§ 4672. GREEN MOUNTAIN CARE BOARD; COST AFFORDABILITY REVIEW

(a) Identification of prescription drug products. The Green Mountain Care Board shall identify a reasonable sample size of prescription drug products that are: brand-name; biologic, and generic; necessary to fully understand the inflationary metrics and effective rates for each respectively.

(b) Selection for review. After identifying prescription drug products pursuant to subsection (a) of this section, the Board shall conduct an affordability review for each identified prescription drug product by

(1) seeking input about the prescription drug product from the Board's prescription drug affordability stakeholder group as defined in subsection (f) of this section; and

(2) To the extent practicable, the Board shall access pricing information for prescription drug products by:

(A) entering a memorandum of understanding with another state or other entity with critical pricing information; and

(B) accessing other available pricing information from other sources

(3) Notwithstanding any provision of 1 V.S.A. § 312 or 313 to the contrary, the Board may meet in executive session to discuss proprietary data and information or to hear from an expert witness who will discuss proprietary data and information.

(c) The Board shall analyze and review the price point(s) and inflation metrics for each drug product identified at each level of the product chain identified below.

(1) The Manufacturer

(2) The Wholesaler

(3) The Pharmacy

(4) The Pharmacy Benefit Manager

(5) The Insurer

(6) The Patient

(d) The Board shall identify any gaps in information that it determines to be critical in understanding prescription drug affordability.

(e) The Board shall identify and model any potential partnership, cooperative, association, or other construct, including sole source wholesale acquisition and distribution, that would further enhance the Board's capability to analyze and monitor prescription drug products, the effect on consumer costs, and the effect of other prescription programs.

(f) Prescription drug affordability stakeholder group. The Board shall establish a prescription drug affordability stakeholder group to advise the Board in making the decisions required by this section. The stakeholder group shall comprise representatives of health care professionals, of health plans, of patients, of health care facilities, of pharmacists, and of prescription drug manufacturers; health care researchers, including researchers specializing in prescription drugs; and other interested stakeholders with applicable subject matter expertise.

(g) Rulemaking. The Green Mountain Care Board may adopt rules in accordance with 3 V.S.A. chapter 25 as needed to carry out its duties under this section.

18 V.S.A.§ 3802. PHARMACY RIGHTS DURING AN AUDIT

Notwithstanding any provision of law to the contrary, whenever a health insurer, a third-party payer, or an entity representing a responsible party conducts an audit of the records of a pharmacy, the pharmacy shall have a right to all of the following:

(1) To have an audit involving clinical or professional judgment be conducted by a pharmacist licensed to practice pharmacy in one or more states, who has at least a familiarity with Vermont pharmacy statutes and rules and who is employed by or working with an auditing entity.

(2) To have all payment data related to audited claims provided in the initial audit request, including payment amount, any DIR/GER fees assessed, submission fees, any other processing fees, date of electronic payment or check date and number, the specific contracted payment metrics for each claim including cost basis, such as MAC, WAC, AWP or AMP, and the respective values used to calculate each claim payment.

~~(2)~~ (3) If an audit is to be conducted on-site at a pharmacy, the entity conducting the audit:

(A) shall give the pharmacy at least 14 days' advance written notice of the audit and the specific prescriptions to be included in the audit; and

(B) may not audit a pharmacy on Mondays or on weeks containing a federal holiday, unless the pharmacy agrees to alternative timing for the audit.

(C) ~~Not to have an~~ may not audit claims that:

(i) were submitted to the pharmacy benefit manager more than 18 months prior to the date of the audit, unless:

(a) required by federal law; or

(b) the originating prescription was dated within the 24-month period preceding the date of the audit; or

~~(B)~~(ii) exceed 200 selected prescription claims

(4) If an audit is to be performed remotely, "desk-audit", the entity conducting the audit:

(A) shall give the pharmacy at least 7 business days to respond to the audit provided receipt is confirmed by pharmacy; and

(B) may not audit claims that:

(i) were submitted to the pharmacy benefit manager more than 3 months prior to the date of the audit or more than a date to which the pharmacy could electronically retransmit a corrected claim; and

(ii) exceed 5 selected prescription claims.

***(continued renumbering) ***

~~(19)~~ (20) To have the preliminary audit report delivered to the pharmacy within ~~60~~ 30 days following the ~~conclusion of the audit~~ preliminary response by the pharmacy.

~~(20)~~ (21) To have at least 30 days following receipt of the preliminary audit report to produce documentation to address any discrepancy found during the audit.

~~(21)~~ (22) To have a final audit repot delivered to the pharmacy within ~~120~~ 30 days after the end of the appeals period, as required by section 3803 of this title.

18 V.S.A. § 9473 PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO PHARMACIES

(b) A pharmacy benefit manager or other entity paying pharmacy claims shall not:

(1) impose a higher co-payment, or patient responsibility, for a prescription drug than the co-payment, or patient responsibility, applicable to the type of drug purchased under the insured's health plan;

(2) impose a higher co-payment, or patient responsibility, for a prescription drug than the maximum allowable cost for the drug;

(3) require a pharmacy to pass through any portion of the insured's copayment to the pharmacy benefit manager or other payer;

(4) prohibit or penalize a pharmacy or pharmacist for providing information to an insured regarding the insured's cost-sharing amount for a prescription drug; or

(5) prohibit or penalize a pharmacy or pharmacist for the pharmacist or other pharmacy employee disclosing to an insured the cash price for a prescription drug or selling a lower cost drug to the insured if one is available.

(6) require a pharmacy to meet any pharmacy accreditation standard or recertification requirement inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy as a condition of network participation.

(c) For each drug for which a pharmacy benefit manager establishes a Maximum allowable cost in order to determine the reimbursement rate, the pharmacy benefit manager shall do all of the following:

(1) Make available, in a format that is readily accessible and understandable by a pharmacist, the actual maximum allowable cost for each drug and the source used to determine the maximum allowable cost. *shall not be dependent on individual beneficiary identification or benefit stage.

(2) Update the maximum allowable cost at least once every seven calendar days. In order to be subject to maximum allowable cost, a drug must be widely available for purchase by all pharmacies in the State, without limitations, from national or regional wholesalers and must not be obsolete or temporarily unavailable.

(3) Establish or maintain a reasonable administrative appeals process to allow a dispensing pharmacy provider to contest a listed maximum allowable cost.

(4) Respond in writing to any appealing pharmacy provider within 10 calendar days after receipt of an appeal, provided that a dispensing pharmacy provider shall file any appeal within 10 calendar days from the date its claim for reimbursement is adjudicated.

(5) Pharmacies shall be given rights to appeal beyond the 10 calendar days in the event the prescription claim is subject to an audit initiated by the PBM or its auditing agent.

(6) If the appeal is denied, the pharmacy benefit manager shall:

(A) Provide the reason for the denial; and

(B) Identify the national drug code and regional distributor of an equivalent drug product that may be purchased by contracted pharmacies at a price at or below the

maximum allowable cost; and, if the appeal is granted, the pharmacy benefit manager shall within 30 business days after granting the appeal, make the change in the maximum allowable cost.

(d) CHOICE OF PHARMACY

(1) A health insurer or pharmacy benefit manager shall permit a plan beneficiary to fill a prescription at the pharmacy of his or her choice and shall not impose differential cost-sharing requirements based on the choice of pharmacy or otherwise promote the use of one pharmacy over another.
(2) A health insurer or pharmacy benefit manager shall permit a participating networked pharmacy to perform all pharmacy services within the lawful scope of practice of the profession of pharmacy as defined under 26 VSA §2022-2023;
(3) ***A pharmacy benefit manager, or licensed pharmacy agree not to make a direct solicitation (as defined in) of a covered beneficiary unless one or more of the following applies: (i) The individual has given written permission to the supplier or the ordering physician or non-physician practitioner to contact them concerning the furnishing of a prescription item that is to be rented or purchased. (ii) The supplier has furnished prescription item to the individual and the supplier is contacting the individual to coordinate the delivery of the item. (iii) If the contact concerns the furnishing of a prescription item other than a prescription item already furnished to the individual, the supplier has furnished at least one prescription item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

Definitions:

1. "Direct solicitation" means direct contact, which includes, but is not limited to, telephone, computer, e-mail, instant messaging or in-person contact, by a Pharmacy Provider or its agents to a beneficiary without his or her consent for the purpose of marketing the Pharmacy Provider's services.

*** Adopted from 42 CFR §424.57