

By: Schwertner, Hinojosa
Van de Putte

S.B. No. 1106

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 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (a-2) 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

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 not later than the
10 45th day after the date a claim for payment is received with
11 documentation reasonably necessary for the managed care
12 organization to process the claim, or within a period, not to exceed
13 60 days, specified by a written agreement between the physician or
14 provider and the managed care organization;

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

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

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

26 (11) a requirement that the managed care
27 organization's usages of out-of-network providers or groups of

1 out-of-network providers may not exceed limits for those usages
2 relating to total inpatient admissions, total outpatient services,
3 and emergency room admissions determined by the commission;

4 (12) if the commission finds that a managed care
5 organization has violated Subdivision (11), a requirement that the
6 managed care organization reimburse an out-of-network provider for
7 health care services at a rate that is equal to the allowable rate
8 for those services, as determined under Sections 32.028 and
9 32.0281, Human Resources Code;

10 (13) a requirement that the organization use advanced
11 practice nurses in addition to physicians as primary care providers
12 to increase the availability of primary care providers in the
13 organization's provider network;

14 (14) a requirement that the managed care organization
15 reimburse a federally qualified health center or rural health
16 clinic for health care services provided to a recipient outside of
17 regular business hours, including on a weekend day or holiday, at a
18 rate that is equal to the allowable rate for those services as
19 determined under Section 32.028, Human Resources Code, if the
20 recipient does not have a referral from the recipient's primary
21 care physician;

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

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

1 (B) the contracting with physicians who are not
2 network providers and who are of the same or related specialty as
3 the appealing physician to resolve claims disputes related to
4 denial on the basis of medical necessity that remain unresolved
5 subsequent to a provider appeal; and

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

9 (16) a requirement that a medical director who is
10 authorized to make medical necessity determinations is available to
11 the region where the managed care organization provides health care
12 services;

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

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

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

24 (20) a requirement that the managed care organization
25 develop and submit to the commission, before the organization
26 begins to provide health care services to recipients, a
27 comprehensive plan that describes how the organization's provider

1 network will provide recipients sufficient access to:

- 2 (A) preventive care;
- 3 (B) primary care;
- 4 (C) specialty care;
- 5 (D) after-hours urgent care; and
- 6 (E) chronic care;

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

10 (A) the organization's provider network has the
11 capacity to serve the number of recipients expected to enroll in a
12 managed care plan offered by the organization;

13 (B) the organization's provider network
14 includes:

15 (i) a sufficient number of primary care
16 providers;

17 (ii) a sufficient variety of provider
18 types; and

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

22 (C) health care services will be accessible to
23 recipients through the organization's provider network to a
24 comparable extent that health care services would be available to
25 recipients under a fee-for-service or primary care case management
26 model of Medicaid managed care;

27 (22) a requirement that the managed care organization

1 develop a monitoring program for measuring the quality of the
2 health care services provided by the organization's provider
3 network that:

4 (A) incorporates the National Committee for
5 Quality Assurance's Healthcare Effectiveness Data and Information
6 Set (HEDIS) measures;

7 (B) focuses on measuring outcomes; and

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

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

15 (A) that exclusively employs the vendor drug
16 program formulary and preserves the state's ability to reduce
17 waste, fraud, and abuse under the Medicaid program;

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

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

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

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

1 (ii) may not receive drug rebate or pricing
2 information that is confidential under Section 531.071;

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

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

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

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

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

25 (H) under which the managed care organization may
26 not prevent a pharmacy or pharmacist from participating as a
27 provider if the pharmacy or pharmacist agrees to comply with the

1 financial terms and conditions of the contract as well as other
2 reasonable administrative and professional terms and conditions of
3 the contract;

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

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

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

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

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

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

25 (ii) must provide to a network pharmacy
26 provider, at the time a contract is entered into or renewed with the
27 network pharmacy provider, the sources used to determine the

1 maximum allowable cost pricing for the maximum allowable cost list
2 specific to that provider;

3 (iii) must review and update maximum
4 allowable cost price information at least once every seven days to
5 reflect any modification of maximum allowable cost pricing;

6 (iv) must, in formulating the maximum
7 allowable cost price for a drug, use only the price of the drug and
8 drugs listed as therapeutically equivalent in the most recent
9 version of the United States Food and Drug Administration's
10 Approved Drug Products with Therapeutic Equivalence Evaluations,
11 also known as the Orange Book;

12 (v) must establish a process for
13 eliminating products from the maximum allowable cost list or
14 modifying maximum allowable cost prices in a timely manner to
15 remain consistent with pricing changes and product availability in
16 the marketplace;

17 (vi) must:

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

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

23 (c) if the challenge is successful,
24 make an adjustment in the drug price effective on the date the
25 challenge is resolved, and make the adjustment applicable to all
26 similarly situated network pharmacy providers, as determined by the
27 managed care organization or pharmacy benefit manager, as

1 appropriate;

2 (d) if the challenge is denied,
3 provide the reason for the denial; and

4 (e) report to the commission every 90
5 days the total number of challenges that were made and denied in the
6 preceding 90-day period for each maximum allowable cost list drug
7 for which a challenge was denied during the period;

8 (vii) must notify the commission not later
9 than the 21st day after implementing a practice of using a maximum
10 allowable cost list for drugs dispensed at retail but not by mail;
11 and

12 (viii) must provide a process for each of
13 its network pharmacy providers to readily access the maximum
14 allowable cost list specific to that provider; and

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

22 (a-2) Except as provided by Subsection (a)(23)(K)(viii), a
23 maximum allowable cost list specific to a provider and maintained
24 by a managed care organization or pharmacy benefit manager is
25 confidential.

26 SECTION 2. (a) The Health and Human Services Commission
27 shall, in a contract between the commission and a managed care

1 organization under Chapter 533, Government Code, that is entered
2 into or renewed on or after the effective date of this Act, require
3 that the managed care organization comply with Subsection (a),
4 Section 533.005, Government Code, as amended by this Act.

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

14 SECTION 3. If before implementing any provision of this Act
15 a state agency determines that a waiver or authorization from a
16 federal agency is necessary for implementation of that provision,
17 the agency affected by the provision shall request the waiver or
18 authorization and may delay implementing that provision until the
19 waiver or authorization is granted.

20 SECTION 4. (a) Except as provided by Subsection (b) of
21 this section, this Act takes effect September 1, 2013.

22 (b) Subparagraph (viii), Paragraph (K), Subdivision (23),
23 Subsection (a), Section 533.005, Government Code, as added by this
24 Act, takes effect March 1, 2014.