By: Hull, Oliverson, Guillen, et al. H.B. No. 2822

A BILL TO BE ENTITLED

AN ACT

relating to the availability of antipsychotic prescription drugs under the vendor drug program and Medicaid managed care.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 531.073, Government Code, is amended by amending Subsection (a) and adding Subsections (a-3), (a-4), and (a-5) to read as follows:

(a) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program and the child health plan program, shall require prior authorization for the reimbursement of a drug that is not included in the appropriate preferred drug list adopted under Section 531.072, except for any drug exempted from prior authorization requirements by federal law and except as provided by Subsections (a-3) and [~~Subsection~~] (j). The executive commissioner may require prior authorization for the reimbursement of a drug provided through any other state program administered by the commission or a state health and human services agency, including a community mental health center and a state mental health hospital if the commission adopts preferred drug lists under Section 531.072 that apply to those facilities and the drug is not included in the appropriate list. The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner.

(a-3) The executive commissioner, in the rules and

1 standards governing the vendor drug program, may not require prior
2 authorization for a nonpreferred antipsychotic drug that is
3 included on the vendor drug formulary and prescribed to an adult
4 patient if:
5 (1) during the preceding year, the patient was
6 prescribed and unsuccessfully treated with a 14-day treatment trial
7 of an antipsychotic drug that is included on the appropriate
8 preferred drug list adopted under Section 531.072 and for which a
9 single claim was paid;
10 (2) the patient has previously been prescribed and
11 obtained prior authorization for the nonpreferred antipsychotic
12 drug and the prescription is for the purpose of drug dosage
13 titration; or
14 (3) subject to federal law on maximum dosage limits
15 and commission rules on drug quantity limits, the patient has
16 previously been prescribed and obtained prior authorization for the
17 nonpreferred antipsychotic drug and the prescription modifies the
18 dosage, dosage frequency, or both, of the drug as part of the same
19 treatment for which the drug was previously prescribed.
20 (a-4) Subsection (a-3) does not affect:
21 (1) the authority of a pharmacist to dispense the
22 generic equivalent or interchangeable biological product of a
23 prescription drug in accordance with Subchapter A, Chapter 562,
24 Occupations Code;
25 (2) any drug utilization review requirements
26 prescribed by state or federal law; or
27 (3) clinical prior authorization edits to preferred

1 and nonpreferred antipsychotic drug prescriptions.
2 (a-5) The executive commissioner, in the rules and
3 standards governing the vendor drug program and as part of the
4 requirements under a contract between the commission and a Medicaid
5 managed care organization, shall:
6 (1) require, to the maximum extent possible based on a
7 pharmacy benefit manager's claim system, automation of clinical
8 prior authorization for each drug in the antipsychotic drug class;
9 and
10 (2) ensure that, at the time a nonpreferred or
11 clinical prior authorization edit is denied, a pharmacist is
12 immediately provided a point-of-sale return message that:
13 (A) clearly specifies the contact and other
14 information necessary for the pharmacist to submit a prior
15 authorization request for the prescription; and
16 (B) instructs the pharmacist to dispense, only if
17 clinically appropriate under federal or state law, a 72-hour supply
18 of the prescription.
19 SECTION 2. Section 533.005(a), Government Code, is amended
20 to read as follows:
21 (a) A contract between a managed care organization and the
22 commission for the organization to provide health care services to
23 recipients must contain:
24 (1) procedures to ensure accountability to the state
25 for the provision of health care services, including procedures for
26 financial reporting, quality assurance, utilization review, and
27 assurance of contract and subcontract compliance;

1 (2) capitation rates that ensure the cost-effective
2 provision of quality health care;
3 (3) a requirement that the managed care organization
4 provide ready access to a person who assists recipients in
5 resolving issues relating to enrollment, plan administration,
6 education and training, access to services, and grievance
7 procedures;
8 (4) a requirement that the managed care organization
9 provide ready access to a person who assists providers in resolving
10 issues relating to payment, plan administration, education and
11 training, and grievance procedures;
12 (5) a requirement that the managed care organization
13 provide information and referral about the availability of
14 educational, social, and other community services that could
15 benefit a recipient;
16 (6) procedures for recipient outreach and education;
17 (7) a requirement that the managed care organization
18 make payment to a physician or provider for health care services
19 rendered to a recipient under a managed care plan on any claim for
20 payment that is received with documentation reasonably necessary
21 for the managed care organization to process the claim:
22 (A) not later than:
23 (i) the 10th day after the date the claim is
24 received if the claim relates to services provided by a nursing
25 facility, intermediate care facility, or group home;
26 (ii) the 30th day after the date the claim
27 is received if the claim relates to the provision of long-term

1 services and supports not subject to Subparagraph (i); and
2 (iii) the 45th day after the date the claim
3 is received if the claim is not subject to Subparagraph (i) or (ii);
4 or
5 (B) within a period, not to exceed 60 days,
6 specified by a written agreement between the physician or provider
7 and the managed care organization;
8 (7-a) a requirement that the managed care organization
9 demonstrate to the commission that the organization pays claims
10 described by Subdivision (7)(A)(ii) on average not later than the
11 21st day after the date the claim is received by the organization;
12 (8) a requirement that the commission, on the date of a
13 recipient's enrollment in a managed care plan issued by the managed
14 care organization, inform the organization of the recipient's
15 Medicaid certification date;
16 (9) a requirement that the managed care organization
17 comply with Section 533.006 as a condition of contract retention
18 and renewal;
19 (10) a requirement that the managed care organization
20 provide the information required by Section 533.012 and otherwise
21 comply and cooperate with the commission's office of inspector
22 general and the office of the attorney general;
23 (11) a requirement that the managed care
24 organization's usages of out-of-network providers or groups of
25 out-of-network providers may not exceed limits for those usages
26 relating to total inpatient admissions, total outpatient services,
27 and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as

1 determined under Section 32.028, Human Resources Code, if the
2 recipient does not have a referral from the recipient's primary
3 care physician;

4 (15) a requirement that the managed care organization
5 develop, implement, and maintain a system for tracking and
6 resolving all provider appeals related to claims payment, including
7 a process that will require:

8 (A) a tracking mechanism to document the status
9 and final disposition of each provider's claims payment appeal;

10 (B) the contracting with physicians who are not
11 network providers and who are of the same or related specialty as
12 the appealing physician to resolve claims disputes related to
13 denial on the basis of medical necessity that remain unresolved
14 subsequent to a provider appeal;

15 (C) the determination of the physician resolving
16 the dispute to be binding on the managed care organization and
17 provider; and

18 (D) the managed care organization to allow a
19 provider with a claim that has not been paid before the time
20 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
21 claim;

22 (16) a requirement that a medical director who is
23 authorized to make medical necessity determinations is available to
24 the region where the managed care organization provides health care
25 services;

26 (17) a requirement that the managed care organization
27 ensure that a medical director and patient care coordinators and

1 provider and recipient support services personnel are located in
2 the South Texas service region, if the managed care organization
3 provides a managed care plan in that region;
4 (18) a requirement that the managed care organization
5 provide special programs and materials for recipients with limited
6 English proficiency or low literacy skills;
7 (19) a requirement that the managed care organization
8 develop and establish a process for responding to provider appeals
9 in the region where the organization provides health care services;
10 (20) a requirement that the managed care organization:
11 (A) develop and submit to the commission, before
12 the organization begins to provide health care services to
13 recipients, a comprehensive plan that describes how the
14 organization's provider network complies with the provider access
15 standards established under Section 533.0061;
16 (B) as a condition of contract retention and
17 renewal:
18 (i) continue to comply with the provider
19 access standards established under Section 533.0061; and
20 (ii) make substantial efforts, as
21 determined by the commission, to mitigate or remedy any
22 noncompliance with the provider access standards established under
23 Section 533.0061;
24 (C) pay liquidated damages for each failure, as
25 determined by the commission, to comply with the provider access
26 standards established under Section 533.0061 in amounts that are
27 reasonably related to the noncompliance; and

1 (D) regularly, as determined by the commission,
2 submit to the commission and make available to the public a report
3 containing data on the sufficiency of the organization's provider
4 network with regard to providing the care and services described
5 under Section 533.0061(a) and specific data with respect to access
6 to primary care, specialty care, long-term services and supports,
7 nursing services, and therapy services on the average length of
8 time between:
9 (i) the date a provider requests prior
10 authorization for the care or service and the date the organization
11 approves or denies the request; and
12 (ii) the date the organization approves a
13 request for prior authorization for the care or service and the date
14 the care or service is initiated;
15 (21) a requirement that the managed care organization
16 demonstrate to the commission, before the organization begins to
17 provide health care services to recipients, that, subject to the
18 provider access standards established under Section 533.0061:
19 (A) the organization's provider network has the
20 capacity to serve the number of recipients expected to enroll in a
21 managed care plan offered by the organization;
22 (B) the organization's provider network
23 includes:
24 (i) a sufficient number of primary care
25 providers;
26 (ii) a sufficient variety of provider
27 types;

1 (iii) a sufficient number of providers of
2 long-term services and supports and specialty pediatric care
3 providers of home and community-based services; and
4 (iv) providers located throughout the
5 region where the organization will provide health care services;
6 and
7 (C) health care services will be accessible to
8 recipients through the organization's provider network to a
9 comparable extent that health care services would be available to
10 recipients under a fee-for-service or primary care case management
11 model of Medicaid managed care;
12 (22) a requirement that the managed care organization
13 develop a monitoring program for measuring the quality of the
14 health care services provided by the organization's provider
15 network that:
16 (A) incorporates the National Committee for
17 Quality Assurance's Healthcare Effectiveness Data and Information
18 Set (HEDIS) measures or, as applicable, the national core
19 indicators adult consumer survey and the national core indicators
20 child family survey for individuals with an intellectual or
21 developmental disability;
22 (B) focuses on measuring outcomes; and
23 (C) includes the collection and analysis of
24 clinical data relating to prenatal care, preventive care, mental
25 health care, and the treatment of acute and chronic health
26 conditions and substance abuse;
27 (23) subject to Subsection (a-1), a requirement that

1 the managed care organization develop, implement, and maintain an
2 outpatient pharmacy benefit plan for its enrolled recipients:
3 (A) that, except as provided by Paragraph
4 (L)(ii), exclusively employs the vendor drug program formulary and
5 preserves the state's ability to reduce waste, fraud, and abuse
6 under Medicaid;
7 (B) that adheres to the applicable preferred drug
8 list adopted by the commission under Section 531.072;
9 (C) that, except as provided by Paragraph (L)(i),
10 includes the prior authorization procedures and requirements
11 prescribed by or implemented under Sections 531.073(b), (c), and
12 (g) for the vendor drug program;
13 (C-1) that does not require a clinical,
14 nonpreferred, or other prior authorization for any antiretroviral
15 drug, as defined by Section 531.073, or a step therapy or other
16 protocol, that could restrict or delay the dispensing of the drug
17 except to minimize fraud, waste, or abuse;
18 (C-2) that does not require prior authorization
19 for a nonpreferred antipsychotic drug prescribed to an adult
20 recipient if the requirements of Section 531.073(a-3) are met;
21 (D) for purposes of which the managed care
22 organization:
23 (i) may not negotiate or collect rebates
24 associated with pharmacy products on the vendor drug program
25 formulary; and
26 (ii) may not receive drug rebate or pricing
27 information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of

the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code;

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

1 (iii) must review and update maximum
2 allowable cost price information at least once every seven days to
3 reflect any modification of maximum allowable cost pricing;
4 (iv) must, in formulating the maximum
5 allowable cost price for a drug, use only the price of the drug and
6 drugs listed as therapeutically equivalent in the most recent
7 version of the United States Food and Drug Administration's
8 Approved Drug Products with Therapeutic Equivalence Evaluations,
9 also known as the Orange Book;
10 (v) must establish a process for
11 eliminating products from the maximum allowable cost list or
12 modifying maximum allowable cost prices in a timely manner to
13 remain consistent with pricing changes and product availability in
14 the marketplace;
15 (vi) must:
16 (a) provide a procedure under which a
17 network pharmacy provider may challenge a listed maximum allowable
18 cost price for a drug;
19 (b) respond to a challenge not later
20 than the 15th day after the date the challenge is made;
21 (c) if the challenge is successful,
22 make an adjustment in the drug price effective on the date the
23 challenge is resolved and make the adjustment applicable to all
24 similarly situated network pharmacy providers, as determined by the
25 managed care organization or pharmacy benefit manager, as
26 appropriate;
27 (d) if the challenge is denied,

1 provide the reason for the denial; and
2 (e) report to the commission every 90
3 days the total number of challenges that were made and denied in the
4 preceding 90-day period for each maximum allowable cost list drug
5 for which a challenge was denied during the period;
6 (vii) must notify the commission not later
7 than the 21st day after implementing a practice of using a maximum
8 allowable cost list for drugs dispensed at retail but not by mail;
9 and
10 (viii) must provide a process for each of
11 its network pharmacy providers to readily access the maximum
12 allowable cost list specific to that provider; and
13 (L) under which the managed care organization or
14 pharmacy benefit manager, as applicable:
15 (i) may not require a prior authorization,
16 other than a clinical prior authorization or a prior authorization
17 imposed by the commission to minimize the opportunity for waste,
18 fraud, or abuse, for or impose any other barriers to a drug that is
19 prescribed to a child enrolled in the STAR Kids managed care program
20 for a particular disease or treatment and that is on the vendor drug
21 program formulary or require additional prior authorization for a
22 drug included in the preferred drug list adopted under Section
23 531.072;
24 (ii) must provide for continued access to a
25 drug prescribed to a child enrolled in the STAR Kids managed care
26 program, regardless of whether the drug is on the vendor drug
27 program formulary or, if applicable on or after August 31, 2023, the

managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(iv) must pay liquidated damages to the commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

1 (26) a requirement that the managed care organization
2 make initial and subsequent primary care provider assignments and
3 changes.

4 SECTION 3. (a) The Health and Human Services Commission
5 shall, in a contract between the commission and a managed care
6 organization under Chapter 533, Government Code, that is entered
7 into or renewed on or after the effective date of this Act, require
8 that the managed care organization comply with Sections
9 531.073(a-5) and 533.005(a)(23)(C-2), Government Code, as added by
10 this Act.

11 (b) The Health and Human Services Commission shall seek to
12 amend contracts entered into with managed care organizations under
13 Chapter 533, Government Code, before the effective date of this Act
14 to require those managed care organizations to comply with Sections
15 531.073(a-5) and 533.005(a)(23)(C-2), Government Code, as added by
16 this Act. To the extent of a conflict between those sections and a
17 provision of a contract with a managed care organization entered
18 into before the effective date of this Act, the contract provision
19 prevails.

20 SECTION 4. If before implementing any provision of this Act
21 a state agency determines that a waiver or authorization from a
22 federal agency is necessary for implementation of that provision,
23 the agency affected by the provision shall request the waiver or
24 authorization and may delay implementing that provision until the
25 waiver or authorization is granted.

26 SECTION 5. This Act takes effect September 1, 2021.