118TH CONGRESS
2D SESSION

H. R. 4758

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 18, 2024

Received; read twice and referred to the Committee on Finance

AN ACT

To amend title XIX of the Social Security Act to streamline enrollment under the Medicaid program of certain providers across State lines, and to prevent the use of abusive spread pricing in Medicaid.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Accelerating Kids' Access to Care Act''.

SEC. 2. STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS UNDER MEDICAID AND CHIP.

(a) IN GENERAL.—Section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)) is amended by adding at the end the following new paragraph:

''(10) STREAMLINED ENROLLMENT PROCESS FOR ELIGIBLE OUT-OF-STATE PROVIDERS.—

''(A) IN GENERAL.—The State—

''(i) adopts and implements a process to allow an eligible out-of-State provider to enroll under the State plan (or a waiver of such plan) to furnish items and services to, or order, prescribe, refer, or certify eligibility for items and services for, qualifying individuals without the imposition of screening or enrollment requirements in addition to those imposed by the State in which the eligible out-of-State provider is located; and

''(ii) provides that an eligible out-of-State provider that enrolls as a participating provider in the State plan (or a

waiver of such plan) through such process shall be so enrolled for a 5-year period, unless the provider is terminated or excluded from participation during such period.

''(B) DEFINITIONS.—In this paragraph:

''(i) ELIGIBLE OUT-OF-STATE PROVIDER.—The term 'eligible out-of-State provider' means, with respect to a State, a provider—

''(I) that is located in any other State;

''(II) that—

''(aa) was determined by the Secretary to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under section 1866(j)(2), has been so screened under such section 1866(j)(2), and is enrolled in the Medicare program under title XVIII; or

''(bb) was determined by the State agency administering or supervising the administration of

the State plan (or a waiver of such plan) of such other State to have a limited risk of fraud, waste, and abuse for purposes of determining the level of screening to be conducted under paragraph (1) of this subsection, has been so screened under such paragraph (1), and is enrolled under such State plan (or a waiver of such plan); and

''(III) that has not been—

''(aa) excluded from participation in any Federal health care program pursuant to section 1128 or 1128A;

''(bb) excluded from participation in the State plan (or a waiver of such plan) pursuant to part 1002 of title 42, Code of Federal Regulations (or any successor regulation), or State law; or

''(cc) terminated from participating in a Federal health

care program or the State plan (or a waiver of such plan) for a reason described in paragraph (8)(A).

''(ii) QUALIFYING INDIVIDUAL.—The term 'qualifying individual' means an individual under 21 years of age who is enrolled under the State plan (or waiver of such plan).

''(iii) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(77) of the Social Security Act (42 U.S.C. 1396a(a)(77)) is amended by inserting ''enrollment,'' after ''screening,''.

(2) The subsection heading for section 1902(kk) of such Act (42 U.S.C. 1396a(kk)) is amended by inserting ''ENROLLMENT,'' after ''SCREENING,''.

(3) Section 2107(e)(1)(G) of such Act (42 U.S.C. 1397gg(e)(1)(G)) is amended by inserting ''enrollment,'' after ''screening,''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 3 years after the date of enactment of this section.

SEC. 3. PREVENTING THE USE OF ABUSIVE SPREAD PRICING IN MEDICAID.

(a) IN GENERAL.—Section 1927 of the Social Security Act (42 U.S.C. 1396r–8) is amended—

(1) in subsection (e), by adding at the end the following new paragraph:

''(6) TRANSPARENT PRESCRIPTION DRUG PASS-THROUGH PRICING REQUIRED.—

''(A) IN GENERAL.—A contract between the State and a pharmacy benefit manager (referred to in this paragraph as a 'PBM'), or a contract between the State and a managed care entity or other specified entity (as such terms are defined in section 1903(m)(9)(D) and collectively referred to in this paragraph as the 'entity') that includes provisions making the entity responsible for coverage of covered outpatient drugs dispensed to individuals enrolled with the entity, shall require that payment for such drugs and related administrative services (as applicable), including payments made by a PBM on behalf of the State or entity, is based

on a transparent prescription drug pass-through pricing model under which—

"(i) any payment made by the entity or the PBM (as applicable) for such a drug—

"(I) is limited to—

"(aa) ingredient cost; and

"(bb) a professional dispensing fee that is not less than the professional dispensing fee that the State would pay if the State were making the payment directly in accordance with the State plan;

"(II) is passed through in its entirety (except as reduced under Federal or State laws and regulations in response to instances of waste, fraud, or abuse) by the entity or PBM to the pharmacy or provider that dispenses the drug; and

"(III) is made in a manner that is consistent with sections 447.502, 447.512, 447.514, and 447.518 of title 42, Code of Federal Regulations

(or any successor regulation) as if such requirements applied directly to the entity or the PBM, except that any payment by the entity or the PBM for the ingredient cost of such drug purchased by a covered entity (as defined in subsection (a)(5)(B)) may exceed the actual acquisition cost (as defined in 447.502 of title 42, Code of Federal Regulations, or any successor regulation) for such drug if—

''(aa) such drug was subject to an agreement under section 340B of the Public Health Service Act;

''(bb) such payment for the ingredient cost of such drug does not exceed the maximum payment that would have been made by the entity or the PBM for the ingredient cost of such drug if such drug had not been purchased by such covered entity; and

''(cc) such covered entity reports to the Secretary (in a form and manner specified by the Secretary), on an annual basis and with respect to payments for the ingredient costs of such drugs so purchased by such covered entity that are in excess of the actual acquisition costs for such drugs, the aggregate amount of such excess;

''(ii) payment to the entity or the PBM (as applicable) for administrative services performed by the entity or PBM is limited to an administrative fee that reflects the fair market value (as defined by the Secretary) of such services;

''(iii) the entity or the PBM (as applicable) makes available to the State, and the Secretary upon request in a form and manner specified by the Secretary, all costs and payments related to covered outpatient drugs and accompanying administrative services (as described in clause (ii)) incurred, received, or made by the entity or

the PBM, broken down (as specified by the Secretary), to the extent such costs and payments are attributable to an individual covered outpatient drug, by each such drug, including any ingredient costs, professional dispensing fees, administrative fees (as described in clause (ii)), post-sale and post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees, and any and all other remuneration; and

''(iv) any form of spread pricing whereby any amount charged or claimed by the entity or the PBM (as applicable) that exceeds the amount paid to the pharmacies or providers on behalf of the State or entity, including any post-sale or post-invoice fees, discounts, or related adjustments such as direct and indirect remuneration fees or assessments (after allowing for an administrative fee as described in clause (ii)) is not allowable for purposes of claiming Federal matching payments under this title.

''(B) MAKING CERTAIN INFORMATION AVAILABLE.—The Secretary shall publish, not less frequently than on an annual basis, information received by the Secretary pursuant to subparagraph (A)(i)(III)(cc). Such information shall be so published in an electronic and searchable format, such as through the 340B Office of Pharmacy Affairs Information System (or a successor system).''; and

(2) in subsection (k), by adding at the end the following new paragraph:

''(12) PHARMACY BENEFIT MANAGER.—The term 'pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a State, managed care entity (as defined in section 1903(m)(9)(D)), or other specified entity (as so defined), and may also more broadly manage aspects of the prescription drug benefits provided by a State, managed care entity, or other specified entity, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the managing of appeals or grievances related to the prescription

drug benefits, contracting with pharmacies, controlling the cost of covered outpatient drugs, or the provision of services related thereto. Such term includes any person or entity that acts as a price negotiator (with regard to payment amounts to pharmacies and providers for a covered outpatient drug or the net cost of the drug) or group purchaser on behalf of a State, managed care entity, or other specified entity, including such a person or entity that carries out 1 or more of the other activities described in the preceding sentence, irrespective of whether such person or entity calls itself a pharmacy benefit manager.''.

(b) CONFORMING AMENDMENTS.—Section 1903(m) of such Act (42 U.S.C. 1396b(m)) is amended—

(1) in paragraph (2)(A)(xiii)—

(A) by striking ''and (III)'' and inserting ''(III)'';

(B) by inserting before the period at the end the following: '', and (IV) if the contract includes provisions making the entity responsible for coverage of covered outpatient drugs, the entity shall comply with the requirements of section 1927(e)(6)''; and

(C) by moving the left margin 2 ems to the left; and

(2) by adding at the end the following new paragraph:

''(10) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by an other specified entity (as defined in paragraph (9)(D)(iii)) unless such services are provided in accordance with a contract between the State and such entity which satisfies the requirements of paragraph (2)(A)(xiii).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts between States and managed care entities, other specified entities, or pharmacy benefit managers that have an effective date beginning on or after the date that is 18 months after the date of enactment of this Act.

(d) IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section by program instruction or otherwise.

(2) NONAPPLICATION OF ADMINISTRATIVE PROCEDURE ACT.—Implementation of the amendments made by this section shall be exempt from the re-

quirements of section 553 of title 5, United States Code.

(e) NONAPPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to any data collection undertaken by the Secretary of Health and Human Services under section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(f)), as amended by this section.

SEC. 4. MEDICAID IMPROVEMENT FUND.

Section 1941(b)(3)(A) of the Social Security Act (42 U.S.C. 1396w–1(b)(3)(A)) is amended by striking ''$0'' and inserting ''$69,000,000''.

Passed the House of Representatives September 17, 2024.

Attest: KEVIN F. MCCUMBER,

Clerk.