

By: Shaheen

H.B. No. 437

A BILL TO BE ENTITLED

AN ACT

relating to allowing Medicaid managed care organizations to adopt their own drug formularies.

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

SECTION 1. Section 531.072(a), Government Code, is amended to read as follows:

(a) In a manner that complies with applicable state and federal law, the commission shall adopt preferred drug lists for the Medicaid vendor drug program and for prescription drugs purchased through the child health plan program. Except as provided by Section 531.0721, the ~~[The]~~ commission may adopt preferred drug lists for community mental health centers, state mental health hospitals, and any other state program administered by the commission or a state health and human services agency.

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0721 to read as follows:

Sec. 531.0721. ADOPTION OF PRESCRIPTION DRUG FORMULARY BY MEDICAID MANAGED CARE ORGANIZATION. A managed care organization providing an outpatient pharmacy benefit plan for its Medicaid enrolled recipients may adopt its own drug formulary and is not required to:

- (1) employ the vendor drug program formulary; or
- (2) otherwise adhere to a preferred drug list the commission adopts under Section 531.072.

1 SECTION 3. Section 531.073, Government Code, is amended by
2 amending Subsection (a) and adding Subsection (j) to read as
3 follows:

4 (a) The executive commissioner, in the rules and standards
5 governing the Medicaid vendor drug program and the child health
6 plan program, shall require prior authorization for the
7 reimbursement of a drug that is not included in the appropriate
8 preferred drug list adopted under Section 531.072, except as
9 provided by Subsection (j) and for any drug exempted from prior
10 authorization requirements by federal law. Except as provided by
11 Subsection (j), the ~~The~~ executive commissioner may require prior
12 authorization for the reimbursement of a drug provided through any
13 other state program administered by the commission or a state
14 health and human services agency, including a community mental
15 health center and a state mental health hospital if the commission
16 adopts preferred drug lists under Section 531.072 that apply to
17 those facilities and the drug is not included in the appropriate
18 list. The executive commissioner shall require that the prior
19 authorization be obtained by the prescribing physician or
20 prescribing practitioner.

21 (j) This section does not apply to a managed care
22 organization that elects to adopt its own drug formulary under
23 Section 531.0721.

24 SECTION 4. Sections 533.005(a) and (a-2), Government Code,
25 are amended to read as follows:

26 (a) A contract between a managed care organization and the
27 commission for the organization to provide health care services to

1 recipients must contain:

2 (1) procedures to ensure accountability to the state
3 for the provision of health care services, including procedures for
4 financial reporting, quality assurance, utilization review, and
5 assurance of contract and subcontract compliance;

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

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

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

17 (5) a requirement that the managed care organization
18 provide information and referral about the availability of
19 educational, social, and other community services that could
20 benefit a recipient;

21 (6) procedures for recipient outreach and education;

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

27 (A) not later than:

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

4 (ii) the 30th day after the date the claim
5 is received if the claim relates to the provision of long-term
6 services and supports not subject to Subparagraph (i); and

7 (iii) the 45th day after the date the claim
8 is received if the claim is not subject to Subparagraph (i) or (ii);
9 or

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

13 (7-a) a requirement that the managed care organization
14 demonstrate to the commission that the organization pays claims
15 described by Subdivision (7)(A)(ii) on average not later than the
16 21st day after the date the claim is received by the organization;

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

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

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

1 (11) a requirement that the managed care
2 organization's usages of out-of-network providers or groups of
3 out-of-network providers may not exceed limits for those usages
4 relating to total inpatient admissions, total outpatient services,
5 and emergency room admissions determined by the commission;

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

12 (13) a requirement that, notwithstanding any other
13 law, including Sections [843.312](#) and [1301.052](#), Insurance Code, the
14 organization:

15 (A) use advanced practice registered nurses and
16 physician assistants in addition to physicians as primary care
17 providers to increase the availability of primary care providers in
18 the organization's provider network; and

19 (B) treat advanced practice registered nurses
20 and physician assistants in the same manner as primary care
21 physicians with regard to:

22 (i) selection and assignment as primary
23 care providers;

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

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

1 (14) a requirement that the managed care organization
2 reimburse a federally qualified health center or rural health
3 clinic for health care services provided to a recipient outside of
4 regular business hours, including on a weekend day or holiday, at a
5 rate that is equal to the allowable rate for those services as
6 determined under Section 32.028, Human Resources Code, if the
7 recipient does not have a referral from the recipient's primary
8 care physician;

9 (15) a requirement that the managed care organization
10 develop, implement, and maintain a system for tracking and
11 resolving all provider appeals related to claims payment, including
12 a process that will require:

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

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

20 (C) the determination of the physician resolving
21 the dispute to be binding on the managed care organization and
22 provider; and

23 (D) the managed care organization to allow a
24 provider with a claim that has not been paid before the time
25 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
26 claim;

27 (16) a requirement that a medical director who is

1 authorized to make medical necessity determinations is available to
2 the region where the managed care organization provides health care
3 services;

4 (17) a requirement that the managed care organization
5 ensure that a medical director and patient care coordinators and
6 provider and recipient support services personnel are located in
7 the South Texas service region, if the managed care organization
8 provides a managed care plan in that region;

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

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

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

16 (A) develop and submit to the commission, before
17 the organization begins to provide health care services to
18 recipients, a comprehensive plan that describes how the
19 organization's provider network complies with the provider access
20 standards established under Section [533.0061](#);

21 (B) as a condition of contract retention and
22 renewal:

23 (i) continue to comply with the provider
24 access standards established under Section [533.0061](#); and

25 (ii) make substantial efforts, as
26 determined by the commission, to mitigate or remedy any
27 noncompliance with the provider access standards established under

1 Section 533.0061;

2 (C) pay liquidated damages for each failure, as
3 determined by the commission, to comply with the provider access
4 standards established under Section 533.0061 in amounts that are
5 reasonably related to the noncompliance; and

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

14 (i) the date a provider requests prior
15 authorization for the care or service and the date the organization
16 approves or denies the request; and

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

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

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

27 (B) the organization's provider network

1 includes:

2 (i) a sufficient number of primary care
3 providers;

4 (ii) a sufficient variety of provider
5 types;

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

9 (iv) providers located throughout the
10 region where the organization will provide health care services;
11 and

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

17 (22) a requirement that the managed care organization
18 develop a monitoring program for measuring the quality of the
19 health care services provided by the organization's provider
20 network that:

21 (A) incorporates the National Committee for
22 Quality Assurance's Healthcare Effectiveness Data and Information
23 Set (HEDIS) measures;

24 (B) focuses on measuring outcomes; and

25 (C) includes the collection and analysis of
26 clinical data relating to prenatal care, preventive care, mental
27 health care, and the treatment of acute and chronic health

1 conditions and substance abuse;

2 (23) [~~subject to Subsection (a-1),~~] a requirement that
3 the managed care organization develop, implement, and maintain an
4 outpatient pharmacy benefit plan and prescription drug formulary
5 for its enrolled recipients:

6 (A) [~~that exclusively employs the vendor drug~~
7 ~~program formulary and preserves the state's ability to reduce~~
8 ~~waste, fraud, and abuse under Medicaid;~~

9 [(B) ~~that adheres to the applicable preferred~~
10 ~~drug list adopted by the commission under Section 531.072;~~

11 [(C) ~~that includes the prior authorization~~
12 ~~procedures and requirements prescribed by or implemented under~~
13 ~~Sections 531.073(b), (c), and (g) for the vendor drug program;~~

14 [(D)] for purposes of which the managed care
15 organization[+]

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

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

21 (B) [(E)] that comply [~~complies~~] with the
22 prohibition under Section 531.089;

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

1 (D) [~~(C)~~] that allow [~~allows~~] the managed care
2 organization or any subcontracted pharmacy benefit manager to
3 contract with a pharmacist or pharmacy providers separately for
4 specialty pharmacy services, except that:

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

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

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

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

27 (G) [~~(J)~~] under which the managed care

1 organization or pharmacy benefit manager, as applicable, must pay
2 claims in accordance with Section 843.339, Insurance Code; and

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

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

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

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

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

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

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

1 Approved Drug Products with Therapeutic Equivalence Evaluations,
2 also known as the Orange Book;

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

8 (vi) must:

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

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

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

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

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

26 (vii) must notify the commission not later
27 than the 21st day after implementing a practice of using a maximum

1 allowable cost list for drugs dispensed at retail but not by mail;
2 and

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

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

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

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

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

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

25 (a-2) Except as provided by Subsection (a)(23)(H)(viii)
26 [~~(a)(23)(K)(viii)~~], a maximum allowable cost list specific to a
27 provider and maintained by a managed care organization or pharmacy

1 benefit manager is confidential.

2 SECTION 5. Section 533.005(a-1), Government Code, is
3 repealed.

4 SECTION 6. As soon as practicable after the effective date
5 of this Act, the executive commissioner of the Health and Human
6 Services Commission shall adopt necessary rules to implement the
7 changes in law made by this Act.

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

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