

By: Wu

H.B. No. 4055

A BILL TO BE ENTITLED

AN ACT

1
2 relating to the availability under Medicaid of certain drugs used
3 to treat human immunodeficiency virus and prevent acquired immune
4 deficiency syndrome.

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

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

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

14 (6) antivirals.

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

17 (a) A contract between a managed care organization and the
18 commission for the organization to provide health care services to
19 recipients must contain:

20 (1) procedures to ensure accountability to the state
21 for the provision of health care services, including procedures for
22 financial reporting, quality assurance, utilization review, and
23 assurance of contract and subcontract compliance;

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

26 (3) a requirement that the managed care organization
27 provide ready access to a person who assists recipients in

1 resolving issues relating to enrollment, plan administration,
2 education and training, access to services, and grievance
3 procedures;

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

8 (5) a requirement that the managed care organization
9 provide information and referral about the availability of
10 educational, social, and other community services that could
11 benefit a recipient;

12 (6) procedures for recipient outreach and education;

13 (7) a requirement that the managed care organization
14 make payment to a physician or provider for health care services
15 rendered to a recipient under a managed care plan on any claim for
16 payment that is received with documentation reasonably necessary
17 for the managed care organization to process the claim:

18 (A) not later than:

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

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

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

27 or

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

4 (7-a) a requirement that the managed care organization
5 demonstrate to the commission that the organization pays claims
6 described by Subdivision (7)(A)(ii) on average not later than the
7 21st day after the date the claim is received by the organization;

8 (8) a requirement that the commission, on the date of a
9 recipient's enrollment in a managed care plan issued by the managed
10 care organization, inform the organization of the recipient's
11 Medicaid certification date;

12 (9) a requirement that the managed care organization
13 comply with Section 533.006 as a condition of contract retention
14 and renewal;

15 (10) a requirement that the managed care organization
16 provide the information required by Section 533.012 and otherwise
17 comply and cooperate with the commission's office of inspector
18 general and the office of the attorney general;

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

24 (12) if the commission finds that a managed care
25 organization has violated Subdivision (11), a requirement that the
26 managed care organization reimburse an out-of-network provider for
27 health care services at a rate that is equal to the allowable rate

1 for those services, as determined under Sections 32.028 and
2 32.0281, Human Resources Code;

3 (13) a requirement that, notwithstanding any other
4 law, including Sections 843.312 and 1301.052, Insurance Code, the
5 organization:

6 (A) use advanced practice registered nurses and
7 physician assistants in addition to physicians as primary care
8 providers to increase the availability of primary care providers in
9 the organization's provider network; and

10 (B) treat advanced practice registered nurses
11 and physician assistants in the same manner as primary care
12 physicians with regard to:

13 (i) selection and assignment as primary
14 care providers;

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

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

19 (14) a requirement that the managed care organization
20 reimburse a federally qualified health center or rural health
21 clinic for health care services provided to a recipient outside of
22 regular business hours, including on a weekend day or holiday, at a
23 rate that is equal to the allowable rate for those services as
24 determined under Section 32.028, Human Resources Code, if the
25 recipient does not have a referral from the recipient's primary
26 care physician;

27 (15) a requirement that the managed care organization

1 develop, implement, and maintain a system for tracking and
2 resolving all provider appeals related to claims payment, including
3 a process that will require:

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

6 (B) the contracting with physicians who are not
7 network providers and who are of the same or related specialty as
8 the appealing physician to resolve claims disputes related to
9 denial on the basis of medical necessity that remain unresolved
10 subsequent to a provider appeal;

11 (C) the determination of the physician resolving
12 the dispute to be binding on the managed care organization and
13 provider; and

14 (D) the managed care organization to allow a
15 provider with a claim that has not been paid before the time
16 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
17 claim;

18 (16) a requirement that a medical director who is
19 authorized to make medical necessity determinations is available to
20 the region where the managed care organization provides health care
21 services;

22 (17) a requirement that the managed care organization
23 ensure that a medical director and patient care coordinators and
24 provider and recipient support services personnel are located in
25 the South Texas service region, if the managed care organization
26 provides a managed care plan in that region;

27 (18) a requirement that the managed care organization

1 provide special programs and materials for recipients with limited
2 English proficiency or low literacy skills;

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

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

7 (A) develop and submit to the commission, before
8 the organization begins to provide health care services to
9 recipients, a comprehensive plan that describes how the
10 organization's provider network complies with the provider access
11 standards established under Section 533.0061;

12 (B) as a condition of contract retention and
13 renewal:

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

16 (ii) make substantial efforts, as
17 determined by the commission, to mitigate or remedy any
18 noncompliance with the provider access standards established under
19 Section 533.0061;

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

24 (D) regularly, as determined by the commission,
25 submit to the commission and make available to the public a report
26 containing data on the sufficiency of the organization's provider
27 network with regard to providing the care and services described

1 under Section 533.0061(a) and specific data with respect to access
2 to primary care, specialty care, long-term services and supports,
3 nursing services, and therapy services on the average length of
4 time between:

5 (i) the date a provider requests prior
6 authorization for the care or service and the date the organization
7 approves or denies the request; and

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

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

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

18 (B) the organization's provider network
19 includes:

20 (i) a sufficient number of primary care
21 providers;

22 (ii) a sufficient variety of provider
23 types;

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

27 (iv) providers located throughout the

1 region where the organization will provide health care services;
2 and

3 (C) health care services will be accessible to
4 recipients through the organization's provider network to a
5 comparable extent that health care services would be available to
6 recipients under a fee-for-service or primary care case management
7 model of Medicaid managed care;

8 (22) a requirement that the managed care organization
9 develop a monitoring program for measuring the quality of the
10 health care services provided by the organization's provider
11 network that:

12 (A) incorporates the National Committee for
13 Quality Assurance's Healthcare Effectiveness Data and Information
14 Set (HEDIS) measures;

15 (B) focuses on measuring outcomes; and

16 (C) includes the collection and analysis of
17 clinical data relating to prenatal care, preventive care, mental
18 health care, and the treatment of acute and chronic health
19 conditions and substance abuse;

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

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

26 (B) that adheres to the applicable preferred drug
27 list adopted by the commission under Section [531.072](#);

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

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

8 (D) for purposes of which the managed care
9 organization:

10 (i) may not negotiate or collect rebates
11 associated with pharmacy products on the vendor drug program
12 formulary; and

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

15 (E) that complies with the prohibition under
16 Section 531.089;

17 (F) under which the managed care organization may
18 not prohibit, limit, or interfere with a recipient's selection of a
19 pharmacy or pharmacist of the recipient's choice for the provision
20 of pharmaceutical services under the plan through the imposition of
21 different copayments;

22 (G) that allows the managed care organization or
23 any subcontracted pharmacy benefit manager to contract with a
24 pharmacist or pharmacy providers separately for specialty pharmacy
25 services, except that:

26 (i) the managed care organization and
27 pharmacy benefit manager are prohibited from allowing exclusive

1 contracts with a specialty pharmacy owned wholly or partly by the
2 pharmacy benefit manager responsible for the administration of the
3 pharmacy benefit program; and

4 (ii) the managed care organization and
5 pharmacy benefit manager must adopt policies and procedures for
6 reclassifying prescription drugs from retail to specialty drugs,
7 and those policies and procedures must be consistent with rules
8 adopted by the executive commissioner and include notice to network
9 pharmacy providers from the managed care organization;

10 (H) under which the managed care organization may
11 not prevent a pharmacy or pharmacist from participating as a
12 provider if the pharmacy or pharmacist agrees to comply with the
13 financial terms and conditions of the contract as well as other
14 reasonable administrative and professional terms and conditions of
15 the contract;

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

21 (J) under which the managed care organization or
22 pharmacy benefit manager, as applicable, must pay claims in
23 accordance with Section [843.339](#), Insurance Code; and

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

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

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

7 (b) the drug is generally available
8 for purchase by pharmacies in the state from national or regional
9 wholesalers and is not obsolete;

10 (ii) must provide to a network pharmacy
11 provider, at the time a contract is entered into or renewed with the
12 network pharmacy provider, the sources used to determine the
13 maximum allowable cost pricing for the maximum allowable cost list
14 specific to that provider;

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

18 (iv) must, in formulating the maximum
19 allowable cost price for a drug, use only the price of the drug and
20 drugs listed as therapeutically equivalent in the most recent
21 version of the United States Food and Drug Administration's
22 Approved Drug Products with Therapeutic Equivalence Evaluations,
23 also known as the Orange Book;

24 (v) must establish a process for
25 eliminating products from the maximum allowable cost list or
26 modifying maximum allowable cost prices in a timely manner to
27 remain consistent with pricing changes and product availability in

1 the marketplace;

2 (vi) must:

3 (a) provide a procedure under which a
4 network pharmacy provider may challenge a listed maximum allowable
5 cost price for a drug;

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

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

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

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

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

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

27 (24) a requirement that the managed care organization

1 and any entity with which the managed care organization contracts
2 for the performance of services under a managed care plan disclose,
3 at no cost, to the commission and, on request, the office of the
4 attorney general all discounts, incentives, rebates, fees, free
5 goods, bundling arrangements, and other agreements affecting the
6 net cost of goods or services provided under the plan;

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

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

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

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

19 SECTION 3. Section 533.005, Government Code, as amended by
20 this Act, applies to a contract entered into or renewed on or after
21 the effective date of this Act. A contract entered into or renewed
22 before that date is governed by the law in effect on the date the
23 contract was entered into or renewed, and that law is continued in
24 effect for that purpose.

25 SECTION 4. If before implementing any provision of this Act
26 a state agency determines that a waiver or authorization from a
27 federal agency is necessary for implementation of that provision,

1 the agency affected by the provision shall request the waiver or
2 authorization and may delay implementing that provision until the
3 waiver or authorization is granted.

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