SENATE DOCKET, NO. 1262 FILED ON: 1/16/2025

SENATE . . . . . No. 830

The Commonwealth of Massachusetts

PRESENTED BY:

Bruce E. Tarr

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to preserve community pharmacies.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Bruce E. Tarr	*First Essex and Middlesex*	
Peter J. Durant	*Worcester and Hampshire*	*3/17/2025*

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SENATE . . . . . No. 830

By Mr. Tarr, a petition (accompanied by bill, Senate, No. 830) of Bruce E. Tarr for legislation to preserve community pharmacies by conducting audits on contracts for pharmacy services. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act to preserve community pharmacies.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 175 of the Massachusetts general laws is hereby amended by adding the following new section:

Section 226A Contracts for Community Pharmacy Services

"Brand name drug", a drug that is: (i) produced or distributed pursuant to an original new drug application approved under 21 U.S.C. 355(c) except for: (A) any drug approved through an application submitted under section 505(b)(2) of the Federal Food, Drug, and Cosmetic Act that is pharmaceutically equivalent, as that term is defined by the United States Food and Drug Administration, to a drug approved under 21 U.S.C. 355(c); (B) an abbreviated new drug 407 application that was approved by the United States Secretary of Health and Human Services under section 505(c) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 355(c), before the date of the enactment of the federal Drug Price Competition and Patent Term Restoration Act of 19 of 58 1984, Public Law 98-417, 98 Stat. 1585; or (C) an authorized generic drug as defined in

42 C.F.R. 447.502; (ii) produced or distributed pursuant to a biologics license application approved 412 under 42 U.S.C. 262(a)(2)(C); or (iii) identified by the health benefit plan as a brand name drug based on available data resources such as Medi-Span.

"Generic drug", a retail drug that is: (i) marketed or distributed pursuant to an abbreviated new drug application approved under 21 U.S.C. 355(j); (ii) an authorized generic drug as defined in 42 C.F.R. 447.502; (iii) a drug that entered the market before January 1, 1962 and was not originally marketed under a new drug application; or (iv) identified by the health benefit plan as a generic drug based on available data resources such as Medi-Span.

"Pharmacy Audit", a process that involves the inspection of pharmacy records to ensure high quality services and the lack of Fraud Waste, and Abuse. This includes desk audits as well as in-person audits.

"Pharmacy Benefit Manager" as defined in MGL c 175 Section 226 (a).

Section 1: Payment for pharmacy services

A contract for pharmacy services between a pharmacy benefit manager and a pharmacy must include an ingredient cost that meets the criteria in section 2 and a dispensing fee equal to what is paid by the State Medicaid Program. Payment for clean claims must include all applicable discounts. Contracts that include retroactive discounts and use "Generic Effective Rate" or "Brand Effective Rate or any other similar retroactive rate reductions are prohibited.

Section 2: Ingredient and Maximum Allowable Cost

(a) For the purposes of this section the term "maximum allowable cost list" shall mean a list of drugs, medical products or devices, or both medical products and devices, for which a

maximum allowable cost has been established by a pharmacy benefits manager or covered entity. The term "maximum allowable cost" shall mean the maximum amount that a pharmacy benefits manager or covered entity will reimburse a pharmacy for the cost of a drug or a medical product or device inclusive of all discounts when the claim is processed or taken retroactively.

(b) The maxim allowable cost (if used) or the ingredient cost (if not used) must be equal to or greater than the cost used by the Massachusetts Medicaid Program

(c) The maximum allowable cost for non-affiliated pharmacies must be equal to or greater than the maximum allowable cost to pharmacies affiliated with or owned by the pharmacy benefit manager.

(d) Before a pharmacy benefits manager or covered entity may place a drug on a maximum allowable cost list the drug must be listed as "A" or "AB" rated in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and that there are at least two therapeutically equivalent, multiple source drugs, or at least one generic drug available from one manufacturer, available for purchase by network pharmacies from national or regional wholesalers registered in Massachusetts.

(e) A pharmacy benefits manager or covered entity shall make available to each pharmacy with which the pharmacy benefits manager or covered entity has a contract and to each pharmacy included in a network of pharmacies served by a pharmacy services administrative organization with which the pharmacy benefits manager or covered entity has a contract, at the beginning of the term of a contract upon renewal of a contract, or upon request:

(1) The sources used to determine the maximum allowable costs for the drugs and medical products and devices on each maximum allowable cost list;

(2) Every maximum allowable cost for individual drugs used by that pharmacy benefits manager or covered entity for patients served by that contracted pharmacy; and

(3) Upon request, every maximum allowable cost list used by that pharmacy benefits manager or covered entity for patients served by that contracted pharmacy.

(f) A pharmacy benefits manager or covered entity shall:

(1) update each maximum allowable cost list at least every 3 business days

(2) Make the updated lists available to every pharmacy with which the pharmacy benefits manager or covered entity has a contract and to every pharmacy included in a network of pharmacies served by a pharmacy services administrative organization with which the pharmacy benefits manager or covered entity has a contract, in a readily accessible, secure and usable web-based format or other comparable format or process; and

(3) Utilize the updated maximum allowable costs to calculate the payments made to the contracted pharmacies within 2 business days.

(g) A pharmacy benefits manager or covered entity shall establish a clearly defined process through which a pharmacy may contest the cost for a particular drug or medical product or device.

(h) A pharmacy may base its appeal on one or more of the following:

(1) The ingredient cost established for a particular drug or medical product, or device is below the cost used by the Massachusetts Medicaid Program

(2) The pharmacy benefits manager or covered entity has placed a drug on the maximum allowable cost list that does not meet the requirements of subsection (d).

(i) The pharmacy must file its appeal within seven business days of its submission of the initial claim for reimbursement for the drug or medical product or device. A Pharmacy Services Administrative Organization (PSAO) may appeal on behalf of a pharmacy or group of pharmacies. The pharmacy benefits manager or covered entity must make a final determination resolving the pharmacy's appeal within seven business days of the pharmacy benefits manager or covered entity's receipt of the appeal.

(j) If the final determination is a denial of the pharmacy's appeal, the pharmacy benefits manager or covered entity must state the reason for the denial and provide the national drug code of an equivalent drug that is generally available for purchase by pharmacies in this state from national or regional wholesalers licensed by the state at a price which is equal to or less than the cost for that drug.

(k) If a pharmacy's appeal is determined to be valid by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall retroactively adjust the cost of the drug or medical product or device and reprocess all claims that were paid incorrectly. The adjustment shall be effective from the date the pharmacy's appeal was filed, and the pharmacy benefits manager or covered entity shall provide reimbursement for all reprocessed claims.

(l) Once a pharmacy's appeal is determined to be valid by the pharmacy benefits manager or covered entity, the pharmacy benefits manager or covered entity shall adjust the cost of the drug or medical product or device for all similar pharmacies in the network as determined by the pharmacy benefits manager within 3 business days.

(m) A pharmacy benefits manager or covered entity shall make available on its secure web site information about the appeals process, including, but not limited to, a telephone number or process that a pharmacy may use to submit cost appeals. The medical products and devices subject to the requirements of this part are limited to the medical products and devices included as a pharmacy benefit under the pharmacy benefits contract.

(n) A pharmacy shall not disclose to any third party the cost lists and any related information it receives from a pharmacy benefits manager or covered entity; provided, a pharmacy may share such lists and related information with a pharmacy services administrative organization or similar entity with which the pharmacy has a contract to provide administrative services for that pharmacy. If a pharmacy shares this information with a pharmacy services administrative organization or similar entity, that organization or entity shall not disclose the information to any third party.

(o) Pharmacy Benefit Managers shall provide annually a report to the Commissioner that details all denied pharmacy appeals for that year to include: the name of the pharmacy, date of service for the claim as well as drug name and billing code used on the claim, and the reason for the denial.

Section 3: The Insurance Commissioner shall enforce this act and shall promulgate regulations to enforce the provisions of this act. The commissioner may examine or audit the

books and records of a pharmacy benefits manager providing claims processing services or other prescription drug or device services for a health benefit plan to determine if the pharmacy benefits manager is in compliance with this act. The information or data acquired during an examination is:

(a) Considered proprietary and confidential; and

(b) Not subject to the Freedom of Information Act of Massachusetts