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S.B. No. 1283

A BILL TO BE ENTITLED

AN ACT

relating to the availability under Medicaid of certain drugs used to treat human immunodeficiency virus or prevent acquired immune deficiency syndrome.

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 Subsection (j) 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 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.

1 (j) The executive commissioner, in the rules and standards
2 governing the Medicaid vendor drug program, may not require a
3 clinical, nonpreferred, or other prior authorization for an
4 antiretroviral drug, or a step therapy or other protocol, that
5 could restrict or delay the dispensing of the drug. In this
6 subsection, "antiretroviral drug" means a drug that treats human
7 immunodeficiency virus infection or prevents acquired immune
8 deficiency syndrome. The term includes:

9 (1) protease inhibitors;
10 (2) non-nucleoside reverse transcriptase inhibitors;
11 (3) nucleoside reverse transcriptase inhibitors;
12 (4) integrase inhibitors;
13 (5) fusion inhibitors;
14 (6) attachment inhibitors;
15 (7) CD4 post-attachment inhibitors;
16 (8) CCR5 receptor antagonists; and
17 (9) other antiretroviral drugs used to treat human
18 immunodeficiency virus infection or prevent acquired immune
19 deficiency syndrome.

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

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

25 (1) procedures to ensure accountability to the state
26 for the provision of health care services, including procedures for
27 financial reporting, quality assurance, utilization review, and

1 assurance of contract and subcontract compliance;

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

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

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

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

17 (6) procedures for recipient outreach and education;

18 (7) a requirement that the managed care organization
19 make payment to a physician or provider for health care services
20 rendered to a recipient under a managed care plan on any claim for
21 payment that is received with documentation reasonably necessary
22 for the managed care organization to process the claim:

23 (A) not later than:

24 (i) the 10th day after the date the claim is
25 received if the claim relates to services provided by a nursing
26 facility, intermediate care facility, or group home;

27 (ii) the 30th day after the date the claim

1 is received if the claim relates to the provision of long-term
2 services and supports not subject to Subparagraph (i); and

3 (iii) the 45th day after the date the claim
4 is received if the claim is not subject to Subparagraph (i) or (ii);
5 or

6 (B) within a period, not to exceed 60 days,
7 specified by a written agreement between the physician or provider
8 and the managed care organization;

9 (7-a) a requirement that the managed care organization
10 demonstrate to the commission that the organization pays claims
11 described by Subdivision (7)(A)(ii) on average not later than the
12 21st day after the date the claim is received by the organization;

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

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

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

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

1 and emergency room admissions determined by the commission;

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

8 (13) a requirement that, notwithstanding any other
9 law, including Sections 843.312 and 1301.052, Insurance Code, the
10 organization:

11 (A) use advanced practice registered nurses and
12 physician assistants in addition to physicians as primary care
13 providers to increase the availability of primary care providers in
14 the organization's provider network; and

15 (B) treat advanced practice registered nurses
16 and physician assistants in the same manner as primary care
17 physicians with regard to:

18 (i) selection and assignment as primary
19 care providers;

20 (ii) inclusion as primary care providers in
21 the organization's provider network; and

22 (iii) inclusion as primary care providers
23 in any provider network directory maintained by the organization;

24 (14) a requirement that the managed care organization
25 reimburse a federally qualified health center or rural health
26 clinic for health care services provided to a recipient outside of
27 regular business hours, including on a weekend day or holiday, at a

1 rate that is equal to the allowable rate for those services as
2 determined under Section 32.028, Human Resources Code, if the
3 recipient does not have a referral from the recipient's primary
4 care physician;

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

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

11 (B) the contracting with physicians who are not
12 network providers and who are of the same or related specialty as
13 the appealing physician to resolve claims disputes related to
14 denial on the basis of medical necessity that remain unresolved
15 subsequent to a provider appeal;

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

19 (D) the managed care organization to allow a
20 provider with a claim that has not been paid before the time
21 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
22 claim;

23 (16) a requirement that a medical director who is
24 authorized to make medical necessity determinations is available to
25 the region where the managed care organization provides health care
26 services;

27 (17) a requirement that the managed care organization

1 ensure that a medical director and patient care coordinators and
2 provider and recipient support services personnel are located in
3 the South Texas service region, if the managed care organization
4 provides a managed care plan in that region;

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

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

11 (20) a requirement that the managed care organization:

12 (A) develop and submit to the commission, before
13 the organization begins to provide health care services to
14 recipients, a comprehensive plan that describes how the
15 organization's provider network complies with the provider access
16 standards established under Section 533.0061;

17 (B) as a condition of contract retention and
18 renewal:

19 (i) continue to comply with the provider
20 access standards established under Section 533.0061; and

21 (ii) make substantial efforts, as
22 determined by the commission, to mitigate or remedy any
23 noncompliance with the provider access standards established under
24 Section 533.0061;

25 (C) pay liquidated damages for each failure, as
26 determined by the commission, to comply with the provider access
27 standards established under Section 533.0061 in amounts that are

1 reasonably related to the noncompliance; and

2 (D) regularly, as determined by the commission,
3 submit to the commission and make available to the public a report
4 containing data on the sufficiency of the organization's provider
5 network with regard to providing the care and services described
6 under Section 533.0061(a) and specific data with respect to access
7 to primary care, specialty care, long-term services and supports,
8 nursing services, and therapy services on the average length of
9 time between:

10 (i) the date a provider requests prior
11 authorization for the care or service and the date the organization
12 approves or denies the request; and

13 (ii) the date the organization approves a
14 request for prior authorization for the care or service and the date
15 the care or service is initiated;

16 (21) a requirement that the managed care organization
17 demonstrate to the commission, before the organization begins to
18 provide health care services to recipients, that, subject to the
19 provider access standards established under Section 533.0061:

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

23 (B) the organization's provider network
24 includes:

25 (i) a sufficient number of primary care
26 providers;

27 (ii) a sufficient variety of provider

1 types;

2 (iii) a sufficient number of providers of
3 long-term services and supports and specialty pediatric care
4 providers of home and community-based services; and

5 (iv) providers located throughout the
6 region where the organization will provide health care services;
7 and

8 (C) health care services will be accessible to
9 recipients through the organization's provider network to a
10 comparable extent that health care services would be available to
11 recipients under a fee-for-service or primary care case management
12 model of Medicaid managed care;

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

17 (A) incorporates the National Committee for
18 Quality Assurance's Healthcare Effectiveness Data and Information
19 Set (HEDIS) measures;

20 (B) focuses on measuring outcomes; and

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

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

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

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

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

9 (C-1) that does not require a clinical,
10 nonpreferred, or other prior authorization for an antiretroviral
11 drug, as defined by Section 531.073, or a step therapy or other
12 protocol, that could restrict or delay the dispensing of the drug;

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

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

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

20 (E) that complies with the prohibition under
21 Section 531.089;

22 (F) under which the managed care organization may
23 not prohibit, limit, or interfere with a recipient's selection of a
24 pharmacy or pharmacist of the recipient's choice for the provision
25 of pharmaceutical services under the plan through the imposition of
26 different copayments;

27 (G) that allows the managed care organization or

1 any subcontracted pharmacy benefit manager to contract with a
2 pharmacist or pharmacy providers separately for specialty pharmacy
3 services, except that:

4 (i) the managed care organization and
5 pharmacy benefit manager are prohibited from allowing exclusive
6 contracts with a specialty pharmacy owned wholly or partly by the
7 pharmacy benefit manager responsible for the administration of the
8 pharmacy benefit program; and

9 (ii) the managed care organization and
10 pharmacy benefit manager must adopt policies and procedures for
11 reclassifying prescription drugs from retail to specialty drugs,
12 and those policies and procedures must be consistent with rules
13 adopted by the executive commissioner and include notice to network
14 pharmacy providers from the managed care organization;

15 (H) under which the managed care organization may
16 not prevent a pharmacy or pharmacist from participating as a
17 provider if the pharmacy or pharmacist agrees to comply with the
18 financial terms and conditions of the contract as well as other
19 reasonable administrative and professional terms and conditions of
20 the contract;

21 (I) under which the managed care organization may
22 include mail-order pharmacies in its networks, but may not require
23 enrolled recipients to use those pharmacies, and may not charge an
24 enrolled recipient who opts to use this service a fee, including
25 postage and handling fees;

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

1 accordance with Section 843.339, Insurance Code; and

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

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

6 (a) the drug is listed as "A" or "B"
7 rated in the most recent version of the United States Food and Drug
8 Administration's Approved Drug Products with Therapeutic
9 Equivalence Evaluations, also known as the Orange Book, has an "NR"
10 or "NA" rating or a similar rating by a nationally recognized
11 reference; and

12 (b) the drug is generally available
13 for purchase by pharmacies in the state from national or regional
14 wholesalers and is not obsolete;

15 (ii) must provide to a network pharmacy
16 provider, at the time a contract is entered into or renewed with the
17 network pharmacy provider, the sources used to determine the
18 maximum allowable cost pricing for the maximum allowable cost list
19 specific to that provider;

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

23 (iv) must, in formulating the maximum
24 allowable cost price for a drug, use only the price of the drug and
25 drugs listed as therapeutically equivalent in the most recent
26 version of the United States Food and Drug Administration's
27 Approved Drug Products with Therapeutic Equivalence Evaluations,

1 also known as the Orange Book;

2 (v) must establish a process for
3 eliminating products from the maximum allowable cost list or
4 modifying maximum allowable cost prices in a timely manner to
5 remain consistent with pricing changes and product availability in
6 the marketplace;

7 (vi) must:

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

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

13 (c) if the challenge is successful,
14 make an adjustment in the drug price effective on the date the
15 challenge is resolved[7] and make the adjustment applicable to all
16 similarly situated network pharmacy providers, as determined by the
17 managed care organization or pharmacy benefit manager, as
18 appropriate;

19 (d) if the challenge is denied,
20 provide the reason for the denial; and

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

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

1 and

2 (viii) must provide a process for each of
3 its network pharmacy providers to readily access the maximum
4 allowable cost list specific to that provider;

5 (24) a requirement that the managed care organization
6 and any entity with which the managed care organization contracts
7 for the performance of services under a managed care plan disclose,
8 at no cost, to the commission and, on request, the office of the
9 attorney general all discounts, incentives, rebates, fees, free
10 goods, bundling arrangements, and other agreements affecting the
11 net cost of goods or services provided under the plan;

12 (25) a requirement that the managed care organization
13 not implement significant, nonnegotiated, across-the-board
14 provider reimbursement rate reductions unless:

15 (A) subject to Subsection (a-3), the
16 organization has the prior approval of the commission to make the
17 reductions [~~reduction~~]; or

18 (B) the rate reductions are based on changes to
19 the Medicaid fee schedule or cost containment initiatives
20 implemented by the commission; and

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

24 SECTION 3. Section 533.005, Government Code, as amended by
25 this Act, applies to a contract entered into or renewed on or after
26 the effective date of this Act. A contract entered into or renewed
27 before that date is governed by the law in effect on the date the

1 contract was entered into or renewed, and that law is continued in
2 effect for that purpose.

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

9 SECTION 5. This Act takes effect September 1, 2019.