PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL
Government Code
Chapter 549
8/15/22

CHAPTER 549. PROVISION OF DRUGS AND DRUG INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS APPLICABLE TO PROVISION OF DRUGS UNDER VENDOR DRUG PROGRAM AND CERTAIN OTHER PROGRAMS

Revised Law

Sec. 549.0001. BULK PURCHASING WITH ANOTHER STATE OF

PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and human services agency the executive commissioner authorizes may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the child health plan program, or another program under the commission's authority.

(b) A joint bulk purchasing agreement may not be entered into until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to spend appropriated money under the proposed agreement.

(c) In determining the feasibility and cost-effectiveness of entering into a joint bulk purchasing agreement, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

(d) If a joint bulk purchasing agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase described by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase. (Gov. Code, Sec. 531.090.)

Source Law

Sec. 531.090. JOINT PURCHASING OF PRESCRIPTION DRUGS AND OTHER MEDICATIONS. (a) Subject to Subsection (b), the commission and each health and

human services agency authorized by the executive commissioner may enter into an agreement with one or more other states for the joint bulk purchasing of prescription drugs and other medications to be used in Medicaid, the state child health plan, or another program under the authority of the commission.

(b) An agreement under this section may not be entered into until:

(1) the commission determines that entering into the agreement would be feasible and cost-effective; and

(2) if appropriated money would be spent under the proposed agreement, the governor and the Legislative Budget Board grant prior approval to expend appropriated money under the proposed agreement.

(c) If an agreement is entered into, the commission shall adopt procedures applicable to an agreement and joint purchase required by this section. The procedures must ensure that this state receives:

(1) all prescription drugs and other medications purchased with money provided by this state; and

(2) an equitable share of any price benefits resulting from the joint bulk purchase.

(d) In determining the feasibility and cost-effectiveness of entering into an agreement under this section, the commission shall identify:

(1) the most cost-effective existing joint bulk purchasing agreement; and

(2) any potential groups of states with which this state could enter into a new cost-effective joint bulk purchasing agreement.

Revisor's Note

(1) Section 531.090(a), Government Code, refers to the "state child health plan." The revised law substitutes "child health plan program" for "state child health plan" for clarity and consistency in the terminology used within the chapter and because "child health plan program" is the defined term under Section 531.001, Government Code, which is revised in this subtitle as Section _____ and applies to the revised law in this chapter.

(2) Section 531.090(c), Government Code, refers to an agreement between certain agencies of this state and other states for the joint bulk purchasing of certain medications as being "required" by Section 531.090. The revised law substitutes "described" for "required" because that section does not require that an agreement be entered into. Instead, that section is

permissive and allows for an agreement to be entered into if certain conditions are met.

Revised Law

Sec. 549.0002. VALUE-BASED ARRANGEMENT IN MEDICAID VENDOR DRUG PROGRAM. (a) In this section, "manufacturer" has the meaning assigned by Section 549.0101.

(b) Subject to Subchapter D, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value. (Gov. Code, Sec. 531.0701.)

Source Law

> Sec. 531.0701. VALUE-BASED ARRANGEMENTS. (a) In this section, "manufacturer" has the meaning assigned by Section 531.070.
>
> (b) Subject to Section 531.071, the commission may enter into a value-based arrangement for the Medicaid vendor drug program by written agreement with a manufacturer based on outcome data or other metrics to which this state and the manufacturer agree in writing. The value-based arrangement may include a rebate, a discount, a price reduction, a contribution, risk sharing, a reimbursement, payment deferral or installment payments, a guarantee, patient care, shared savings payments, withholds, a bonus, or any other thing of value.

Revised Law

Sec. 549.0003. PERIOD OF VALIDITY OF PRESCRIPTIONS UNDER MEDICAID. (a) This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

(b) In the rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing of prescriptions and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under

Medicaid is valid for the lesser of:

(1) the period for which the prescription is written; or

(2) one year. (Gov. Code, Sec. 531.0694.)

Source Law

> Sec. 531.0694. PERIOD OF VALIDITY FOR PRESCRIPTION. In the rules and standards governing the vendor drug program, the executive commissioner, to the extent allowed by federal law and laws regulating the writing and dispensing of prescription medications, shall ensure that a prescription written by an authorized health care provider under Medicaid is valid for the lesser of the period for which the prescription is written or one year. This section does not apply to a prescription for a controlled substance, as defined by Chapter 481, Health and Safety Code.

Revised Law

Sec. 549.0004. CERTAIN MEDICATIONS FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowed under federal law, the commission may not provide a sexual performance enhancing medication under the vendor drug program or any other health and human services program to an individual required to register as a sex offender under Chapter 62, Code of Criminal Procedure.

(b) The executive commissioner may adopt rules as necessary to implement this section. (Gov. Code, Sec. 531.089.)

Source Law

> Sec. 531.089. CERTAIN MEDICATION FOR SEX OFFENDERS PROHIBITED. (a) To the maximum extent allowable under federal law, the commission may not provide sexual performance enhancing medication under the Medicaid vendor drug program or any other health and human services program to a person required to register as a sex offender under Chapter 62, Code of Criminal Procedure.
>
> (b) The executive commissioner may adopt rules as necessary to implement this section.

Revisor's Note

(1) Section 531.089(a), Government Code, prohibits the Health and Human Services Commission from providing certain medications to sex offenders "under the Medicaid vendor drug program or any other health and human services program." The revised law omits the term "Medicaid" as unnecessarily restrictive

because the prohibition also applies to any health and human services program, which includes all other health and human services programs for which the vendor drug program provides medications.

(2) Section 531.089(a), Government Code, refers to a "person required to register as a sex offender under Chapter 62, Code of Criminal Procedure." Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005, Government Code (Code Construction Act), which applies to this code.

Revised Law

Sec. 549.0005. PRIOR APPROVAL OF AND PHARMACY PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS AND ENROLLEES. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program the commission administers that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients or enrollees collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of the recipients or enrollees who are to receive the communication access to the communication. (Gov. Code, Sec. 531.0697.)

Source Law

Sec. 531.0697. PRIOR APPROVAL AND PROVIDER ACCESS TO CERTAIN COMMUNICATIONS WITH CERTAIN RECIPIENTS. (a) This section applies to:

(1) the vendor drug program for Medicaid and the child health plan program;

(2) the kidney health care program;

(3) the children with special health care needs program; and

(4) any other state program administered by the commission that provides prescription drug benefits.

(b) A managed care organization, including a health maintenance organization, or a pharmacy benefit manager, that administers claims for prescription drug benefits under a program to which this section applies shall, at least 10 days before the date the organization or pharmacy benefit manager intends to deliver a communication to recipients collectively under a program:

(1) submit a copy of the communication to the commission for approval; and

(2) if applicable, allow the pharmacy providers of recipients who are to receive the communication access to the communication.

Revisor's Note

Section 531.0697(b), Government Code, refers to "recipients" under certain programs, including Medicaid and the child health plan program. A person who receives benefits under Medicaid is generally referred to as a "recipient" and a person who receives benefits under the child health plan program is generally referred to as an "enrollee." The revised law substitutes "recipients or enrollees" for the references to "recipients" for accuracy and consistency throughout Subtitle I, Title 4, Government Code, which includes this chapter.

SUBCHAPTER B. REVIEW AND ANALYSIS OF CERTAIN PRESCRIPTION DRUG PURCHASES AND PATTERNS

Revised Law

Sec. 549.0051. PERIODIC REVIEW OF VENDOR DRUG PROGRAM PURCHASES. (a) The commission shall periodically review all

purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by this state under a Medicaid managed care program or the child health plan program.

(b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates this state receives. (Gov. Code, Sec. 531.069.)

Source Law

> Sec. 531.069. PERIODIC REVIEW OF VENDOR DRUG PROGRAM. (a) The commission shall periodically review all purchases made under the vendor drug program to determine the cost-effectiveness of including a component for prescription drug benefits in any capitation rate paid by the state under a Medicaid managed care program or the child health plan program.
>
> (b) In making the determination required by Subsection (a), the commission shall consider the value of any prescription drug rebates received by the state.

Revised Law

Sec. 549.0052. MEDICAID PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. The commission shall:

(1) monitor and analyze Medicaid prescription drug use and expenditure patterns;

(2) identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures; and

(3) post the data the commission identifies under this section on the commission's Internet website and update the information on a quarterly basis. (Gov. Code, Sec. 531.0693.)

Source Law

> Sec. 531.0693. PRESCRIPTION DRUG USE AND EXPENDITURE PATTERNS. (a) The commission shall monitor and analyze prescription drug use and expenditure patterns in Medicaid. The commission shall identify the therapeutic prescription drug classes and individual prescription drugs that are most often prescribed to patients or that represent the greatest expenditures.
>
> (b) The commission shall post the data determined by the commission under Subsection (a) on the commission's website and update the information on a quarterly basis.

SUBCHAPTER C. SUPPLEMENTAL REBATES OR PROGRAM BENEFITS FOR PRESCRIPTION DRUGS

Revised Law

Sec. 549.0101. DEFINITIONS. In this subchapter:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.33; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5), including a subsidiary or affiliate of a manufacturer.

(3) "Supplemental rebate" means a cash rebate a manufacturer pays to this state:

(A) on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products; and

(B) in accordance with a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under 42 U.S.C. Section 1396r-8.

(4) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety Code. (Gov. Code, Secs. 531.070(a), (b).)

Source Law

Sec. 531.070. SUPPLEMENTAL REBATES. (a) In this section:

(1) "Labeler" means a person that:

(A) has a labeler code from the United States Food and Drug Administration under 21 C.F.R. Section 207.20; and

(B) receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale.

(2) "Manufacturer" means a manufacturer of prescription drugs as defined by 42 U.S.C. Section 1396r-8(k)(5) and its subsequent amendments, including a subsidiary or affiliate of a manufacturer.

(3) "Wholesaler" means a person licensed under Subchapter I, Chapter 431, Health and Safety

Code.

(b) For purposes of this section, the term "supplemental rebates" means cash rebates paid by a manufacturer to the state on the basis of appropriate quarterly health and human services program utilization data relating to the manufacturer's products, pursuant to a state supplemental rebate agreement negotiated with the manufacturer and, if necessary, approved by the federal government under Section 1927 of the federal Social Security Act (42 U.S.C. Section 1396r-8).

Revisor's Note

(1) Section 531.070(a)(1)(A), Government Code, refers to a labeler code under 21 C.F.R. Section 207.20. The regulation 21 C.F.R. Section 207.20 was revised in August 2016 (see 81 Fed. Reg. 60170 (August 31, 2016)), and the relevant provisions for obtaining a labeler code are now codified in 21 C.F.R. Section 207.33. The revised law is drafted accordingly.

(2) Section 531.070(a)(2), Government Code, refers to 42 U.S.C. Section 1396r-8(k)(5) "and its subsequent amendments." Throughout this chapter, the revised law omits the quoted language because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute applies to all reenactments, revisions, or amendments of that statute, unless expressly provided otherwise.

Revised Law

Sec. 549.0102. REQUIREMENT TO NEGOTIATE FOR SUPPLEMENTAL REBATES FOR CERTAIN PROGRAMS. (a) Subject to Subsection (b), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental

health center or state mental health hospital.

(b) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on the commission's behalf. (Gov. Code, Secs. 531.070(h), (i).)

Source Law

(h) Subject to Subsection (i), the commission shall negotiate with manufacturers and labelers, including generic manufacturers and labelers, to obtain supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and state mental health hospitals.

(i) The commission may by contract authorize a private entity to negotiate with manufacturers and labelers on behalf of the commission.

Revised Law

Sec. 549.0103. MANUFACTURER AND LABELER NEGOTIATION FOR SUPPLEMENTAL REBATES VOLUNTARY. A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8;

(2) the child health plan program; and

(3) any other state program the commission or a health and human services agency administers, including a community mental health center or state mental health hospital. (Gov. Code, Sec. 531.070(j).)

Source Law

(j) A manufacturer or labeler that sells prescription drugs in this state may voluntarily negotiate with the commission and enter into an agreement to provide supplemental rebates for prescription drugs provided under:

(1) the Medicaid vendor drug program in excess of the Medicaid rebates required by 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) the child health plan program; and

(3) any other state program administered by the commission or a health and human services agency, including community mental health centers and

state mental health hospitals.

Revised Law

Sec. 549.0104. CONSIDERATIONS IN SUPPLEMENTAL REBATE NEGOTIATIONS. (a) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Section 549.0106(b).

(b) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price as defined in 42 U.S.C. Section 1396r-8(k)(1) as the cost basis for the product. (Gov. Code, Secs. 531.070(k), (m).)

Source Law

(k) In negotiating terms for a supplemental rebate amount, the commission shall consider:

(1) rebates calculated under the Medicaid rebate program in accordance with 42 U.S.C. Section 1396r-8 and its subsequent amendments;

(2) any other available information on prescription drug prices or rebates; and

(3) other program benefits as specified in Subsection (c).

(m) In negotiating terms for a supplemental rebate, the commission shall use the average manufacturer price (AMP), as defined in 42 U.S.C. Section 1396r-8(k)(1), as the cost basis for the product.

Revised Law

Sec. 549.0105. REQUIRED DISCLOSURES IN NEGOTIATIONS FOR SUPPLEMENTAL REBATES. Before or during supplemental rebate agreement negotiations for a prescription drug being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred drug list during the contract period. Clinical edits may not be imposed for a preferred drug during the contract period unless the disclosure is made. (Gov. Code, Sec. 531.070(n).)

Source Law

(n) Prior to or during supplemental rebate agreement negotiations for drugs being considered for the preferred drug list, the commission shall disclose to pharmaceutical manufacturers any clinical edits or clinical protocols that may be imposed on drugs within a particular drug category that are placed on the preferred list during the contract period. Clinical edits will not be imposed for a preferred drug during the contract period unless the above disclosure is made.

Revised Law

Sec. 549.0106. PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES; MONETARY CONTRIBUTION OR DONATION. (a) For purposes of this section, a program benefit may mean a disease management program authorized under this title, a drug product donation program, a drug utilization control program, prescriber and beneficiary counseling and education, a fraud or abuse initiative, and another service or administrative investment with guaranteed savings to a program a health and human services agency operates.

(b) The commission may enter into a written agreement with a manufacturer to accept a program benefit instead of a supplemental rebate only if:

(1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;

(2) the manufacturer:

(A) posts a performance bond guaranteeing savings to this state; and

(B) agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to this state, less any savings that were achieved; and

(3) the program benefit is in addition to other program benefits the manufacturer currently offers to recipients of Medicaid or related programs.

(c) For purposes of this subchapter, the commission may

consider a monetary contribution or donation to the arrangements described in Subsection (b) for the purpose of offsetting expenditures to other state health care programs, but that funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount this state would have benefited under a supplemental rebate. The commission may consider an arrangement under this subchapter as satisfying the requirements of Section 549.0204(a). (Gov. Code, Secs. 531.070(c), (d), (g).)

Source Law

> (c) The commission may enter into a written agreement with a manufacturer to accept certain program benefits in lieu of supplemental rebates, as defined by this section, only if:
>
> (1) the program benefit yields savings that are at least equal to the amount the manufacturer would have provided under a state supplemental rebate agreement during the current biennium as determined by the written agreement;
>
> (2) the manufacturer posts a performance bond guaranteeing savings to the state, and agrees that if the savings are not achieved in accordance with the written agreement, the manufacturer will forfeit the bond to the state less any savings that were achieved; and
>
> (3) the program benefit is in addition to other program benefits currently offered by the manufacturer to recipients of Medicaid or related programs.
>
> (d) For purposes of this section, a program benefit may mean disease management programs authorized under this title, drug product donation programs, drug utilization control programs, prescriber and beneficiary counseling and education, fraud and abuse initiatives, and other services or administrative investments with guaranteed savings to a program operated by a health and human services agency.
>
> (g) For purposes of this section, the commission may consider a monetary contribution or donation to the arrangements described in Subsection (c) for the purpose of offsetting expenditures to other state health care programs, but which funding may not be used to offset expenditures for covered outpatient drugs as defined by 42 U.S.C. Section 1396r-8(k)(2) under the vendor drug program. An arrangement under this subsection may not yield less than the amount the state would have benefited under a supplemental rebate. The commission may consider an arrangement under this section as satisfying the requirements related to Section 531.072(b).

Revisor's Note

Section 531.070(c), Government Code, refers to supplemental rebates "as defined by this section," meaning Section 531.070, Government Code, which is revised as this subchapter. The revised law omits the quoted language as unnecessary. Section 531.070(b), Government Code, revised in this subchapter as Section 549.0101(3), defines "supplemental rebate." That definition applies by its own terms to the law revised in this section.

Revised Law

Sec. 549.0107. LIMITATIONS ON AGREEMENT TO ACCEPT PROGRAM BENEFITS INSTEAD OF SUPPLEMENTAL REBATES. (a) A commission agreement to accept a program benefit described by Section 549.0106:

(1) may not prohibit the commission from entering into a similar agreement with another entity that relates to a different drug class;

(2) must be limited to a period the commission expressly determines; and

(3) subject to Subsection (b), may cover only a product that has received United States Food and Drug Administration approval as of the date the commission enters into the agreement.

(b) A new product the United States Food and Drug Administration approves after the commission enters into the agreement may be incorporated into the agreement only under an amendment to the agreement. (Gov. Code, Sec. 531.070(f).)

Source Law

(f) Agreements by the commission to accept program benefits as defined by this section:

(1) may not prohibit the commission from entering into similar agreements related to different drug classes with other entities;

(2) shall be limited to a time period expressly determined by the commission; and

(3) may only cover products that have received approval by the Federal Drug Administration

at the time of the agreement, and new products approved after the agreement may be incorporated only under an amendment to the agreement.

Revisor's Note

(1) Section 531.070(f), Government Code, refers to program benefits "as defined by this section," meaning Section 531.070, Government Code. The revised law substitutes "described" for "defined" because Section 531.070(d), Government Code, revised in this subchapter as Section 549.0106(a), describes but does not define "program benefits."

(2) Section 531.070(f)(3), Government Code, refers to the "Federal Drug Administration." The revised law substitutes "United States Food and Drug Administration" for "Federal Drug Administration" to reflect the correct name of the federal agency.

Revised Law

Sec. 549.0108. TREATMENT OF PROGRAM BENEFITS FOR CERTAIN PURPOSES. Other than as required to satisfy the provisions of this subchapter, a program benefit described by Section 549.0106 is considered an alternative to, and not the equivalent of, a supplemental rebate. A program benefit must be treated in this state's submissions to the federal government, including, as appropriate, waiver requests and quarterly Medicaid claims, so as to maximize the availability of federal matching payments. (Gov. Code, Sec. 531.070(e).)

Source Law

(e) Other than as required to satisfy the provisions of this section, the program benefits shall be deemed an alternative to, and not the equivalent of, supplemental rebates and shall be treated in the state's submissions to the federal government (including, as appropriate, waiver requests and quarterly Medicaid claims) so as to maximize the availability of federal matching payments.

SUBCHAPTER D. CONFIDENTIALITY OF INFORMATION RELATING TO PRESCRIPTION DRUG REBATE NEGOTIATIONS AND AGREEMENTS

Revised Law

Sec. 549.0151. CERTAIN PRESCRIPTION DRUG INFORMATION

CONFIDENTIAL. (a) Notwithstanding any other state law other than Sections 549.0152 and 549.0153, information the commission obtains or maintains regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by that subsection that the commission obtains or maintains in connection with:

(1) the vendor drug program;

(2) the child health plan program;

(3) the kidney health care program;

(4) the children with special health care needs program; or

(5) another state program the commission or a health and human services agency administers. (Gov. Code, Secs. 531.071(a), (b).)

Source Law

Sec. 531.071. CONFIDENTIALITY OF INFORMATION REGARDING DRUG REBATES, PRICING, AND NEGOTIATIONS. (a) Notwithstanding any other state law, information obtained or maintained by the commission regarding prescription drug rebate negotiations or a supplemental Medicaid or other rebate agreement, including trade secrets, rebate amount, rebate percentage, and manufacturer or labeler pricing, is confidential and not subject to disclosure under Chapter 552.

(b) Information that is confidential under Subsection (a) includes information described by Subsection (a) that is obtained or maintained by the commission in connection with the Medicaid vendor drug program, the child health plan program, the kidney health care program, the children with special health care needs program, or another state program administered by the commission or a health and human services agency.

Revisor's Note

(1) Section 531.071(a), Government Code, provides that "[n]otwithstanding any other state law," information the Health and Human Services Commission obtains or maintains with respect to prescription drug

rebate negotiations or a supplemental Medicaid or other rebate agreement is confidential and not subject to disclosure under Chapter 552, Government Code. Sections 531.071(c) and (d), revised in this subchapter as Sections 549.0152 and 549.0153, respectively, provide exceptions to the confidentiality requirement. Because the exceptions are revised as separate sections of the subchapter, the revised law adds "other than Sections 549.0152 and 549.0153" immediately after "[n]otwithstanding any other state law" to avoid ambiguity and ensure application of the exceptions.

(2) Section 531.071(b), Government Code, refers to the "Medicaid vendor drug program . . . or another state program administered by the commission or a health and human services agency." The revised law omits the reference to "Medicaid" for the reason stated in Revisor's Note (1) to Section 549.0004 of this chapter.

Revised Law

Sec. 549.0152. GENERAL PRESCRIPTION DRUG INFORMATION NOT CONFIDENTIAL; EXCEPTION. General information about the aggregate costs of different classes of prescription drugs is not confidential under Section 549.0151(a), except that a drug name or information that could reveal a drug name is confidential. (Gov. Code, Sec. 531.071(c).)

Source Law

(c) General information about the aggregate costs of different classes of drugs is not confidential under Subsection (a), except that a drug name or information that could reveal a drug name is confidential.

Revised Law

Sec. 549.0153. EXISTENCE OR NONEXISTENCE OF SUPPLEMENTAL REBATE AGREEMENT NOT CONFIDENTIAL. Information about whether the commission and a manufacturer or labeler reached or did not reach a

supplemental rebate agreement under Subchapter C for a particular prescription drug is not confidential under Section 549.0151(a). (Gov. Code, Sec. 531.071(d).)

Source Law

> (d) Information about whether the commission and a manufacturer or labeler reached or did not reach a supplemental rebate agreement under Section 531.070 for a particular drug is not confidential under Subsection (a).

SUBCHAPTER E. PREFERRED DRUG LISTS

Revised Law

Sec. 549.0201. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (New.)

Revisor's Note

The definition of "board" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 549.0202. PREFERRED DRUG LISTS REQUIRED FOR MEDICAID VENDOR DRUG AND CHILD HEALTH PLAN PROGRAMS. In a manner that complies with state and federal law, the commission shall adopt preferred drug lists for:

(1) the Medicaid vendor drug program; and

(2) prescription drugs purchased through the child health plan program. (Gov. Code, Sec. 531.072(a) (part).)

Source Law

> Sec. 531.072. PREFERRED DRUG LISTS. (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. . . .

Revised Law

Sec. 549.0203. PREFERRED DRUG LISTS AUTHORIZED FOR CERTAIN PROGRAMS. The commission may adopt preferred drug lists for:

(1) community mental health centers;

(2) state mental health hospitals; and

(3) any state program the commission or a state health and human services agency administers other than a program for which Section 549.0202 requires the adoption of preferred drug lists. (Gov. Code, Sec. 531.072(a) (part).)

Source Law

> (a) . . . 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.

Revised Law

Sec. 549.0204. LIMITATION ON DRUGS INCLUDED ON PREFERRED DRUG LISTS; EXCEPTIONS. (a) The preferred drug lists adopted under this subchapter may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Subchapter C.

(b) Notwithstanding Subsection (a), the preferred drug lists may contain:

(1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that including the drug on the preferred drug lists will not have a negative cost impact to this state; or

(2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits instead of supplemental rebates as described by Subchapter C. (Gov. Code, Secs. 531.072(b), (b-1).)

Source Law

> (b) The preferred drug lists may contain only drugs provided by a manufacturer or labeler that reaches an agreement with the commission on supplemental rebates under Section 531.070.
>
> (b-1) Notwithstanding Subsection (b), the preferred drug lists may contain:
>
> (1) a drug provided by a manufacturer or labeler that has not reached a supplemental rebate agreement with the commission if the commission determines that inclusion of the drug on the preferred drug lists will have no negative cost impact to the state; or
>
> (2) a drug provided by a manufacturer or labeler that has reached an agreement with the commission to provide program benefits in lieu of

supplemental rebates, as described by Section 531.070.

Revised Law

Sec. 549.0205. CONSIDERATIONS FOR INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In making a decision regarding the placement of a drug on each of the preferred drug lists adopted under this subchapter, the commission shall consider:

(1) the board's recommendations under Section 549.0309;

(2) the drug's clinical efficacy;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(b) The commission shall consider including on a preferred drug list:

(1) multiple methods of delivery within each drug class, including liquid, capsule, and tablet, including an orally disintegrating tablet; and

(2) all strengths and dosage forms of a drug. (Gov. Code, Secs. 531.072(b-2), (c), (c-1).)

Source Law

(b-2) Consideration must be given to including all strengths and dosage forms of a drug on the preferred drug lists.

(c) In making a decision regarding the placement of a drug on each of the preferred drug lists, the commission shall consider:

(1) the recommendations of the Drug Utilization Review Board under Section 531.0736;

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; and

(4) program benefit offerings solely or in conjunction with rebates and other pricing information.

(c-1) In addition to the considerations listed under Subsection (c), the commission shall consider the inclusion of multiple methods of delivery within each drug class, including liquid, tablet, capsule, and orally disintegrating tablets.

Revisor's Note

(1) Section 531.072(c)(1), Government Code, refers to Drug Utilization Review Board

recommendations under Section 531.0736, Government Code. The provisions of Section 531.0736 relating to board recommendations are revised in this chapter as Section 549.0309, and the revised law is drafted accordingly.

(2) Section 531.072(c-1), Government Code, requires the Health and Human Services Commission to consider certain factors with respect to preferred drug lists "[i]n addition to the considerations listed under Subsection (c)" of Section 531.072, Government Code. The revised law omits the quoted language as unnecessary because the requirement to consider the factors listed in Subsection (c), which is revised as Subsection (a) of this section, applies by its own terms.

Revised Law

Sec. 549.0206. SUBMISSION OF EVIDENCE TO SUPPORT INCLUDING DRUG ON PREFERRED DRUG LISTS. (a) In this section, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101.

(b) The commission shall ensure that a manufacturer or labeler may submit written evidence that supports including a drug on the preferred drug lists before a supplemental rebate agreement is reached with the commission. (Gov. Code, Sec. 531.072(e) (part).)

Source Law

(e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 531.070. The commission shall ensure that:

(1) a manufacturer or labeler may submit written evidence supporting the inclusion of a drug on the preferred drug lists before a supplemental agreement is reached with the commission; and

. . .

Revisor's Note

Section 531.072(e), Government Code, refers to definitions provided under Section 531.070, Government Code. The relevant definitions are revised

in this chapter as Section 549.0101, and the revised law is drafted accordingly.

Revised Law

Sec. 549.0207. PUBLICATION OF INFORMATION RELATING TO AND DISTRIBUTION OF PREFERRED DRUG LISTS. (a) The commission shall publish on the commission's Internet website any decisions on preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each reviewed drug;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Subchapter C; and

(3) the rationale for any departure from a board recommendation under Section 549.0309.

(b) The commission shall:

(1) provide for the distribution of current copies of the preferred drug lists adopted under this subchapter by posting the lists on the Internet; and

(2) mail copies of the lists to a health care provider on the provider's request. (Gov. Code, Secs. 531.072(d), 531.0741.)

Source Law

[Sec. 531.072]

(d) The commission shall provide for the distribution of current copies of the preferred drug lists by posting the list on the Internet. In addition, the commission shall mail copies of the lists to any health care provider on request of that provider.

Sec. 531.0741. PUBLICATION OF INFORMATION REGARDING COMMISSION DECISIONS ON PREFERRED DRUG LIST PLACEMENT. The commission shall publish on the commission's Internet website any decisions on preferred drug list placement, including:

(1) a list of drugs reviewed and the commission's decision for or against placement on a preferred drug list of each drug reviewed;

(2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070; and

(3) the rationale for any departure from a recommendation of the Drug Utilization Review Board

under Section 531.0736.

Revisor's Note

Section 531.0741(3), Government Code, refers to Drug Utilization Review Board recommendations under Section 531.0736, Government Code. The revised law substitutes a reference to Section 549.0309 of this chapter for the reference to Section 531.0736, Government Code, for the reason stated in Revisor's Note (1) to Section 549.0205 of this chapter.

SUBCHAPTER F. PRIOR AUTHORIZATION FOR CERTAIN DRUGS

Revised Law

Sec. 549.0251. DRUGS SUBJECT TO PRIOR AUTHORIZATION REQUIREMENTS. (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 Subchapter E unless:

(1) the drug is exempt from prior authorization requirements by federal law; or

(2) the executive commissioner is prohibited under Sections 549.0252 and 549.0253(a) from requiring prior authorization for the drug.

(b) The executive commissioner may require prior authorization for the reimbursement of a drug provided through any state program, other than a program described by Subsection (a), that the commission or a state health and human services agency administers, including a community mental health center and a state mental health hospital if the commission adopts a preferred drug list under Subchapter E that applies to that facility and the drug is not included in the appropriate list.

(c) The executive commissioner shall require that the prior authorization be obtained by the prescribing physician or prescribing practitioner. (Gov. Code, Sec. 531.073(a).)

Source Law

Sec. 531.073. PRIOR AUTHORIZATION FOR CERTAIN PRESCRIPTION DRUGS. (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 Subsections (a-3) and (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.

Revisor's Note

Section 531.073(a), Government Code, refers to preferred drug lists adopted under Section 531.072, Government Code. The provisions of Section 531.072 relating to the adoption of preferred drug lists are revised in this chapter as Subchapter E, and the revised law is drafted accordingly.

Revised Law

Sec. 549.0252. PRIOR AUTHORIZATION AND CERTAIN PROTOCOL REQUIREMENTS PROHIBITED FOR CERTAIN ANTIRETROVIRAL DRUGS. (a) In this section, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:

(1) protease inhibitors;

(2) non-nucleoside reverse transcriptase inhibitors;

(3) nucleoside reverse transcriptase inhibitors;

(4) integrase inhibitors;

(5) fusion inhibitors;

(6) attachment inhibitors;

(7) CD4 post-attachment inhibitors;

(8) CCR5 receptor antagonists; and

(9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

(b) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for an antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. (Gov. Code, Sec. 531.073(j).)

Source Law

> (j) The executive commissioner, in the rules and standards governing the Medicaid vendor drug program, may not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse. In this subsection, "antiretroviral drug" means a drug that treats human immunodeficiency virus infection or prevents acquired immune deficiency syndrome. The term includes:
>
> (1) protease inhibitors;
>
> (2) non-nucleoside reverse transcriptase inhibitors;
>
> (3) nucleoside reverse transcriptase inhibitors;
>
> (4) integrase inhibitors;
>
> (5) fusion inhibitors;
>
> (6) attachment inhibitors;
>
> (7) CD4 post-attachment inhibitors;
>
> (8) CCR5 receptor antagonists; and
>
> (9) other antiretroviral drugs used to treat human immunodeficiency virus infection or prevent acquired immune deficiency syndrome.

Revised Law

Sec. 549.0253. PRIOR AUTHORIZATION PROHIBITED FOR CERTAIN NONPREFERRED ANTIPSYCHOTIC DRUGS. (a) The executive commissioner, in the rules and standards governing the vendor drug program, may not require prior authorization for a nonpreferred antipsychotic drug that is included on the vendor drug formulary and prescribed to an adult patient if:

(1) during the preceding year, the patient was prescribed and unsuccessfully treated with a 14-day treatment trial of an antipsychotic drug that is included on the appropriate preferred drug list adopted under Subchapter E and for which a single claim was paid;

(2) the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription is for the purpose of drug dosage titration; or

(3) subject to federal law on maximum dosage limits and commission rules on drug quantity limits, the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) Subsection (a) does not affect:

(1) a pharmacist's authority to dispense the generic equivalent or interchangeable biological product of a prescription drug in accordance with Subchapter A, Chapter 562, Occupations Code;

(2) any drug utilization review requirements prescribed by state or federal law; or

(3) clinical prior authorization edits to preferred and nonpreferred antipsychotic drug prescriptions. (Gov. Code, Secs. 531.073(a-3), (a-4).)

Source Law

(a-3) The executive commissioner, in the rules and standards governing the vendor drug program, may not require prior authorization for a nonpreferred antipsychotic drug that is included on the vendor drug formulary and prescribed to an adult patient if:

(1) during the preceding year, the patient was prescribed and unsuccessfully treated with a 14-day treatment trial of an antipsychotic drug that is included on the appropriate preferred drug list adopted under Section 531.072 and for which a single claim was paid;

(2) the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription is for the purpose of drug dosage titration; or

(3) subject to federal law on maximum dosage limits and commission rules on drug quantity limits, the patient has previously been prescribed and obtained prior authorization for the nonpreferred antipsychotic drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(a-4) Subsection (a-3) does not affect:

(1) the authority of a pharmacist to

dispense the generic equivalent or interchangeable biological product of a prescription drug in accordance with Subchapter A, Chapter 562, Occupations Code;

(2) any drug utilization review requirements prescribed by state or federal law; or

(3) clinical prior authorization edits to preferred and nonpreferred antipsychotic drug prescriptions.

Revisor's Note

Section 531.073(a-3)(1), Government Code, refers to a preferred drug list adopted under Section 531.072, Government Code. The revised law substitutes a reference to Subchapter E of this chapter for the reference to Section 531.072 for the reason stated in the revisor's note to Section 549.0251 of this chapter.

Revised Law

Sec. 549.0254. ADMINISTRATION OF PRIOR AUTHORIZATION REQUIREMENTS. (a) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by Sections 549.0251 and 549.0255 through 549.0259 on the commission's behalf.

(b) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to this state and any administrative burden placed on providers. (Gov. Code, Secs. 531.073(e), (f).)

Source Law

(e) The commission may by contract authorize a private entity to administer the prior authorization requirements imposed by this section on behalf of the commission.

(f) The commission shall ensure that the prior authorization requirements are implemented in a manner that minimizes the cost to the state and any administrative burden placed on providers.

Revised Law

Sec. 549.0255. PREREQUISITE TO IMPLEMENTING PRIOR AUTHORIZATION REQUIREMENT FOR CERTAIN DRUGS. Until the commission completes a study evaluating the impact of a prior authorization requirement on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies. (Gov. Code, Sec. 531.073(a-1).)

Source Law

(a-1) Until the commission has completed a study evaluating the impact of a requirement of prior authorization on recipients of certain drugs, the executive commissioner shall delay requiring prior authorization for drugs that are used to treat patients with illnesses that:

(1) are life-threatening;

(2) are chronic; and

(3) require complex medical management strategies.

Revised Law

Sec. 549.0256. NOTICE OF PRIOR AUTHORIZATION REQUIREMENT IMPLEMENTATION AND PROCEDURES. Not later than the 30th day before the date a prior authorization requirement is implemented, the commission shall post on the Internet for consumers and providers:

(1) notice of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization. (Gov. Code, Sec. 531.073(a-2).)

Source Law

(a-2) Not later than the 30th day before the date on which prior authorization requirements are implemented, the commission shall post on the Internet for consumers and providers:

(1) a notification of the implementation date; and

(2) a detailed description of the procedures to be used in obtaining prior authorization.

Revised Law

Sec. 549.0257. PRIOR AUTHORIZATION PROCEDURES. (a) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) are met. The procedures must ensure that:

(1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the

Drug Utilization Review Board under Subchapter G;

(2) a response to a request for prior authorization is provided by telephone or other telecommunications device within 24 hours after receipt of the request; and

(3) a 72-hour supply of the drug prescribed is provided in an emergency or if the commission does not provide a response within the period required by Subdivision (2).

(b) The commission shall implement procedures to ensure that a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission administers, or an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, receives continuity of care in relation to certain prescriptions the commission identifies.

(c) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(d) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request. (Gov. Code, Secs. 531.073(b), (d), (g), (h).)

Source Law

> (b) The commission shall establish procedures for the prior authorization requirement under the Medicaid vendor drug program to ensure that the requirements of 42 U.S.C. Section 1396r-8(d)(5) and its subsequent amendments are met. Specifically, the procedures must ensure that:
>
> (1) a prior authorization requirement is not imposed for a drug before the drug has been considered at a meeting of the Drug Utilization Review Board under Section 531.0736;
>
> (2) there will be a response to a request for prior authorization by telephone or other telecommunications device within 24 hours after receipt of a request for prior authorization; and
>
> (3) a 72-hour supply of the drug prescribed will be provided in an emergency or if the commission does not provide a response within the time required by Subdivision (2).

(d) The commission shall implement procedures to ensure that a recipient under the child health plan program, Medicaid, or another state program administered by the commission or a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency receives continuity of care in relation to certain prescriptions identified by the commission.

(g) The commission shall ensure that requests for prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet.

(h) The commission shall provide an automated process that may be used to assess a Medicaid recipient's medical and drug claim history to determine whether the recipient's medical condition satisfies the applicable criteria for dispensing a drug without an additional prior authorization request.

Revisor's Note

Section 531.073(d), Government Code, refers to a "recipient" under Medicaid or the child health plan program. The revised law substitutes "recipient or enrollee" for the quoted language for the reason stated in the revisor's note to Section 549.0005 of this chapter.

Revised Law

Sec. 549.0258. PRIOR AUTHORIZATION AUTOMATION AND POINT-OF-SALE REQUIREMENTS. The executive commissioner, in the rules and standards governing the vendor drug program and as part of the requirements under a contract between the commission and a Medicaid managed care organization, shall:

(1) require, to the maximum extent possible based on a pharmacy benefit manager's claim system, automation of clinical prior authorization for each drug in the antipsychotic drug class; and

(2) ensure that, at the time a nonpreferred or clinical prior authorization edit is denied, a pharmacist is immediately provided a point-of-sale return message that:

(A) clearly specifies the contact and other information necessary for the pharmacist to submit a prior authorization request for the prescription; and

(B) instructs the pharmacist to dispense, only if clinically appropriate under federal or state law, a 72-hour supply of the prescription. (Gov. Code, Sec. 531.073(a-5).)

Source Law

> (a-5) The executive commissioner, in the rules and standards governing the vendor drug program and as part of the requirements under a contract between the commission and a Medicaid managed care organization, shall:
>
> (1) require, to the maximum extent possible based on a pharmacy benefit manager's claim system, automation of clinical prior authorization for each drug in the antipsychotic drug class; and
>
> (2) ensure that, at the time a nonpreferred or clinical prior authorization edit is denied, a pharmacist is immediately provided a point-of-sale return message that:
>
> (A) clearly specifies the contact and other information necessary for the pharmacist to submit a prior authorization request for the prescription; and
>
> (B) instructs the pharmacist to dispense, only if clinically appropriate under federal or state law, a 72-hour supply of the prescription.

Revised Law

Sec. 549.0259. APPLICABILITY OF PRIOR AUTHORIZATION REQUIREMENTS TO PRIOR PRESCRIPTIONS. The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient or enrollee under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, or for an individual who becomes eligible under Medicaid, the child health plan program, or another state program the commission or a health and human services agency administers, is not subject to any prior authorization requirement under this subchapter until the earlier of:

(1) the date the recipient or enrollee exhausts all the prescription, including any authorized refills; or

(2) the expiration of a period the commission prescribes. (Gov. Code, Sec. 531.073(c).)

Source Law

> (c) The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient under the child health plan program,

Medicaid, or another state program administered by the commission or a health and human services agency or for a person who becomes eligible under the child health plan program, Medicaid, or another state program administered by the commission or a health and human services agency is not subject to any requirement for prior authorization under this section unless the recipient has exhausted all the prescription, including any authorized refills, or a period prescribed by the commission has expired, whichever occurs first.

Revisor's Note

Section 531.073(c), Government Code, refers to a "recipient" under Medicaid or the child health plan program. The revised law substitutes "recipient or enrollee" for the quoted language for the reason stated in the revisor's note to Section 549.0005 of this chapter.

Revised Law

Sec. 549.0260. APPEAL OF PRIOR AUTHORIZATION DENIAL UNDER MEDICAID VENDOR DRUG PROGRAM. A recipient of drug benefits under the Medicaid vendor drug program may appeal through the Medicaid fair hearing process a denial of prior authorization under this subchapter for a covered drug or covered dosage. (Gov. Code, Sec. 531.072(f).)

Source Law

(f) A recipient of drug benefits under the Medicaid vendor drug program may appeal a denial of prior authorization under Section 531.073 of a covered drug or covered dosage through the Medicaid fair hearing process.

SUBCHAPTER G. DRUG UTILIZATION REVIEW BOARD

Revised Law

Sec. 549.0301. DEFINITION. In this subchapter, "board" means the Drug Utilization Review Board. (Gov. Code, Sec. 531.0736(a).)

Source Law

Sec. 531.0736. DRUG UTILIZATION REVIEW BOARD. (a) In this section, "board" means the Drug Utilization Review Board.

Revised Law

Sec. 549.0302. BOARD COMPOSITION; APPLICATION PROCESS. (a)

The composition of the board must comply with federal law, including 42 C.F.R. Section 456.716. The executive commissioner shall determine the board's composition, which must include:

(1) two representatives of managed care organizations, one of whom must be a physician and one of whom must be a pharmacist, as nonvoting members;

(2) at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(3) a consumer advocate who represents Medicaid recipients.

(b) The executive commissioner by rule shall develop and implement a process by which an individual may apply to become a board member and shall post the application and information regarding the application process on the commission's Internet website. (Gov. Code, Secs. 531.0736(c), (c-1).)

Source Law

(c) The executive commissioner shall determine the composition of the board, which must:

(1) comply with applicable federal law, including 42 C.F.R. Section 456.716;

(2) include two representatives of managed care organizations as nonvoting members, one of whom must be a physician and one of whom must be a pharmacist;

(3) include at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each

of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(4) include a consumer advocate who represents Medicaid recipients.

(c-1) The executive commissioner by rule shall develop and implement a process by which a person may apply to become a member of the board and shall post the application and information regarding the application process on the commission's Internet website.

Revised Law

Sec. 549.0303. CONFLICTS OF INTEREST. (a) A voting board member may not have a contractual relationship with, ownership interest in, or other conflict of interest with:

(1) a pharmaceutical manufacturer or labeler; or

(2) an entity the commission engages to assist in developing preferred drug lists or administering the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by:

(1) adopting rules that identify prohibited relationships and conflicts; or

(2) requiring the board to develop a conflict-of-interest policy that applies to the board. (Gov. Code, Sec. 531.0737.)

Source Law

Sec. 531.0737. DRUG UTILIZATION REVIEW BOARD: CONFLICTS OF INTEREST. (a) A voting member of the Drug Utilization Review Board may not have a contractual relationship, ownership interest, or other conflict of interest with a pharmaceutical manufacturer or labeler or with an entity engaged by the commission to assist in the development of the preferred drug lists or in the administration of the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may implement this section by adopting rules that identify prohibited relationships and conflicts or requiring the board to develop a conflict-of-interest policy that applies to the board.

Revised Law

Sec. 549.0304. BOARD MEMBER TERMS. Board members serve staggered four-year terms. (Gov. Code, Sec. 531.0736(e).)

Source Law

(e) Members of the board serve staggered four-year terms.

Revised Law

Sec. 549.0305. PRESIDING OFFICER. The voting board members shall elect from among the voting members a presiding officer. The presiding officer must be a physician. (Gov. Code, Sec. 531.0736(f).)

Source Law

(f) The voting members of the board shall elect from among the voting members a presiding officer. The presiding officer must be a physician.

Revised Law

Sec. 549.0306. INAPPLICABILITY OF OTHER LAW TO BOARD. Chapter 2110 does not apply to the board. (Gov. Code, Sec. 531.0736(m).)

Source Law

(m) Chapter 2110 does not apply to the board.

Revised Law

Sec. 549.0307. ADMINISTRATIVE SUPPORT FOR BOARD. The commission shall provide administrative support and resources as necessary for the board to perform the board's duties. (Gov. Code, Sec. 531.0736(l).)

Source Law

(l) The commission shall provide administrative support and resources as necessary for the board to perform its duties.

Revised Law

Sec. 549.0308. RULES FOR BOARD OPERATION. (a) The executive commissioner shall adopt rules governing the board's operation, including:

(1) rules governing the procedures the board uses to provide notice of a meeting; and

(2) rules prohibiting the board from discussing confidential information described by Subchapter D in a public meeting.

(b) The board shall comply with the rules adopted under this section and Section 549.0311. (Gov. Code, Sec. 531.0736(i).)

Source Law

> (i) The executive commissioner shall adopt rules governing the operation of the board, including rules governing the procedures used by the board for providing notice of a meeting and rules prohibiting the board from discussing confidential information described by Section 531.071 in a public meeting. The board shall comply with the rules adopted under this subsection and Subsection (j).

Revised Law

Sec. 549.0309. GENERAL POWERS AND DUTIES OF BOARD. (a) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for the preferred drug lists the commission adopts under Subchapter E;

(2) suggest to the commission restrictions or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to the commission.

(b) In developing recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of, and any program benefit associated with, a product.

(c) To the extent feasible, the board:

(1) shall review all drug classes included in the preferred drug lists at least once every 12 months; and

(2) may recommend inclusions in and exclusions from the lists to ensure that the lists provide for a range of clinically

effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals. (Gov. Code, Secs. 531.0736(b), (h), (k).)

Source Law

(b) In addition to performing any other duties required by federal law, the board shall:

(1) develop and submit to the commission recommendations for preferred drug lists adopted by the commission under Section 531.072;

(2) suggest to the commission restrictions or clinical edits on prescription drugs;

(3) recommend to the commission educational interventions for Medicaid providers;

(4) review drug utilization across Medicaid; and

(5) perform other duties that may be specified by law and otherwise make recommendations to the commission.

(h) In developing its recommendations for the preferred drug lists, the board shall consider the clinical efficacy, safety, and cost-effectiveness of and any program benefit associated with a product.

(k) To the extent feasible, the board shall review all drug classes included in the preferred drug lists adopted under Section 531.072 at least once every 12 months and may recommend inclusions to and exclusions from the lists to ensure that the lists provide for a range of clinically effective, safe, cost-effective, and medically appropriate drug therapies for the diverse segments of the Medicaid population, children receiving health benefits coverage under the child health plan program, and any other affected individuals.

Revisor's Note

Section 531.0736(b)(1), Government Code, refers to preferred drug lists adopted by the Health and Human Services Commission under Section 531.072, Government Code. The revised law substitutes a reference to Subchapter E of this chapter for the reference to Section 531.072, Government Code, for the reason stated in the revisor's note to Section 549.0251 of this chapter.

Revised Law

Sec. 549.0310. BOARD MEETINGS; REVIEW OF CERTAIN PRODUCTS. (a) The board shall hold a public meeting quarterly at the call of

the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists the commission adopts under Subchapter E, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state.

(b) The board shall hold public meetings at other times at the call of the presiding officer.

(c) Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved.

(d) The board may meet in executive session to discuss confidential information as described by Section 549.0308.

(e) Board members appointed under Section 549.0302(a)(1) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(f) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section 549.0101. The commission shall ensure that a drug that has been approved or had any of the drug's particular uses approved by the United States Food and Drug Administration under a priority review classification is reviewed by the board at the next regularly scheduled board meeting. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled board meeting. (Gov. Code, Secs. 531.072(e) (part), 531.0736(b) (part), (d), (g).)

Source Law

[Sec. 531.072]

(e) In this subsection, "labeler" and "manufacturer" have the meanings assigned by Section

531.070. The commission shall ensure that:

. . .

(2) any drug that has been approved or has had any of its particular uses approved by the United States Food and Drug Administration under a priority review classification will be reviewed by the Drug Utilization Review Board at the next regularly scheduled meeting of the board. On receiving notice from a manufacturer or labeler of the availability of a new product, the commission, to the extent possible, shall schedule a review for the product at the next regularly scheduled meeting of the board.

[Sec. 531.0736]

(b) . . . [the board shall:

(1) develop and submit . . . recommendations for] preferred drug lists adopted by the commission under Section 531.072;

. . .

(d) Members appointed under Subsection (c)(2) may attend quarterly and other regularly scheduled meetings, but may not:

(1) attend executive sessions; or

(2) access confidential drug pricing information.

(g) The board shall hold a public meeting quarterly at the call of the presiding officer and shall permit public comment before voting on any changes in the preferred drug lists, the adoption of or changes to drug use criteria, or the adoption of prior authorization or drug utilization review proposals. The location of the quarterly public meeting may rotate among different geographic areas across this state, or allow for public input through teleconferencing centers in various geographic areas across this state. The board shall hold public meetings at other times at the call of the presiding officer. Minutes of each meeting shall be made available to the public not later than the 10th business day after the date the minutes are approved. The board may meet in executive session to discuss confidential information as described by Subsection (i).

Revised Law

Sec. 549.0311. BOARD SUMMARY OF CERTAIN INFORMATION REQUIRED. (a) The executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list the commission adopts under Subchapter E that is provided to the board by a private entity that contracted with the commission to provide the information. Confidential information described by Subchapter D must be omitted from the summary.

(b) The board or the board's designee shall provide the summary in electronic form before the public meeting at which

consideration of the drug occurs.

(c) The summary must be posted on the commission's Internet website. (Gov. Code, Secs. 531.0736(b) (part), (j).)

Source Law

(b) . . . [the board shall:

(1) develop and submit . . . recommendations for] preferred drug lists adopted by the commission under Section 531.072;

. . .

(j) In addition to the rules under Subsection (i), the executive commissioner by rule shall require the board or the board's designee to present a summary of any clinical efficacy and safety information or analyses regarding a drug under consideration for a preferred drug list that is provided to the board by a private entity that has contracted with the commission to provide the information. The board or the board's designee shall provide the summary in electronic form before the public meeting at which consideration of the drug occurs. Confidential information described by Section 531.071 must be omitted from the summary. The summary must be posted on the commission's Internet website.

Revisor's Note

Section 531.0736(j), Government Code, states that "[i]n addition to the rules under Subsection (i)," which is revised as Section 549.0308 of this chapter, the executive commissioner of the Health and Human Services Commission by rule shall require the Drug Utilization Review Board to perform certain other acts. The revised law omits the quoted language as unnecessary because each requirement to adopt rules applies by its own terms and because the absence of the language does not imply that the requirement to adopt rules under this section negates the executive commissioner's duty to adopt rules under other law.

Revised Law

Sec. 549.0312. PUBLIC DISCLOSURE OF CERTAIN BOARD RECOMMENDATIONS REQUIRED. (a) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The

disclosure must include:

(1) the general basis for the recommendation for each drug class; and

(2) for each recommendation, whether a supplemental rebate agreement or program benefit agreement was reached under Subchapter C.

(b) The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list. (Gov. Code, Sec. 531.0736(n).)

Source Law

> (n) The commission or the commission's agent shall publicly disclose, immediately after the board's deliberations conclude, each specific drug recommended for or against preferred drug list status for each drug class included in the preferred drug list for the Medicaid vendor drug program. The disclosure must be posted on the commission's Internet website not later than the 10th business day after the date of conclusion of board deliberations that result in recommendations made to the executive commissioner regarding the placement of drugs on the preferred drug list. The public disclosure must include:
>
> (1) the general basis for the recommendation for each drug class; and
>
> (2) for each recommendation, whether a supplemental rebate agreement or a program benefit agreement was reached under Section 531.070.

SUBCHAPTER H. MEDICAID DRUG UTILIZATION REVIEW PROGRAM

Revised Law

Sec. 549.0351. DEFINITIONS. In this subchapter:

(1) "Medicaid Drug Utilization Review Program" means the program the vendor drug program operates to improve the quality of pharmaceutical care under Medicaid.

(2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.

(3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing. (Gov. Code, Sec. 531.0735(a).)

Source Law

Sec. 531.0735. MEDICAID DRUG UTILIZATION REVIEW PROGRAM: DRUG USE REVIEWS AND ANNUAL REPORT. (a) In this section:

(1) "Medicaid Drug Utilization Review Program" means the program operated by the vendor drug program to improve the quality of pharmaceutical care under Medicaid.

(2) "Prospective drug use review" means the review of a patient's drug therapy and prescription drug order or medication order before dispensing or distributing a drug to the patient.

(3) "Retrospective drug use review" means the review of prescription drug claims data to identify patterns of prescribing.

Revised Law

Sec. 549.0352. DRUG USE REVIEWS. (a) The commission shall provide for an increase in the number and types of retrospective drug use reviews performed each year under the Medicaid Drug Utilization Review Program in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(b) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid spending;

(2) consider implementing disease-specific retrospective drug use reviews that:

(A) address ongoing drug therapy problems in this state; and

(B) reduced Medicaid prescription drug use expenditures in another state; and

(3) regularly examine Medicaid prescription drug claims data to identify occurrences of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state or another state. (Gov. Code, Secs. 531.0735(b), (c).)

Source Law

(b) The commission shall provide for an increase in the number and types of retrospective drug use

reviews performed each year under the Medicaid Drug Utilization Review Program, in comparison to the number and types of reviews performed in the state fiscal year ending August 31, 2009.

(c) In determining the number and types of drug use reviews to be performed, the commission shall:

(1) allow for the repeat of retrospective drug use reviews that address ongoing drug therapy problems and that, in previous years, improved client outcomes and reduced Medicaid spending;

(2) consider implementing disease-specific retrospective drug use reviews that address ongoing drug therapy problems in this state and that reduced Medicaid prescription drug use expenditures in other states; and

(3) regularly examine Medicaid prescription drug claims data to identify occurrences of potential drug therapy problems that may be addressed by repeating successful retrospective drug use reviews performed in this state and other states.

Revised Law

Sec. 549.0353. ANNUAL REPORT. (a) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(b) The cost-saving estimates for prospective drug use reviews under Subsection (a) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Subchapter F.

(c) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's Internet website. (Gov. Code, Secs. 531.0735(d), (e), (f).)

Source Law

(d) In addition to any other information required by federal law, the commission shall include the following information in the annual report regarding the Medicaid Drug Utilization Review Program:

(1) a detailed description of the program's activities; and

(2) estimates of cost savings anticipated to result from the program's performance of prospective and retrospective drug use reviews.

(e) The cost-saving estimates for prospective drug use reviews under Subsection (d) must include savings attributed to drug use reviews performed through the vendor drug program's electronic claims processing system and clinical edits screened through the prior authorization system implemented under Section 531.073.

(f) The commission shall post the annual report regarding the Medicaid Drug Utilization Review Program on the commission's website.

Revisor's Note

Section 531.0735(e), Government Code, refers to the prior authorization system implemented under Section 531.073, Government Code, which is revised in this chapter in Subchapter F. That subchapter also includes the revision of Section 531.072(f), Government Code. The revised law substitutes a reference to Subchapter F in its entirety for the reference to Section 531.073 because the provision of that subchapter derived from Section 531.072(f) relates to the same prior authorization system, and its inclusion in the reference has no substantive effect.

SUBCHAPTER I. PHARMACEUTICAL PATIENT ASSISTANCE PROGRAM INFORMATION

Revised Law

Sec. 549.0401. DEFINITION. In this subchapter, "patient assistance program" means a program a pharmaceutical company offers under which the company provides a drug to individuals in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial. (Gov. Code, Sec. 531.351.)

Source Law

Sec. 531.351. DEFINITION. In this subchapter, "patient assistance program" means a program offered by a pharmaceutical company under which the company provides a drug to persons in need of assistance at no charge or at a substantially reduced cost. The term does not include the provision of a drug as part of a clinical trial.

Revised Law

Sec. 549.0402. PROVISION OF PROGRAM INFORMATION BY PHARMACEUTICAL COMPANY. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of:

(1) the existence of the program;

(2) the eligibility requirements for the program;

(3) the drugs covered by the program; and

(4) information used for applying for the program, such as a telephone number. (Gov. Code, Sec. 531.352.)

Source Law

> Sec. 531.352. PROVIDING INFORMATION TO COMMISSION. Each pharmaceutical company that does business in this state and that offers a patient assistance program shall inform the commission of the existence of the program, the eligibility requirements for the program, the drugs covered by the program, and information such as a telephone number used for applying for the program.

Revised Law

Sec. 549.0403. PUBLIC ACCESS TO PROGRAM INFORMATION. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with individuals who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether an individual may be eligible to participate in a program; and

(3) assist an individual who wishes to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and drug prescribers. (Gov. Code, Sec. 531.353.)

Source Law

> Sec. 531.353. TOLL-FREE TELEPHONE NUMBER. (a) The commission shall establish a system under which members of the public can call a toll-free telephone number to obtain information about available patient

assistance programs. The commission shall ensure that the system is staffed at least during normal business hours with persons who can:

(1) determine whether a patient assistance program is offered for a particular drug;

(2) determine whether a person may be eligible to participate in a program; and

(3) assist persons who wish to apply for a program.

(b) The commission shall publicize the telephone number to pharmacies and prescribers of drugs.

SUBCHAPTER J. STATE PRESCRIPTION DRUG PROGRAM

Revised Law

Sec. 549.0451. DEVELOPMENT AND IMPLEMENTATION OF STATE PRESCRIPTION DRUG PROGRAM. The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients. (Gov. Code, Sec. 531.301(a).)

Source Law

Sec. 531.301. DEVELOPMENT AND IMPLEMENTATION OF STATE PROGRAM; FUNDING. (a) The commission shall develop and implement a state prescription drug program that operates in the same manner as the vendor drug program operates in providing prescription drug benefits to Medicaid recipients.

Revised Law

Sec. 549.0452. PROGRAM ELIGIBILITY. An individual is eligible for prescription drug benefits under the state prescription drug program if the individual is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1);

(2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii);

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s); or

(4) a qualifying individual who is eligible for assistance under Medicaid under 42 U.S.C. Section 1396a(a)(10)(E)(iv). (Gov. Code, Sec. 531.301(b).)

Source Law

(b) A person is eligible for prescription drug benefits under the state program if the person is:

(1) a qualified Medicare beneficiary, as defined by 42 U.S.C. Section 1396d(p)(1), as amended;

(2) a specified low-income Medicare beneficiary who is eligible for assistance under Medicaid for Medicare cost-sharing payments under 42 U.S.C. Section 1396a(a)(10)(E)(iii), as amended;

(3) a qualified disabled and working individual, as defined by 42 U.S.C. Section 1396d(s), as amended; or

(4) a qualifying individual who is eligible for that assistance under 42 U.S.C. Section 1396a(a)(10)(E)(iv).

Revisor's Note

Sections 531.301(b)(1), (2), and (3), Government Code, refer to 42 U.S.C. Section 1396d(p)(1), 42 U.S.C. Section 1396a(a)(10)(E)(iii), and 42 U.S.C. Section 1396d(s), respectively, "as amended." The revised law omits "as amended" for the reason stated in Revisor's Note (2) to Section 549.0101 of this chapter.

Revised Law

Sec. 549.0453. RULES. (a) The executive commissioner shall adopt rules necessary for implementing the state prescription drug program.

(b) In adopting rules for the state prescription drug program, the executive commissioner:

(1) shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists the executive commissioner appoints; and

(2) may:

(A) require an individual who is eligible for prescription drug benefits to pay a cost-sharing payment;

(B) authorize the use of a prescription drug formulary to specify which prescription drugs the state prescription drug program will cover;

(C) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor

drug program; and

(D) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state prescription drug program. (Gov. Code, Sec. 531.302.)

Source Law

> Sec. 531.302. RULES. (a) The executive commissioner shall adopt all rules necessary for implementation of the state prescription drug program.
>
> (b) In adopting rules for the state prescription drug program, the executive commissioner may:
>
> (1) require a person who is eligible for prescription drug benefits to pay a cost-sharing payment;
>
> (2) authorize the use of a prescription drug formulary to specify which prescription drugs the state program will cover;
>
> (3) to the extent possible, require clinically appropriate prior authorization for prescription drug benefits in the same manner as prior authorization is required under the vendor drug program; and
>
> (4) establish a drug utilization review program to ensure the appropriate use of prescription drugs under the state program.
>
> (c) In adopting rules for the state prescription drug program, the executive commissioner shall consult with an advisory panel composed of an equal number of physicians, pharmacists, and pharmacologists appointed by the executive commissioner.

Revised Law

Sec. 549.0454. GENERIC EQUIVALENT AUTHORIZED. In rules adopted for the state prescription drug program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, a pharmacist may select a generic equivalent of the prescribed drug. (Gov. Code, Sec. 531.303.)

Source Law

> Sec. 531.303. GENERIC EQUIVALENT AUTHORIZED. In adopting rules under the state program, the executive commissioner may require that, unless the practitioner's signature on a prescription clearly indicates that the prescription must be dispensed as written, the pharmacist may select a generic equivalent of the prescribed drug.

Revised Law

Sec. 549.0455. PROGRAM FUNDING AND FUNDING PRIORITIES. (a) Prescription drugs under the state prescription drug program may be funded only with state money unless money is available under

federal law to fund all or part of the program.

(b) If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all individuals who are eligible under Section 549.0452, the commission shall:

(1) limit the number of enrollees based on available funding; and

(2) provide the prescription drug benefits to eligible individuals in the following order of priority:

(A) individuals eligible under Section 549.0452(1);

(B) individuals eligible under Section 549.0452(2); and

(C) individuals eligible under Sections 549.0452(3) and (4). (Gov. Code, Secs. 531.301(c), 531.304.)

Source Law

[Sec. 531.301]

(c) Prescription drugs under the state program may be funded only with state money, unless funds are available under federal law to fund all or part of the program.

Sec. 531.304. PROGRAM FUNDING PRIORITIES. If money available for the state prescription drug program is insufficient to provide prescription drug benefits to all persons who are eligible under Section 531.301(b), the commission shall limit the number of enrollees based on available funding and shall provide the prescription drug benefits to eligible persons in the following order of priority:

(1) persons eligible under Section 531.301(b)(1);

(2) persons eligible under Section 531.301(b)(2); and

(3) persons eligible under Sections 531.301(b)(3) and (4).

Revisor's Note

Section 531.301(c), Government Code, refers to "funds" available under federal law. The revised law substitutes "money" for "funds" because, in context, the meaning is the same and "money" is the more commonly used term.