HOUSE BILL REPORT
ESHB 2565

As Passed House:
February 9, 2018

Title: An act relating to drug and gene therapy payment for medicaid managed care organizations.

Brief Description: Concerning drug and gene therapy payment for medicaid managed care organizations.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representative Schmick).

Brief History:
Committee Activity:
Health Care & Wellness: 1/30/18, 2/2/18 [DPS].
Floor Activity:
Passed House: 2/9/18, 98-0.

Brief Summary of Engrossed Substitute Bill

- Adds members from each Medicaid managed care organization to the Health Care Authority's (Authority) Drug Utilization Review (DUR) Board.
- Requires the DUR Board to consider the safety, efficacy, and cost-effectiveness of new drugs and innovative therapies in its recommendations to the Director of the Authority regarding coverage under medical assistance programs.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 16 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

Staff: Chris Blake (786-7392).

Background:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Federal Medicaid regulations require that states operate a Drug Utilization Review (DUR) Program consisting of prospective drug review, retrospective drug review, and an educational program. The goal of the DUR Program is to ensure appropriate drug therapy, while permitting sufficient professional perogatives to allow for individualized drug therapy. As part of the DUR Program, a state must establish a DUR Board to review and make recommendations on standards received from the Medicaid agency and make recommendations on interventions to improve the quality of drug therapy. Federal law requires the DUR Board to include health care professionals who have knowledge and expertise in clinically appropriate prescribing, dispensing, and monitoring of outpatient drugs; drug use review, evaluation, and intervention; and medical quality assurance. Between 33 and 51 percent of members of the DUR Board must be physicians and at least 33 percent must be pharmacists.

State agencies that administer state-purchased health care programs must establish independent pharmacy and therapeutics committees to evaluate the effectiveness of prescription drugs. The Health Care Authority has established the Pharmacy and Therapeutics (P&T) Committee to serve as both the state's Medicaid DUR Board and agency P&T Committee.

Summary of Engrossed Substitute Bill:

The Drug Utilization Review (DUR) Board established by the Health Care Authority (Authority) must include representatives from each managed care organization that administers a Medicaid managed care plan. The representatives must be either the managed care organization's chief medical officer, medical director, or pharmacy director.

When making recommendations to the Director of the Authority regarding coverage for drugs and innovative therapies in medical assistance programs, the DUR Board must consider the safety, efficacy, and cost-effectiveness of new drugs and innovative therapies compared to other equally effective, more conservative, or substantially less costly courses of treatment. Consideration related to the cost of the drug must reflect:

- the total cost of care associated with the course of treatment for which the drug is prescribed, such as transportation, housing, and treatment of adverse events;
- costs incurred by the state medical assistance program if the patient does not receive the course of treatment; and
- examples of other services offered through the state medical assistance program that could be funded.

The DUR Board's recommendations and conclusions related to cost-effectiveness must be separated from the deliberations of the Pharmacy and Therapeutics Committee.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) High cost drugs are an important issue affecting Medicaid and the state budget. This bill outlines a process for evaluating these drugs for Medicaid coverage and handling new high-cost drugs in the Medicaid rate review process. When the federal Food and Drug Administration approves a drug after rates have been set, Medicaid managed care organizations are at financial risk for covering specialty, high-cost drugs without a clear mechanism for reimbursement. It is important to establish a process as new, expensive drugs come to market so the drugs will be available to the Medicaid caseload with an informed rate-setting process. It is difficult to have predictability when high-costs drugs are federally approved in the middle of the year without any cost and utilization data to provide guidance.

In addition to cost concerns, there is no established process to effectively manage high-cost drug situations and the Medicaid managed care organizations would like consistency in applying medical necessity criteria and prior authorization requirements for specialty high-cost drugs. This bill puts in place a process for the next hepatitis C drug that exposes the state to liability. This bill is trying to replicate the process that was used with the recent hepatitis C drug where the Health Care Authority (Authority) convened all of the medical directors and pharmacy directors to develop medical necessity criteria to be applied uniformly across all Medicaid plans and beneficiaries.

Medicaid managed care organizations do not have a seat on the Pharmacy and Therapeutics (P&T) Committee even though they are at-risk for the drugs and related treatments that are approved. Each of the five Medicaid managed care organizations should have a seat on the P&T Committee so they can provide their expertise on treating the Medicaid population and advise the P&T Committee and work as partners with the Authority to determine the right kinds of drugs for patients. With the move toward a single formulary for Medicaid, the Medicaid managed care organizations should have input on the P&T Committee.

(Opposed) This bill puts a lot of control in the hands of the Medicaid managed care organizations by giving them a third of the seats on the P&T Committee. The state has demonstrated that it can be creative in finding ways to pay for high-cost patients, as it has done with the Centers for Excellence model for bleeding disorders. There should be a work group to bring stakeholders together to find creative ways to work with high-cost patients in the future. Even though the cost of these therapies is overwhelming, the treatment can greatly change people's lives.

While cost is an important issue, there is concern about the addition of Medicaid managed care organizations having undue influence on the P&T Committee which is highly medical and has the purpose of evaluating the efficacy of a particular treatment. Placing Medicaid managed care organizations as voting members on the P&T Committee is not appropriate at this time.

Persons Testifying: (In support) Representative Schmick, prime sponsor; Patty Seib, Molina Health; Caitlin Safford, Amerigroup; Dave Knutson, Community Healthplans of Washington; and Andrea Davis, Coordinated Care.

(Opposed) Stephanie Simpson, Bleeding Disorder Foundation of Washington; and Katie Kolan, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying: None.