BILL ANALYSIS

Senate Research Center

S.B. 1096
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Health & Human Services
6/14/2019
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Medically Dependent Children Program (MDCP) serves approximately 5,600 children and young adults under the age of 21. The program offers community-based services for children with disabilities who require a nursing facility level of care. MDCP allows children with disabilities and complex medical needs to access Medicaid services on a medical-needs-based criteria, allowing the child to remain at home with family while still accessing and receiving life-sustaining, medically necessary services which keep them alive, stable, and in the community.

Currently, some drugs on the formulary may require prior authorization. Pharmacy prior authorization services for Medicaid Managed Care enrollees are administered by the managed care organization, and the MCOs/PBMs often add their own clinical edits, clinical authorizations, cost ceilings in violation of federal EPSDT and state Medicaid policies, and other additional requirements or barriers, including fail-first or step therapy requirements.

This causes unnecessary and harmful denials and delays, resulting in the child decompensating, their condition deteriorating, and/or causing further complications; ER visits; hospitalizations solely to access medications that could be administered at home or in an outpatient setting; and increased level of care, again resulting in costly and harmful delays; and increased costs to the state.

S.B. 1096 will ensure a prior authorization for a drug that is prescribed to an MDCP enrollee is approved if that drug appears on the formulary without additional barriers, clinical edits or other requirements, fail-first or step therapy, or authorizations, regardless of whether the drug is preferred or not.

The bill also ensures continued access to medications already prescribed for a program enrollee. (Original Author's/Sponsor's Statement of Intent)

S.B. 1096 amends current law relating to the Medicaid managed care program, including the provision of pharmacy benefits.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 533.00253, Government Code, by adding Subsections (m) and (n), as follows:

> (m) Requires the STAR Kids Managed Care Advisory Committee (advisory committee) or a successor committee to explore the feasibility of adopting a private duty nursing assessment for use in the STAR Kids managed care program and provide recommendations to the Health and Human Services Commission (HHSC) on adopting a private duty nursing assessment tool that would streamline the documentation for prior

authorization of private duty nursing. Provides that this subsection expires September 1, 2021.

(n) Requires HHSC, at least once every two years, to conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

SECTION 2. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.002821, as follows:

Sec. 533.002821. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. Requires a contract between a managed care organization and HHSC described by Section 533.005 (Required Contract Provisions), in addition to the requirements of that section, to require that, notwithstanding any other law, the organization review and issue determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames:

(1) within one business day after receiving the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition.

SECTION 3. Amends Section 533.005, Government Code, by amending Subsection (a) and adding Subsection (g), as follows:

(a) Requires a contract between a managed care organization and HHSC for the organization to provide health care services to recipients to contain:

(1)–(21) makes no changes to these subdivisions;

(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; and

(B) and (C) makes no changes to these paragraphs;

(23) subject to Subsection (a-1) (relating to prohibiting certain requirements from being enforced on and after August 31, 2023), 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) makes no changes to this paragraph;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b) (relating to prior authorization procedures), (c) (relating to prescriptions prescribed before implementation of a prior authorization requirement), and (g) (relating to methods of submitting requests for prior authorization) for the vendor drug program;

(D)-(I) makes no changes to these paragraphs;

(J)-(K) makes nonsubstantive changes to these paragraphs; and

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

(i) is prohibited from requiring a prior authorization, other than a clinical prior authorization or a prior authorization imposed by HHSC to minimize the opportunity for waste, fraud, or abuse, for or imposing any other barriers to a drug that is prescribed to a child enrolled in the STAR KIDS managed care program for a particular disease or treatment and that is on the vendor drug program formulary or requiring additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072 (Preferred Drug Lists);

(ii) is required to provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) is prohibited from using 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) is required to pay liquidated damages to HHSC for each failure, as determined by HHSC, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

(24) makes no changes to this subdivision;

(25) makes a nonsubstantive change to this subdivision; and

(26) makes no changes to this subdivision.

(g) Requires HHSC to provide guidance and additional education to managed care organizations with which HHSC enters into contracts described by Subsection (a) regarding requirements under federal law to continue to provide services during an internal appeal, a Medicaid fair hearing, or any other review.

SECTION 4. (a) Makes application of Section 533.002821, Government Code, as added by this Act, and 533.005, Government Code, as amended by this Act, prospective.

(b) Requires HHSC, as soon as practicable after the effective date of this Act but not later than September 1, 2020, to seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act

to include the provisions required by Section 533.002821, Government Code, as added by this Act, and Section 533.005, Government Code, as amended by this Act.

SECTION 5. Requires a state agency affected by any provision of this Act, if before implementing the provision the state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 6. Provides that HHSC is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Authorizes, but does not require, HHSC, if the legislature does not appropriate money specifically for that purpose, to implement a provision of this Act using other appropriations available for that purpose.

SECTION 7. Effective date: September 1, 2019.