By: Schwertner S.B. No. 1922

A BILL TO BE ENTITLED

AN ACT

relating to prescription drug benefits in the Medicaid managed care program.

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

SECTION 1. Chapter 533, Government Code, is amended by adding Subchapter B to read as follows:

SUBCHAPTER B. PRESCRIPTION DRUG BENEFITS

Sec. 533.051. DEFINITIONS. In this subchapter:

(1) "Labeler" and "manufacturer" have the meanings assigned by Section 531.070.

(2) "Recipient" means a Medicaid recipient.

(3) "Step therapy protocol" means a protocol that requires a recipient to use a prescription drug or sequence of prescription drugs other than the drug that the recipient's physician recommends for the recipient's treatment before a managed care organization provides coverage for the recommended drug.

Sec. 533.052. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to an outpatient pharmacy benefit plan implemented by a managed care organization that contracts with the commission to provide health care benefits to recipients.

(b) To the extent of a conflict between the requirements for an outpatient pharmacy benefit plan for a managed care organization's enrolled recipients specified by Sections 533.005(a)(23)(A), (B), and (C) and the requirements for that plan

specified by this subchapter, the requirements specified by Sections 533.005(a)(23)(A), (B), and (C) prevail. This subsection expires August 31, 2018.

Sec. 533.053. STEP THERAPY PROTOCOL EXCEPTION REQUESTS. (a) A managed care organization shall establish a process in a user-friendly format through which an exception request under this section may be submitted by a prescribing provider. The process must be readily accessible to:

(1) a recipient who enrolls in a managed care plan offered by the managed care organization or transfers to a managed care plan offered by the managed care organization from a managed care plan offered by another managed care organization; and

(2) the provider.

(b) A prescribing provider on behalf of a recipient may submit to the recipient's managed care organization a written request for an exception to a step therapy protocol required by the recipient's managed care organization. The executive commissioner by rule shall prescribe the form of the written request.

(c) A managed care organization shall grant a written request under Subsection (b) if the request includes the prescribing provider's written statement stating that:

(1) the drug required under the step therapy protocol:

(A) is contraindicated;

(B) will likely cause an adverse reaction in or physical or mental harm to the recipient; or

(C) is expected to be ineffective based on the known clinical characteristics of the recipient and the known

characteristics of the prescription drug regimen;

(2) the recipient previously discontinued taking the drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the required drug:

(A) while enrolled in a managed care plan offered by the recipient's current managed care organization or while enrolled in a managed care plan offered by another managed care organization; and

(B) because the drug was not effective or had a diminished effect or because of an adverse event;

(3) the drug required under the step therapy protocol is not in the best interest of the recipient, based on clinical appropriateness, because the recipient's use of the drug is expected to:

(A) cause a significant barrier to the recipient's adherence to or compliance with the recipient's plan of care;

(B) worsen a comorbid condition of the recipient; or

(C) decrease the recipient's ability to achieve or maintain reasonable functional ability in performing daily activities; or

(4) the drug that is subject to the step therapy protocol was prescribed for the recipient's condition while enrolled in a managed care plan offered by the recipient's current managed care organization or while enrolled in a managed care plan

offered by a previous managed care organization and the recipient is stable on the drug.

(d) Except as provided by Subsection (e), if a managed care organization does not deny an exception request described by Subsection (b) before 72 hours after the managed care organization receives the request, the request is considered granted.

(e) If a written statement described by Subsection (c) also states that the prescribing provider reasonably believes that denial of the request makes the death of or serious harm to the recipient probable, the request is considered granted if the managed care organization does not deny the request before 24 hours after the managed care organization receives the request.

Sec. 533.054. CONTINUITY OF CARE. A managed care organization shall provide coverage to a recipient who enrolls in a managed care plan offered by the managed care organization or transfers to a managed care plan offered by the managed care organization from a managed care plan offered by another managed care organization for a prescription drug prescribed for the recipient before the enrollment or transfer for a 90-day period following the date of the enrollment or transfer, regardless of whether the prescription drug is on the managed care organization's preferred drug list.

Sec. 533.055. ACCESS TO INFORMATION REGARDING PRESCRIPTION DRUG REBATES, PRICING, AND NEGOTIATIONS. (a) The commission may require the submission of and review information obtained or maintained by a managed care organization regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate

agreement, including the rebate amount, rebate percentage, and manufacturer or labeler pricing.

(b) Information described by Subsection (a) that a managed care organization submits to the commission as required by the commission is confidential and not subject to disclosure under Chapter 552.

(c) Subsection (b) does not:

(1) authorize the commission to withhold from individual members, agencies, or committees of the legislature for use for legislative purposes information described by Subsection (a) that a managed care organization submits to the commission; or

(2) affect the applicability of Section 552.008.

Sec. 533.056. PREFERRED DRUG LIST. A managed care organization shall provide for the distribution of current copies of the managed care organization's preferred drug list by posting the list on the managed care organization's Internet website.

Sec. 533.057. PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS. (a) Except as provided by Subsection (b), a managed care organization may not require prior authorization for prescription drugs that, as determined by the commission, are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies.

(b) Subsection (a) applies only to a drug that is prescribed for a use approved by the United States Food and Drug Administration. A managed care organization may require prior

authorization for a drug prescribed for a use that is not approved by the United States Food and Drug Administration.

(c) Once every 10 years, the commission shall conduct a study to evaluate and determine the classes of prescription drugs for which prior authorizations are prohibited under Subsection (a).

(d) A managed care organization shall ensure that a drug prescribed before the managed care organization implements a prior authorization requirement for that drug is not subject to the prior authorization requirement until the earlier of:

(1) the date the recipient exhausts the prescription, including any authorized refills; or

(2) the expiration of a period specified by the managed care organization.

SECTION 2. Not later than September 1, 2018, the Health and Human Services Commission shall conduct the initial study required by Section 533.057(c), Government Code, as added by this Act.

SECTION 3. 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 4. This Act takes effect September 1, 2017.