By: Kolkhorst S.B. No. 2267

A BILL TO BE ENTITLED

AN ACT

relating to the provision of pharmacy benefits through Medicaid managed care.

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

SECTION 1. Sections 533.005(a) and (a-2), Government Code, are 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;

1 (5) a requirement that the managed care organization
2 provide information and referral about the availability of
3 educational, social, and other community services that could
4 benefit a recipient;
5 (6) procedures for recipient outreach and education;
6 (7) a requirement that the managed care organization
7 make payment to a physician or provider for health care services
8 rendered to a recipient under a managed care plan on any claim for
9 payment that is received with documentation reasonably necessary
10 for the managed care organization to process the claim:
11 (A) not later than:
12 (i) the 10th day after the date the claim is
13 received if the claim relates to services provided by a nursing
14 facility, intermediate care facility, or group home;
15 (ii) the 30th day after the date the claim
16 is received if the claim relates to the provision of long-term
17 services and supports not subject to Subparagraph (i); and
18 (iii) the 45th day after the date the claim
19 is received if the claim is not subject to Subparagraph (i) or (ii);
20 or
21 (B) within a period, not to exceed 60 days,
22 specified by a written agreement between the physician or provider
23 and the managed care organization;
24 (7-a) a requirement that the managed care organization
25 demonstrate to the commission that the organization pays claims
26 described by Subdivision (7)(A)(ii) on average not later than the
27 21st day after the date the claim is received by the 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, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care

1 providers to increase the availability of primary care providers in
2 the organization's provider network; and
3 (B) treat advanced practice registered nurses
4 and physician assistants in the same manner as primary care
5 physicians with regard to:
6 (i) selection and assignment as primary
7 care providers;
8 (ii) inclusion as primary care providers in
9 the organization's provider network; and
10 (iii) inclusion as primary care providers
11 in any provider network directory maintained by the organization;
12 (14) a requirement that the managed care organization
13 reimburse a federally qualified health center or rural health
14 clinic for health care services provided to a recipient outside of
15 regular business hours, including on a weekend day or holiday, at a
16 rate that is equal to the allowable rate for those services as
17 determined under Section 32.028, Human Resources Code, if the
18 recipient does not have a referral from the recipient's primary
19 care physician;
20 (15) a requirement that the managed care organization
21 develop, implement, and maintain a system for tracking and
22 resolving all provider appeals related to claims payment, including
23 a process that will require:
24 (A) a tracking mechanism to document the status
25 and final disposition of each provider's claims payment appeal;
26 (B) the contracting with physicians who are not
27 network providers and who are of the same or related specialty as

1 the appealing physician to resolve claims disputes related to
2 denial on the basis of medical necessity that remain unresolved
3 subsequent to a provider appeal;
4 (C) the determination of the physician resolving
5 the dispute to be binding on the managed care organization and
6 provider; and
7 (D) the managed care organization to allow a
8 provider with a claim that has not been paid before the time
9 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
10 claim;
11 (16) a requirement that a medical director who is
12 authorized to make medical necessity determinations is available to
13 the region where the managed care organization provides health care
14 services;
15 (17) a requirement that the managed care organization
16 ensure that a medical director and patient care coordinators and
17 provider and recipient support services personnel are located in
18 the South Texas service region, if the managed care organization
19 provides a managed care plan in that region;
20 (18) a requirement that the managed care organization
21 provide special programs and materials for recipients with limited
22 English proficiency or low literacy skills;
23 (19) a requirement that the managed care organization
24 develop and establish a process for responding to provider appeals
25 in the region where the organization provides health care services;
26 (20) a requirement that the managed care organization:
27 (A) develop and submit to the commission, before

1 the organization begins to provide health care services to
2 recipients, a comprehensive plan that describes how the
3 organization's provider network complies with the provider access
4 standards established under Section 533.0061;
5 (B) as a condition of contract retention and
6 renewal:
7 (i) continue to comply with the provider
8 access standards established under Section 533.0061; and
9 (ii) make substantial efforts, as
10 determined by the commission, to mitigate or remedy any
11 noncompliance with the provider access standards established under
12 Section 533.0061;
13 (C) pay liquidated damages for each failure, as
14 determined by the commission, to comply with the provider access
15 standards established under Section 533.0061 in amounts that are
16 reasonably related to the noncompliance; and
17 (D) regularly, as determined by the commission,
18 submit to the commission and make available to the public a report
19 containing data on the sufficiency of the organization's provider
20 network with regard to providing the care and services described
21 under Section 533.0061(a) and specific data with respect to access
22 to primary care, specialty care, long-term services and supports,
23 nursing services, and therapy services on the average length of
24 time between:
25 (i) the date a provider requests prior
26 authorization for the care or service and the date the organization
27 approves or denies the request; and

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

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

(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;

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

(iv) 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;

1 (22) a requirement that the managed care organization
2 develop a monitoring program for measuring the quality of the
3 health care services provided by the organization's provider
4 network that:
5 (A) incorporates the National Committee for
6 Quality Assurance's Healthcare Effectiveness Data and Information
7 Set (HEDIS) measures;
8 (B) focuses on measuring outcomes; and
9 (C) includes the collection and analysis of
10 clinical data relating to prenatal care, preventive care, mental
11 health care, and the treatment of acute and chronic health
12 conditions and substance abuse;
13 (23) subject to Subsection (a-1) <u>and Section</u>
14 <u>533.00513</u>, a requirement that the managed care organization
15 develop, implement, and maintain an outpatient pharmacy benefit
16 plan for its enrolled recipients:
17 (A) that exclusively employs the vendor drug
18 program formulary and preserves the state's ability to reduce
19 waste, fraud, and abuse under Medicaid;
20 (B) that adheres to the applicable preferred drug
21 list adopted by the commission under Section 531.072;
22 (C) that includes the prior authorization
23 procedures and requirements prescribed by or implemented under
24 Sections 531.073(b), (c), and (g) for the vendor drug program;
25 (D) for purposes of which the managed care
26 organization:
27 (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

1 not prevent a pharmacy or pharmacist from participating as a
2 provider if the pharmacy or pharmacist agrees to comply with the
3 financial terms and conditions of the contract as well as other
4 reasonable administrative and professional terms and conditions of
5 the contract;

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

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

14 (K) under which the managed care organization [~~or~~
15 ~~pharmacy benefit manager, as applicable~~]:

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

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

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

27 (ii) must provide to a network pharmacy

provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

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

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent 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;

(v) must establish a 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 and product availability in the marketplace;

(vi) must:

(a) provide a 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) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved[,] and make the adjustment applicable to all

similarly situated network pharmacy providers, as determined by the managed care organization [~~or pharmacy benefit manager, as appropriate~~];

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

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

(vii) 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

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

(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;

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

(A) subject to Subsection (a-3), the

organization has the prior approval of the commission to make the reductions [~~reduction~~]; or

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

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

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

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00513 to read as follows:

Sec. 533.00513. PROHIBITED SUBCONTRACTS. A managed care organization that contracts with the commission under this chapter to provide health care services to recipients may not contract with a pharmacy benefit manager for purposes of maintaining an outpatient pharmacy benefit plan for the organization's enrolled recipients as required by Section 533.005(a)(23).

SECTION 3. Section 533.012(a), Government Code, is amended to read as follows:

(a) Each managed care organization contracting with the commission under this chapter shall submit the following, at no cost, to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business

relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, [~~pharmacy benefit manager,~~] and exclusive provider organization, necessary for the commission to determine the actual cost of administering the managed care plan.

SECTION 4. Section 32.046(a), Human Resources Code, is amended to read as follows:

(a) The executive commissioner shall adopt rules governing sanctions and penalties that apply to a provider who participates in the vendor drug program or is enrolled as a network pharmacy provider of a managed care organization contracting with the commission under Chapter 533, Government Code, [~~or its subcontractor~~] and who submits an improper claim for reimbursement under the program.

SECTION 5. Sections 533.003(b) and 533.056, Government Code, are repealed.

SECTION 6. (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

1 into or renewed on or after the effective date of this Act, require
2 that the managed care organization comply with Section 533.005,
3 Government Code, as amended by this Act, and Section 533.00513,
4 Government Code, as added 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 Section
9 533.005, Government Code, as amended by this Act, and Section
10 533.00513, Government Code, as added by this Act. To the extent of
11 a conflict between those sections and a provision of a contract with
12 a managed care organization entered into before the effective date
13 of this Act, the contract provision prevails.

14 SECTION 7. 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 8. This Act takes effect September 1, 2019.