

2. The Department may enter into a contract with ~~[:~~

~~(a) A pharmacy benefit manager for the provision of any services described in subsection 1.~~

~~(b) A health maintenance organization pursuant to NRS 422.273 for the provision of any of the services described in subsection 1 for recipients of Medicaid or recipients of insurance through the Children's Health Insurance Program who receive coverage through a Medicaid managed care program.~~

~~(c) One]~~ ***one*** or more public or private entities from this State, the District of Columbia or other states or territories of the United States for the collaborative purchasing of prescription drugs in accordance with subsection 3 of NRS 277.110.

3. ~~[A]~~ ***The*** contract entered into pursuant to ~~[paragraph (a) or (b) of]~~ subsection ~~[2]~~ ***1*** must:

(a) Include the provisions required by NRS 422.4056;

(b) Require the ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ to disclose to the Department any information relating to the services covered by the contract, including, without limitation, information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees and charges imposed by the ***state*** pharmacy benefit manager ~~[or health maintenance organization]~~ pursuant to the contract; ~~[and]~~

(c) Require the ***state*** pharmacy benefit manager ~~[or health maintenance organization]~~ to comply with the provisions of this chapter regarding the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program to the same extent as the Department ~~[.~~

~~4. In addition to meeting the requirements of subsection 3, a contract entered into pursuant to:~~

~~(a) Paragraph (a) of subsection 2 may require]~~ ***;***

(d) Require the state pharmacy benefit manager to comply with all other applicable state and federal laws;

(e) Require the state pharmacy benefit manager to negotiate and enter into agreements to purchase the drugs included on the list of preferred prescription drugs developed pursuant to NRS 422.4025, except where those drugs are purchased through a contract pursuant to subsection 2;

(f) Prohibit the state pharmacy benefit manager from discriminating with regard to participation in any network established for the provision of benefits under the contract or preferred status in such a network against any pharmacy or pharmacist that is:

(1) Located within the geographic coverage area of the network; and

(2) Willing to accept the reasonable terms and conditions of the state pharmacy benefit manager for participation in the network or preferred status, as applicable;

(g) Require the state pharmacy benefit manager to transmit claims to any applicable Medicaid managed care organization or to the Department, as applicable, within 48 hours after processing the claim;

(h) Require the ***state*** pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department ~~[.~~

~~(b) Paragraph (b) of subsection 2 must require the health maintenance organization to provide to the Department the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, less an administrative fee in an amount prescribed by the contract. The Department shall adopt policies prescribing the maximum amount of such an administrative fee.~~**]** ***; and***

(i) Establish a fiduciary duty between the Department and the state pharmacy benefit manager.

4. In addition to meeting the requirements of subsection 2, a contract entered into pursuant to subsection 1 must prohibit the state pharmacy benefit manager from:

(a) Using spread pricing;

(b) Directly or indirectly reducing payment for services provided by a pharmacy or pharmacist under a reconciliation process to an effective rate of reimbursement, including, without limitation, creating, imposing or establishing direct or indirect remuneration fees, generic effective rates, dispensing effective rates, brand effective rates, any other effective rates, in-network fees, performance fees, pre-adjudication fees, post-adjudication

fees or any other mechanism that reduces or aggregately reduces payments for services provided by a pharmacy or pharmacist;

(c) Creating, modifying, implementing or indirectly establishing any fee to be imposed upon a pharmacy, a pharmacist or a recipient of benefits under the contract without first seeking and obtaining written approval from the Department;

(d) Requiring a recipient of benefits under the contract to obtain a specialty drug from a specialty pharmacy owned by or otherwise associated with the state pharmacy benefit manager;

(e) Requiring or incentivizing a recipient of benefits under the contract to use a specific pharmacy; and

(f) Requiring a recipient of benefits under the contract to use a mail order pharmaceutical distributor or mail order pharmacy.

5. As used in this section, "spread pricing" means any technique by which a pharmacy benefit manager charges or claims an amount from an insurer for drugs or services provided by a pharmacy or pharmacist that is different from the amount the pharmacy benefit manager pays the pharmacy or pharmacist, as applicable, for those drugs or services.

Sec. 14. NRS 422.4056 is hereby amended to read as follows:

422.4056 1. ~~[Any]~~ ***The*** contract between the Department and ~~[a]~~ ***the state*** pharmacy benefit manager ~~[or health maintenance organization entered into pursuant to NRS 422.4053]~~ must require the ***state*** pharmacy benefit manager ~~[or health maintenance organization, as applicable,]~~ to:

(a) Submit to and cooperate with an annual audit by the Department to evaluate the compliance of the ***state*** pharmacy benefit manager ~~[or health maintenance organization]~~ with the agreement and generally accepted accounting and business practices. The audit must analyze all claims processed by the ***state*** pharmacy benefit manager ~~[or health maintenance organization]~~ pursuant to the agreement.

(b) Obtain from an independent accountant, at the expense of the ***state*** pharmacy benefit manager ***,*** ~~[or health maintenance organization, as applicable,]~~ an annual audit of internal controls to ensure the integrity of financial transactions and claims processing.

2. The Department shall post the results of any audit conducted pursuant to paragraph (a) of subsection 1 on an Internet website maintained by the Department.

Sec. 15. NRS 683A.1785 is hereby amended to read as follows:

683A.1785 1. A pharmacy benefit manager shall not:

(a) Discriminate against a covered entity, a contract pharmacy or a 340B drug in the amount of reimbursement for any item or service or the procedures for obtaining such reimbursement;

(b) Assess any fee, chargeback, clawback or adjustment against a covered entity or contract pharmacy on the basis that the covered entity or contract pharmacy dispenses a 340B drug or otherwise limit the ability of a covered entity or contract pharmacy to receive the full benefit of purchasing the 340B drug at or below the ceiling price, as calculated pursuant to 42 U.S.C. § 256b(a)(1);

(c) Exclude a covered entity or contract pharmacy from any network because the covered entity or contract pharmacy dispenses a 340B drug;

(d) Restrict the ability of a person to receive a 340B drug, including, without limitation, by imposing a copayment, coinsurance, deductible or other cost-sharing obligation on the drug that is different from a similar drug on the basis that the drug is a 340B drug;

(e) Restrict the methods by which a covered entity or contract pharmacy may dispense or deliver a 340B drug or the entity through which a covered entity may dispense or deliver such a drug in a manner that does not apply to drugs that are not 340B drugs; or

(f) Prohibit a covered entity or contract pharmacy from purchasing a 340B drug or interfere with the ability of a covered entity or contract pharmacy to purchase a 340B drug.

2. This section does not:

(a) Apply to ~~[a]~~ ***the state*** pharmacy benefit manager ~~[that has entered into a contract with the Department of Health and Human Services pursuant to NRS 422.4053]~~ when the ***state*** pharmacy benefit manager is managing prescription drug benefits under Medicaid, including, without limitation, where such benefits are delivered through a Medicaid managed care organization.

(b) Prohibit the Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department of Health and Human Services or a Medicaid managed care organization from taking such actions as are necessary to:

(1) Prevent duplicate discounts or rebates where prohibited by 42 U.S.C. § 256b(a)(5)(A); or

(2) Ensure the financial stability of the Medicaid program, including, without limitation, by including or enforcing provisions in ~~[any]~~ ***the*** contract with ~~[a]~~ ***the state*** pharmacy benefit manager ***.*** ~~[entered into pursuant to NRS 422.4053.]~~

3. As used in this section:

(a) "340B drug" means a prescription drug that is purchased by a covered entity under the 340B Program.

(b) "340B Program" means the drug pricing program established by the United States Secretary of Health and Human Services pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended.

(c) "Contract pharmacy" means a pharmacy that enters into a contract with a covered entity to dispense 340B drugs and provide related pharmacy services to the patients of the covered entity.

(d) "Covered entity" has the meaning ascribed to it in 42 U.S.C. § 256b(a)(4).

(e) "Medicaid managed care organization" has the meaning ascribed to it in 42 U.S.C. § 1396b(m).

(f) "Network" means a defined set of providers of health care who are under contract with a pharmacy benefit manager or third party to provide health care services to covered persons.

(g) "State pharmacy benefit manager" has the meaning ascribed to it in section 3 of this act.

Sec. 16. 1. The amendatory provisions of this act do not affect any contract between the Department of Health and Human Services and a pharmacy benefit manager or health maintenance organization entered into pursuant to NRS 422.4053 before January 1, 2026. The state pharmacy benefit manager shall assume the responsibilities previously carried out by the pharmacy benefit manager or health maintenance organization, as applicable, upon the expiration of the current term of any such contract.

2. As used in this section:

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

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

(c) "State pharmacy benefit manager" has the meaning ascribed to it in section 3 of this act.

Sec. 17. The provisions of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 18. 1. This section becomes effective on passage and approval.

2. Sections 1 to 17, 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.

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