By: Hull 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) and (a-4) 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
2 clinical, nonpreferred, or other prior authorization for an
3 antipsychotic drug prescribed to an adult patient if:
4 (1) the patient has a diagnosed mental illness, as
5 defined by Section 571.003, Health and Safety Code, for which the
6 drug is prescribed;
7 (2) the prescribing physician or other health care
8 provider determines there is a medical necessity for prescribing
9 the drug based on:
10 (A) the treatment failure of a comparable drug on
11 an appropriate preferred drug list or within any subclass of a drug
12 on that list;
13 (B) medical contraindication of a drug on an
14 appropriate preferred drug list; or
15 (C) an allergic reaction to a drug on an
16 appropriate preferred drug list;
17 (3) the prescribing physician or other health care
18 provider determines, in consultation with the patient, that the
19 drug is the most appropriate course of treatment for the patient's
20 mental illness;
21 (4) the drug is approved for use by the United States
22 Food and Drug Administration;
23 (5) the prescribing physician or other health care
24 provider clearly indicates on the prescription that the drug must
25 be dispensed as written; and
26 (6) the prescribing physician or other health care
27 provider documents in the patient's health care record that each

1 requirement under this subsection has been satisfied.
2 (a-4) Subsection (a-3) does not affect:
3 (1) the authority of a pharmacist to dispense the
4 generic equivalent or interchangeable biological product of a
5 prescription drug in accordance with Subchapter A, Chapter 562,
6 Occupations Code; or
7 (2) any drug utilization review requirements
8 prescribed by state or federal law.
9 SECTION 2. Section 533.005(a), Government Code, is amended
10 to read as follows:
11 (a) A contract between a managed care organization and the
12 commission for the organization to provide health care services to
13 recipients must contain:
14 (1) procedures to ensure accountability to the state
15 for the provision of health care services, including procedures for
16 financial reporting, quality assurance, utilization review, and
17 assurance of contract and subcontract compliance;
18 (2) capitation rates that ensure the cost-effective
19 provision of quality health care;
20 (3) a requirement that the managed care organization
21 provide ready access to a person who assists recipients in
22 resolving issues relating to enrollment, plan administration,
23 education and training, access to services, and grievance
24 procedures;
25 (4) a requirement that the managed care organization
26 provide ready access to a person who assists providers in resolving
27 issues relating to payment, plan administration, education and

1 training, and grievance procedures;
2 (5) a requirement that the managed care organization
3 provide information and referral about the availability of
4 educational, social, and other community services that could
5 benefit a recipient;
6 (6) procedures for recipient outreach and education;
7 (7) a requirement that the managed care organization
8 make payment to a physician or provider for health care services
9 rendered to a recipient under a managed care plan on any claim for
10 payment that is received with documentation reasonably necessary
11 for the managed care organization to process the claim:
12 (A) not later than:
13 (i) the 10th day after the date the claim is
14 received if the claim relates to services provided by a nursing
15 facility, intermediate care facility, or group home;
16 (ii) the 30th day after the date the claim
17 is received if the claim relates to the provision of long-term
18 services and supports not subject to Subparagraph (i); and
19 (iii) the 45th day after the date the claim
20 is received if the claim is not subject to Subparagraph (i) or (ii);
21 or
22 (B) within a period, not to exceed 60 days,
23 specified by a written agreement between the physician or provider
24 and the managed care organization;
25 (7-a) a requirement that the managed care organization
26 demonstrate to the commission that the organization pays claims
27 described by Subdivision (7)(A)(ii) on average not later than the

1 21st day after the date the claim is received by the organization;
2 (8) a requirement that the commission, on the date of a
3 recipient's enrollment in a managed care plan issued by the managed
4 care organization, inform the organization of the recipient's
5 Medicaid certification date;
6 (9) a requirement that the managed care organization
7 comply with Section 533.006 as a condition of contract retention
8 and renewal;
9 (10) a requirement that the managed care organization
10 provide the information required by Section 533.012 and otherwise
11 comply and cooperate with the commission's office of inspector
12 general and the office of the attorney general;
13 (11) a requirement that the managed care
14 organization's usages of out-of-network providers or groups of
15 out-of-network providers may not exceed limits for those usages
16 relating to total inpatient admissions, total outpatient services,
17 and emergency room admissions determined by the commission;
18 (12) if the commission finds that a managed care
19 organization has violated Subdivision (11), a requirement that the
20 managed care organization reimburse an out-of-network provider for
21 health care services at a rate that is equal to the allowable rate
22 for those services, as determined under Sections 32.028 and
23 32.0281, Human Resources Code;
24 (13) a requirement that, notwithstanding any other
25 law, including Sections 843.312 and 1301.052, Insurance Code, the
26 organization:
27 (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 determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

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

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

(B) the contracting with physicians who are not

1 network providers and who are of the same or related specialty as
2 the appealing physician to resolve claims disputes related to
3 denial on the basis of medical necessity that remain unresolved
4 subsequent to a provider appeal;
5 (C) the determination of the physician resolving
6 the dispute to be binding on the managed care organization and
7 provider; and
8 (D) the managed care organization to allow a
9 provider with a claim that has not been paid before the time
10 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
11 claim;
12 (16) a requirement that a medical director who is
13 authorized to make medical necessity determinations is available to
14 the region where the managed care organization provides health care
15 services;
16 (17) a requirement that the managed care organization
17 ensure that a medical director and patient care coordinators and
18 provider and recipient support services personnel are located in
19 the South Texas service region, if the managed care organization
20 provides a managed care plan in that region;
21 (18) a requirement that the managed care organization
22 provide special programs and materials for recipients with limited
23 English proficiency or low literacy skills;
24 (19) a requirement that the managed care organization
25 develop and establish a process for responding to provider appeals
26 in the region where the organization provides health care services;
27 (20) a requirement that the managed care organization:

1 (A) develop and submit to the commission, before
2 the organization begins to provide health care services to
3 recipients, a comprehensive plan that describes how the
4 organization's provider network complies with the provider access
5 standards established under Section 533.0061;
6 (B) as a condition of contract retention and
7 renewal:
8 (i) continue to comply with the provider
9 access standards established under Section 533.0061; and
10 (ii) make substantial efforts, as
11 determined by the commission, to mitigate or remedy any
12 noncompliance with the provider access standards established under
13 Section 533.0061;
14 (C) pay liquidated damages for each failure, as
15 determined by the commission, to comply with the provider access
16 standards established under Section 533.0061 in amounts that are
17 reasonably related to the noncompliance; and
18 (D) regularly, as determined by the commission,
19 submit to the commission and make available to the public a report
20 containing data on the sufficiency of the organization's provider
21 network with regard to providing the care and services described
22 under Section 533.0061(a) and specific data with respect to access
23 to primary care, specialty care, long-term services and supports,
24 nursing services, and therapy services on the average length of
25 time between:
26 (i) the date a provider requests prior
27 authorization for the care or service and the date the organization

1 approves or denies the request; and
2 (ii) the date the organization approves a
3 request for prior authorization for the care or service and the date
4 the care or service is initiated;
5 (21) a requirement that the managed care organization
6 demonstrate to the commission, before the organization begins to
7 provide health care services to recipients, that, subject to the
8 provider access standards established under Section 533.0061:
9 (A) the organization's provider network has the
10 capacity to serve the number of recipients expected to enroll in a
11 managed care plan offered by the organization;
12 (B) the organization's provider network
13 includes:
14 (i) a sufficient number of primary care
15 providers;
16 (ii) a sufficient variety of provider
17 types;
18 (iii) a sufficient number of providers of
19 long-term services and supports and specialty pediatric care
20 providers of home and community-based services; and
21 (iv) providers located throughout the
22 region where the organization will provide health care services;
23 and
24 (C) health care services will be accessible to
25 recipients through the organization's provider network to a
26 comparable extent that health care services would be available to
27 recipients under a fee-for-service or primary care case management

model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that, except as provided by Paragraph (L)(ii), exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements

1 prescribed by or implemented under Sections 531.073(b), (c), and
2 (g) for the vendor drug program;
3 (C-1) that does not require a clinical,
4 nonpreferred, or other prior authorization for any antiretroviral
5 drug, as defined by Section 531.073, or a step therapy or other
6 protocol, that could restrict or delay the dispensing of the drug
7 except to minimize fraud, waste, or abuse;
8 (C-2) that does not require a clinical,
9 nonpreferred, or other prior authorization for an antipsychotic
10 drug prescribed to an adult recipient if the requirements of
11 Section 531.073(a-3) are met;
12 (D) for purposes of which the managed care
13 organization:
14 (i) may not negotiate or collect rebates
15 associated with pharmacy products on the vendor drug program
16 formulary; and
17 (ii) may not receive drug rebate or pricing
18 information that is confidential under Section 531.071;
19 (E) that complies with the prohibition under
20 Section 531.089;
21 (F) under which the managed care organization may
22 not prohibit, limit, or interfere with a recipient's selection of a
23 pharmacy or pharmacist of the recipient's choice for the provision
24 of pharmaceutical services under the plan through the imposition of
25 different copayments;
26 (G) that allows the managed care organization or
27 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;

1 (K) under which the managed care organization or
2 pharmacy benefit manager, as applicable:
3 (i) to place a drug on a maximum allowable
4 cost list, must ensure that:
5 (a) the drug is listed as "A" or "B"
6 rated in the most recent version of the United States Food and Drug
7 Administration's Approved Drug Products with Therapeutic
8 Equivalence Evaluations, also known as the Orange Book, has an "NR"
9 or "NA" rating or a similar rating by a nationally recognized
10 reference; and
11 (b) the drug is generally available
12 for purchase by pharmacies in the state from national or regional
13 wholesalers and is not obsolete;
14 (ii) must provide to a network pharmacy
15 provider, at the time a contract is entered into or renewed with the
16 network pharmacy provider, the sources used to determine the
17 maximum allowable cost pricing for the maximum allowable cost list
18 specific to that provider;
19 (iii) must review and update maximum
20 allowable cost price information at least once every seven days to
21 reflect any modification of maximum allowable cost pricing;
22 (iv) must, in formulating the maximum
23 allowable cost price for a drug, use only the price of the drug and
24 drugs listed as therapeutically equivalent in the most recent
25 version of the United States Food and Drug Administration's
26 Approved Drug Products with Therapeutic Equivalence Evaluations,
27 also known as the Orange Book;

1 (v) must establish a process for
2 eliminating products from the maximum allowable cost list or
3 modifying maximum allowable cost prices in a timely manner to
4 remain consistent with pricing changes and product availability in
5 the marketplace;
6 (vi) must:
7 (a) provide a procedure under which a
8 network pharmacy provider may challenge a listed maximum allowable
9 cost price for a drug;
10 (b) respond to a challenge not later
11 than the 15th day after the date the challenge is made;
12 (c) if the challenge is successful,
13 make an adjustment in the drug price effective on the date the
14 challenge is resolved and make the adjustment applicable to all
15 similarly situated network pharmacy providers, as determined by the
16 managed care organization or pharmacy benefit manager, as
17 appropriate;
18 (d) if the challenge is denied,
19 provide the reason for the denial; and
20 (e) report to the commission every 90
21 days the total number of challenges that were made and denied in the
22 preceding 90-day period for each maximum allowable cost list drug
23 for which a challenge was denied during the period;
24 (vii) must notify the commission not later
25 than the 21st day after implementing a practice of using a maximum
26 allowable cost list for drugs dispensed at retail but not by mail;
27 and

1 (viii) must provide a process for each of
2 its network pharmacy providers to readily access the maximum
3 allowable cost list specific to that provider; and
4 (L) under which the managed care organization or
5 pharmacy benefit manager, as applicable:
6 (i) may not require a prior authorization,
7 other than a clinical prior authorization or a prior authorization
8 imposed by the commission to minimize the opportunity for waste,
9 fraud, or abuse, for or impose any other barriers to a drug that is
10 prescribed to a child enrolled in the STAR Kids managed care program
11 for a particular disease or treatment and that is on the vendor drug
12 program formulary or require additional prior authorization for a
13 drug included in the preferred drug list adopted under Section
14 531.072;
15 (ii) must provide for continued access to a
16 drug prescribed to a child enrolled in the STAR Kids managed care
17 program, regardless of whether the drug is on the vendor drug
18 program formulary or, if applicable on or after August 31, 2023, the
19 managed care organization's formulary;
20 (iii) may not use a protocol that requires a
21 child enrolled in the STAR Kids managed care program to use a
22 prescription drug or sequence of prescription drugs other than the
23 drug that the child's physician recommends for the child's
24 treatment before the managed care organization provides coverage
25 for the recommended drug; and
26 (iv) must pay liquidated damages to the
27 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

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

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

1 (b) The Health and Human Services Commission shall seek to
2 amend contracts entered into with managed care organizations under
3 Chapter 533, Government Code, before the effective date of this Act
4 to require those managed care organizations to comply with Section
5 533.005(a)(23)(C-2), Government Code, as added by this Act. To the
6 extent of a conflict between that section and a provision of a
7 contract with a managed care organization entered into before the
8 effective date of this Act, the contract provision prevails.

9 SECTION 4. If before implementing any provision of this Act
10 a state agency determines that a waiver or authorization from a
11 federal agency is necessary for implementation of that provision,
12 the agency affected by the provision shall request the waiver or
13 authorization and may delay implementing that provision until the
14 waiver or authorization is granted.

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