HOUSE BILL REPORT
2SSB 5213

As Passed House - Amended:
April 24, 2013

Title: An act relating to prescription review for medicaid managed care enrollees.

Brief Description: Concerning prescription review for medicaid managed care enrollees.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Becker, Tom, Bailey, Honeyford and Frockt).

Brief History:
Committee Activity:
Health Care & Wellness: 3/19/13, 3/28/13 [DPA];
Appropriations: 4/5/13 [DPA(APP w/o HCW)].
Floor Activity:
Passed House - Amended: 4/24/13, 97-0.

Brief Summary of Second Substitute Bill
(As Amended by House)

- Requires that contracts with managed health care systems under Medicaid include incentives for pharmacists and primary care providers to provide services to review the appropriateness and effectiveness of drugs for patients with medications for multiple chronic conditions.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 14 members: Representatives Jinkins, Vice Chair; Schmick, Ranking Minority Member; Hope, Assistant Ranking Minority Member; Angel, Clibborn, Green, Harris, Manweller, Moeller, Riccelli, Rodne, Ross, Short and Tharinger.

Minority Report: Without recommendation. Signed by 3 members: Representatives Cody, Chair; Morrell and Van De Wege.

Staff: Chris Blake (786-7392).

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.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 30 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Alexander, Ranking Minority Member; Chandler, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Cody, Dahlquist, Dunshee, Fagan, Green, Haigh, Haler, Harris, Hudgins, Hunt, Jinkins, Kagi, Maxwell, Morrell, Parker, Pedersen, Pike, Ross, Schmick, Seaquist, Springer, Sullivan and Taylor.

Staff: Erik Cornellier (786-7116).

Background:

The Health Care Authority (Authority) administers the state's Medicaid program which provides health care for eligible low-income residents. The Authority purchases health care services either on a fee-for-service basis or under a managed care arrangement. In a fee-for-service system, health care providers are paid by the Authority for each service that is delivered to an eligible client. Under a managed care program, the Authority contracts with a health care plan to provide a comprehensive set of medical care services to Medicaid enrollees pursuant to a capitated monthly premium for each covered individual. Managed care is currently provided for eligible families, children under age 19, pregnant women, and certain blind or disabled individuals.

In contracts with managed health care systems providing services to recipients of Temporary Assistance for Needy Families, the Authority's contracts must include several specified arrangements. These provisions relate to: (1) standards for the quality of services; (2) financial integrity; (3) provider reimbursement methods that incentivize chronic care management within health homes; (4) provider reimbursement methods that reward health homes that use chronic care management to reduce emergency department and inpatient use; and (5) the promotion of provider participation in the Department of Health's training program for caring for people with chronic conditions. The Authority may apply these provisions to contracts with managed health care systems for other Medicaid eligibility categories.

Summary of Amended Bill:

Legislative findings are made regarding the importance of chronic care management, including comprehensive medication management services, as a collaborative approach to treating chronic disease to improve care and reduce cost in treating chronic diseases.

The Health Care Authority (Authority) must include in its Medicaid contracts with managed health care systems providing services to recipients of Temporary Assistance for Needy Families a provision regarding reimbursement methods to incentivize pharmacists or other qualified providers to deliver comprehensive medication management services. Comprehensive medication management services are to be provided by pharmacists or other qualified providers to patients with multiple chronic conditions. The services must be provided consistent with the bill's findings and goals.

The comprehensive medication management services provisions must be included in contracts issued or renewed after January 1, 2015. The contracts must also include evaluation and reporting on the impact of comprehensive medication management services on patient clinical outcomes and total health care costs. The Authority may apply this provision to contracts with managed health care systems for other Medicaid eligibility categories. Contracts with comprehensive medication management services provisions may not cost more than the rates would be without those provisions.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) This bill is a good way to review patient medications for adverse reactions. It makes sense to have a health care professional doing a periodic review of the medications of patients taking at least five different drugs to make sure that the drugs are compatible. There are many over-the-counter products that can interact negatively with prescription drugs and this bill will help them all be reviewed. This bill will address preventable problems by looking at all of the medications that a patient is taking at a single time. This bill will align incentives for providers to spend time with patients to help them understand the drugs that they are using. This concept is also being looked at on a national level. This bill encourages health plans to establish incentives to have pharmacists and providers choose to conduct comprehensive medication management services with their patients. This bill is designed to be permissive for providers. This bill does not mandate anything that is inconsistent with Medicare requirements.

Figures show that $290 billion are spent annually on non-adherence to drug therapy and medication misuse. This bill will save money by preventing adverse drug outcomes. This approach has saved money in other states through reductions in unnecessary emergency department visits and physician visits.

(With concerns) The goals of reducing costs through avoiding adverse drug interactions are worthwhile; however, there is concern about how managed care will reimburse for these additional services. This process may capture some patients who are being managed well on their medications and do not need this intervention. This could increase managed care rates. This new process may be duplicative of health reform requirements. The threshold for the number of medications should be increased to 10, not five. Medication management is an evolving concept and should not be defined in the bill. The bill creates competing requirements for people who qualify for both Medicare and Medicaid.

(Opposed) Health plans have specialized care management programs that provide comprehensive care for people with chronic conditions and this bill would require that medications be pulled out of that process for a new, separate review to be layered on top of

the existing program. This bill will add to administration and cost. Any savings that the bill could create will be offset by the number of Medicaid patients who would be receiving these services, resulting in higher Medicaid rates.

Staff Summary of Public Testimony (Appropriations):

(In support) This policy has been well vetted in the Health Care and Wellness Committee. There are examples of improved cost outcomes and savings. In Minnesota, the Medicaid program saved $1,500 per patient. The Asheville Project reduced costs by $1,200 to $1,800 per patient. The goal is to improve health outcomes for the patient by making sure the patient is taking the right drugs, watching out for adverse effects, ensuring proper dosage, and maintaining adherence. This helps avoid long-term downstream costs from emergency room visits.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Senator Becker, prime sponsor; Jeff Rochon, Washington State Pharmacy Association; and Lisa Thatcher, GlaxoSmithKline.

(With concerns) Leslie Emerick, Association of Advanced Practice Psychiatric Nurses; Melissa Johnson, ARNPs United; and Mary Clogston, Academy of Family Physicians.

(Opposed) Sydney Smith Zvara, Association of Washington Healthcare Plans.

Persons Testifying (Appropriations): Lisa Thatcher, GlaxoSmithKline.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.