By: J. Davis of Harris H.B. No. 1137

A BILL TO BE ENTITLED

AN ACT

relating to the use of maximum allowable cost lists under a Medicaid managed care pharmacy benefit plan.

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

SECTION 1. Section 531.021, Government Code, is amended by adding Subsection (h) to read as follows:

(h) The executive commissioner shall:

(1) adopt rules and establish procedures under which a pharmacy participating in the network of a managed care organization contracting with the commission under Chapter 533 may appeal and have the commission review a denial by the managed care organization or a subcontracted pharmacy benefit manager, as applicable, of a challenge by the pharmacy of the managed care organization's or pharmacy benefit manager's maximum allowable cost price for a drug; and

(2) require the managed care organization or pharmacy benefit manager, as applicable, to make any required adjustment in the maximum allowable cost price for the drug:

(A) retroactive to the date the challenge was made; and

(B) applicable to all pharmacies participating in the network.

SECTION 2. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan not later than the 45th day after the date a claim for payment is received with

documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, 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 the organization use advanced

practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

(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 network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

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

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to

the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:

(A) the organization's provider network has the

capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

(iii) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to 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;

(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 exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program;

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

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing 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; [~~and~~]

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in

accordance with Section 843.339, Insurance Code; and

(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 has at least three nationally available, therapeutically equivalent, multiple source drugs with a significant cost difference;

(b) the drug is listed as therapeutically and pharmaceutically equivalent or "A" 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; and

(c) the drug is available for purchase without limitation by all pharmacies in the state from national or regional wholesalers and is not obsolete or temporarily unavailable;

(ii) must disclose to its network pharmacy providers and to the commission the basis of the maximum allowable cost price for each drug on the list and the methodology and sources used to determine that price;

(iii) must update maximum allowable cost price information at least every seven days and establish a reasonable process to allow for the prompt notification of network pharmacy providers and the commission of pricing updates;

(iv) must establish a reasonable process for eliminating products from the maximum allowable cost list or

modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes in the marketplace;

(v) must:

(a) provide a reasonable procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) make an adjustment in the drug price retroactive to the date the challenge was made and make the adjustment applicable to all network pharmacy providers, if the challenge is successful;

(d) if the challenge is denied, provide the reason for the denial and notify the network pharmacy provider of where the drug may be purchased at a price at or below the maximum allowable cost price for the relevant time period;

(e) allow a network pharmacy provider to appeal a denied challenge by having the denial reviewed by the commission according to rules adopted and procedures established by the executive commissioner; and

(f) report to the commission every 90 days, and to each network pharmacy provider upon request, the total number of challenges that were denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vi) must notify the commission not later than the 21st day after implementing a practice of using a maximum

allowable cost list for drugs dispensed at retail but not by mail; and

(vii) must disclose to the commission whether the maximum allowable cost list used with respect to billing the commission is the same as the list used when reimbursing network pharmacy providers and, if not, disclose to the commission any variance between amounts paid to network pharmacy providers and amounts charged to the commission; and

(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.

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), Government Code, as amended by this Act.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to require those managed care organizations to comply with Section 533.005(a), Government Code, as amended by this Act. To the extent of a conflict between that subsection and a provision of a contract

with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

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

SECTION 5. This Act takes effect September 1, 2013.