Washington State Pharmacy and Therapeutics Committee
Drug Utilization Review Board Special Meeting
July 7, 2017

Lisa Chew: I'm chairing the meeting for today. I'll convene the special meeting of the Washington State P&T Committee. Maybe, Leta, do you want to read off the committee names [inaudible] present?

Leta Evaskus: Yes, thank you. Diane Schwilke?

Diane Schwilke: I'm here. Good morning.

Leta Evaskus: Nancy Lee?

Nancy Lee: Present.

Leta Evaskus: Dale Sanderson?

Dale Sanderson: Present.

Leta Evaskus: Amber Figueroa?

Amber Figueroa: I'm here.

Leta Evaskus: Po Karczewski?

Po Karczewski: Present.

Leta Evaskus: Jordan Storhaug?

Jordan Storhaug: Good morning.

Leta Evaskus: Susan Flatebo?

Susan Flatebo: Present.

Leta Evaskus: And Michael Johnson is absent and Catherine Brown is also absent just for the record.

Nancy Lee: Okay. Introductions around the table. Ryan, why don't you go ahead and start.

Ryan Pistoresi: Ryan Pistoresi, Health Care Authority.

Charity Harris: Charity Harris, Health Care Authority.

Jaymie Mai: Jaymie Mai, Labor and Industries.

Leta Evaskus: Leta Evaskus, Health Care Authority.

Donna Sullivan: Donna Sullivan, Health Care Authority.

Ray Hanley: Ray Hanley, Health Care Authority.

Petra Eichelsdoerfer: Petra Eichelsdoerfer, United Healthcare.

Fran McGaugh: Fran McGaugh, Community Health Plan of Washington.

Mary Eckhart: Mary Eckhart, Community Health Plan of Washington.

Donna Sullivan: Is there anybody from Health Care Authority on the phone? It looks like we have Dr. Transue. Anyone else from Health Care Authority?

Emily Transue: Yes, I'm here.

Donna Sullivan: Okay. So I think with that we will go ahead and get started. We are here today to talk about a budget proviso that was passed with the budget on June 30th and the purpose of the meeting is really to go through the proviso and tell you what we think it means to us. We will talk about our priorities and what we're doing to try to prepare for this work. We're then going to get asked questioned from the committee and then we'll ask questions from the stakeholders. This is really kind of an information-gathering meeting. I'm not expecting us to have a lot of answers to your questions because we just haven't

had time to really absorb all of this. But we will do the best we can. And then once we have answered as many questions as we can we'll ask you to give you as many questions… or give us as many questions and then we'll take those back and we will prepare answers and get them posted online so all the stakeholders can have—everybody has the same amount of information.

And then afterwards we'll wrap up and kind of talk about how we're going to move forward with trying to get this work finished.

So the budget proviso, it's in… it was House Bill or Senate Bill 5883 if you want to go find it online. It's the entire budget so it's several hundred pages long. So what I've done is I've just kind of extracted the actual proviso language out of the budget bill. What it does is it directed the Health Care Authority to develop and implement [inaudible] standard Medicaid preferred drug list and it is to be used by all of the managed care Medicaid managed care plans on or before January 1st of 2018. The ATA is supposed to create this preferred drug list in consultation with all of the Medicaid [inaudible] health care systems, as well as the P&T Committee and the DUR Board. So you will note… in future meetings you will see that our managed care colleagues will be invited to these meetings and will be sitting around the table with the rest of the staff. We were specifically directed to ensure that there's access to clinically effective and appropriate drug therapies in each of the drug classes, but also to maximize federal and supplemental rebates. There was also some comment in there that 340B entities will continue to operate under their current pricing agreement unless there was changes in federal rules. I don't think that we'll talk much about that, the 340B today.

It allows the Health Care Authority to use consultants that have expertise in evidence-based drug class reviews, pharmacy benefit management and prescription drug purchasing. All of the managed care plans are required to use the preferred drug list and the budget specific prohibited them from negotiating or collecting their own rebates for drugs listed on the preferred drug list regardless of whether they were listed as preferred or non-preferred. The managed care plans will also need to provide the Health Care

Authority with drug specific financial information in a format and frequency determined by Health Care Authority including the amount paid to pharmacies, the amount charged to the plan and the rebates they received on a drug specific basis. This information is really necessary for the Health Care Authority to provide the analysis on the reports that are fired back to the legislature.

The budget proviso also goes to say that the financial and proprietary information that the health plans disclosed to the Health Care Authority or their pharmacy benefit managers or manufacturers is to be kept confidential and specifically it is not subject to the Washington Public Records Act. The Health Care Authority must provide an annual report to the governor and the legislature beginning November 15, 2018 and again November 15, 2019 and we are asked to compare the amount spent on prescription drugs in the previous two fiscal years compared to the amount spent on prescription under the first year of using this preferred drug list. Also to look at the top drug classes and the top 25 drugs by total expenditure. The budget did include a savings expectation of approximately 10% or about $144 million over the biennium.

So I wanted to talk about the health care priorities. There was a pretty large budget savings and that was expected or assumed in the budget and I just want to emphasize that the Health Care Authority's priorities are really patient care first and making sure that they have access to the necessary medications and that there is not a lot of member disruption or that we can minimize the amount of member disruption. We want to make sure that patients, prescribers, and pharmacies have easy access to the right information. So come January of 2018 they understand who to contact if a prescription needs prior authorization or if there is a formulary change or something like that. So we've been working on the communications. Again, it's the… to minimize the patient and provider disruption and then we will try the best we can to meet those budget targets.

We started to work on a draft work plan starting to identify all aspects of the Health Care Authority, all of the different divisions in the Health Care Authority that are impacted by the single preferred

drug list in addition to the managed care plans and the work that they will have to do in order to get this implemented by January 1st. So we are looking at, you know, data analysis to figure out how far apart the formularies look. We are setting up… I am setting up weekly meetings with the pharmacy directors from the health plans so that we can try to figure out how we're going to work through the process of creating the preferred drug list. We will potentially need to amend our Medicaid state plan with CMS. The managed care contracts need to be amended to include the single PDL language before January of 2018. We are going to try to create a single online kind of portal where the preferred drug list will be posted, as well as clinical criteria for prior authorizations. So we're hoping that, you know, we'll have something by January. We are assuming that there will be a file, an NCPDP file that will be shared with the plan so that everybody is getting the same information. We're working really hard on identifying a pretty comprehensive communication strategy for providers, patients, as well as the rest of the stakeholders that are impacted or might be interested in the work that's going on. There are technology requirements of programming the claims processing systems, making sure that those… the formulary gets programmed and tested and is ready to go. There's finance that we have to work through as far as the supplemental rebates that we might be collecting and how that impacts the managed care plan rates. And other changes like changing to the Washington Administrative Code, potentially contracting with a vendor in order to get the evidence-based reviews and potentially supplemental rebates. And then really, you know, figure out what is going to be our process. How are we going to do this work to just create the single PDL itself? That is a lot of work, but there is also a ton of work that needs to be done around getting this operational.

That's the information that I have to share. I want to ask for questions from the committee first.

Dale Sanderson: Do you anticipate additional P&T meetings?

Donna Sullivan: Yes. I think we will have to have additional meetings and at this time I think we will be expecting a monthly meeting through at least the end

of the year so we will be scheduling one in September, as well as potentially in November depending on where the timing is. Part of the reason we are doing at least the September meeting is we feel that we have to have the single preferred drug list created and finalized by the first of October. That's our goal. With that… so that the managed care plans have ample time in order to make the system changes that they need to make. We might have more frequent meetings, Dale. We have booked this conference room out on a weekly basis in case we do need to have more impromptu meetings, but we will let you know when those occur.

Lisa Chew: Do you have a sense of how far apart the lists look between the HCA and the MCOs? And if there is a discrepancy how is it going to be decided?

Donna Sullivan: That's a really good question, Lisa. I do have a sense. There's many drug classes… the older drug classes where most of the drugs are generic where the plans are very, very close together. I would say 50% of the drugs that we cover are probably the same. So like the penicillin, you know, the beta blockers, ACE inhibitors, there's very little difference in many of those. I don't… for where the plans are different I don't really have a sense of what those differences are. I've started to compile some of that information and then we will… I'll be working with the Medicaid… the pharmacy directors from the managed care plans and we'll try to figure out how we're going to work through those discrepancies and any suggestions from the committee, you know, we would appreciate any help from you. We will bring this to you I think in August with our recommended plan of going forward.

Lisa Chew: Thank you.

Donna Sullivan: Any other questions from the committee? Okay. So I think what we will do is we can ask the audience if they have questions. If you guys on the phone can think of a question feel free to just chime in and we will get you… let you speak.

Leta Evaskus: So no stakeholders signed up, but if anybody would like to come up and ask a question, if you could just sit at the table. There's a microphone there. We're recording the meeting. State your name and what company you're with.

Scott [inaudible]: Sure. I'm Scott [inaudible] and I'm with Life Long AIDS Alliance and I've got seven comments that are… hopefully that will get directed by this… One, I just wanted to make sure that HIV meds that are co-formulated aren't substituted for their [inaudible] parts without some kind of patient consultation or providers representing them. That prescriptions are dispensed as directed by the prescribing authority without substitution originally. That Truvada is on the preferred drug list for pre-exposure prophylaxis and is on a tier 1 without any kind of prior authorization. The preferred drug list is released in sufficient time for review by providers and medical case management agencies representing your interests. That all HIV and hepatitis C meds are on the tier 1 preferred drug list without prior authorization in addition to drugs that treat opportunistic infections and the prescription drug list is created with stakeholder input beyond pharmaceutical companies to include aligned medical case management agencies like ourselves. And the prescription drug list is aligned with our state's ADAP program. I'm happy to send this stuff in because that was a lot.

Donna Sullivan: If you picked up a handout at the end of the presentation there's an email address. I'm hoping you don't all send me something. I'm going out of town for two weeks so you won't get anything back. But we have a specific email account that we're setting up to get questions or comments from you that you might come up with after this meeting. Then we will track responses and get back with you.

In addition there are index cards that if you want to write down your question so that we can get that information back out to you, we will collect any written questions or comments that you have and respond to those. Anybody else have a question?

Leslie Mann: I'm Leslie Mann from Celgene. A couple of questions. So the current managed Medicaid plans that exist in Washington State, with this new program do you anticipate that they you will expand that list of

managed Medicaid plans that are currently serving your patients? I believe there are about six, I believe.

Donna Sullivan: At this point in time there are five managed care plans. I don't believe that there is any intent to do a procurement to increase the number of managed care plans.

Leslie Mann: With the new PDL that you're going to form will this have a different structure in terms of there will be tiering, there will be a different structure with regards to like prior authorization forms? Is this a total overhaul or just working on the PDL?

Donna Sullivan: What will happen is there will be a single preferred drug list and all of the managed care plans will use it. So essentially it will be an entire overhaul. The intent is to align all prior authorization criteria in quantity limits, all limitations that if there are limitations that the plans are requiring or they have the same policy. So if something needs prior authorization in one plan they are the same requirements in a different plan. So when patients are switching from plan to plan, you know, they won't have to change their medication because it will already be on formulary. If it's been prior authorized in one plan and it requires prior authorization in the other plan we will do our best to minimize, you know, the burden on the provider because the new plan might not have that information. We'll do our best to try to expedite those situations whenever possible. And I think I've lost the rest of what you were asking.

Leslie Mann: That's the heart of it. And you hopefully, from what I heard, you want to have an initial draft by August, which is right around the corner. Will you be prioritizing different therapeutic classes in terms of working on those first [inaudible] and will stakeholders be advised of that?

Donna Sullivan: What the process is, is that, you know, no decisions can be made on this policy unless they are done within an open public meeting such as the meeting we're having today. What you've asked, you know, how are we going to, you know, tackle this? That is something that I will be working with the managed care pharmacy directors with to

kind of do a plan of attack and how to implement this. Some of it might be just like the classes that we've already… that we determine, you know, where they all are the same. We might just bring a list to the committee and say, you know, here they are all the same. We approve this. And then we'll have to figure out how we're going to go about making product selections for classes where there's diversity in drugs that are currently preferred. We'll have to take into account, you know, the utilization, how many people are on these medications, you know, grandfathering is going to have to be considered. Maybe it is too many people to try to switch that we couldn't do it without a lot of disruption or it's not clinically appropriate for patients to switch medications. So all of that is the work that we will be doing and we will be bringing recommendations back to the P&T Committee on what the products should be and if we need to have clinical reviews to bring those clinical reviews, as well.

Somebody on the phone is typing. If you could mute yourself that would be great. Thank you.

Does that answer your question?

Leslie Mann: Yeah, I think so. Thank you very much.

Donna Sullivan: I guess one comment that I do want to make is that there's different states that have a single PDL. Some of them have what is called a common core PDL versus a, you know, a single PDL. It is the expectation that the PDL will be the same, exactly the same. The plans will be able to add or subtract additional drugs to it. I know I've heard some comments or questions about that.

Fran McGaugh: I had a question kind of about the scope of the PDL. Has it been decided if it's going to be like a core 30 therapeutic classes or is it going to be comprehensive, every drug? So if a new drug hits the market we cannot even do anything with it until it is decided and put on PDL or not.

Donna Sullivan: I mean I think that's part of what we will have to figure out. The question really will be is it feasible for us to, you know, plunk down a

comprehensive PDL that covers every single drug class by January 2018? Or do we have to focus on those medications or drug classes that have the most impact? I really don't know. We will have to go back and look at the data and see how far apart we are and the feasibility of how [inaudible]. When new drugs do come out if they are in a class that's preferred then those would be non-preferred until a decision is made that they can [inaudible].

Fran McGaugh: One more question. Also about the medical benefit drugs, will we be doing that in coordination or will they be separate or maybe after the first of the year?

Donna Sullivan: I've been asked that question several times. I think that the primary focus will be on drugs that are covered in the outpatient setting, unless there are certain drugs that we are well aware of that are being used and there are supplemental rebate opportunities that we can take advantage of that we're not currently taking advantage of. We will include those, but the primary focus initially for January is going to be the PDL for outpatient pharmacy use and then eventually I expect it to be more comprehensive to include drugs that are covered under the medical benefit [inaudible].

Fran McGaugh: Thank you.

Donna Sullivan: Any other questions?

Dale Sanderson: I'm wondering [inaudible] the amount of background [inaudible] and where did they come up with this significant financial savings?

Donna Sullivan: Those are great questions. I've asked the same ones. Really I believe where this came from is last summer we… or actually last year after the end of the last fiscal… the legislative session, several legislators wrote a letter to the agency director of the Health Care Authority and asked Health Care Authority to investigate the high cost of prescription drugs and come up with some recommendations on how we can kind of curve the trend. One of the recommendations that was in the report that went back to the legislature in November was a single preferred drug list. We had recommended that we actually do

a study. That we do a cost-effectiveness study, an impact… looking at the impact of doing this and trying to figure out what it would actually take to lift this off the ground and then potentially implement after have all of those facts. The legislature chose to move ahead more quickly and has obviously directed us just to go ahead and create and implement the single PDL prior to doing really a lot of that analysis up front.

The savings, you know, we can't validate really any of the savings assumptions. The legislature came up with a budget model and they estimated 10% and we were not engaged in that conversion at all so we had no input into what any potential savings that we thought we could garnish from going to a single preferred drug list. So I really can't comment on the savings that's in the budget. Any other follow-up questions, Dale? If not, we'll move to Craig.

Craig Sexton: Craig Sexton with GlaxoSmithKline and I just had a question related to the supplemental rebates and certainly manufacturers may have contracts with the Health Care Authority directly for the Fee-for-Service or with the managed care organizations through their PBMs. Should we assume that effective January 1, 2018 that all of those contracts are going to come under the Fee-for-Service contract? Or are you going to renegotiate these classes where there are active contracts enforced?

Donna Sullivan: At this point in time it is expected for the Medicaid programs that the state will collect supplemental rebates on all drug utilization, fee-for-service and the managed care plans. So we'll get federal rebates and we'll be getting supplemental rebates on the utilization for the entire Medicaid population. Our expectation is that we will change how we submit or request supplemental rebates. Most likely we are going to contract with one of the vendors that is already negotiating supplemental rebates on behalf of other Medicaid states. There's several supplemental rebate pools out there. So we're looking to see what our best strategy is. We don't have the resources in-house in order to manage, negotiate and contract on a scale of a complete preferred drug list. So we're expecting to contract that one out.

Craig Sexton: And that will happen in the next two months?

Donna Sullivan: Yeah. I'm hoping that we can get a contract in place as soon as possible so that we can… until we know which drugs are going to be preferred and have access to what those rebates might be it will be very difficult for us to start selecting products. So I'm thinking before the August meeting… P&T Committee that we'll at least know who that vendor is going to be and then we can try to give more information about what the new process is going to be for manufacturers as far as rebating and contracting. But, yes, the main answer to your question is the contracts will be cancelled and there will be a new system in place in January.

Craig Sexton: Okay. Thank you.

Donna Sullivan: I just want to put something out there too. We just had a June P&T Committee and before there was recommendations made by the P&T Committee and so we are going to delay doing the cost analysis on those classes until we have the new supplemental rebate contracts. We're still working through April's meeting and they haven't been implemented yet. So we don't think it is worth anybody's time to try to get a contract in place for maybe one or two months at the end of the year and then have to cancel it. So the June P&T decisions will be held off and will be effective January 2018.

Any other questions? So one of the other questions that I have been asked is, you know, what happens with the Uniform Medical Plan and Labor and Industries? So the single preferred drug list was specific to Medicaid. So you will see that there will become a divergence between what is currently the Washington preferred drug list and the Medicaid preferred drug list. A lot of that is going to be because of the way Medicaid is funded through the Federal Rebate Program that sometimes having the same preferred drugs in the same class is not going to be possible for Uniform Medical Plan and Labor and Industries due to the costs of those medications just being [inaudible] for UMP and L&I, but relatively inexpensive for Medicaid and that's really for the consumer price index penalty, as well as the federal

rebates. So I just wanted to let you know that you will see that [inaudible] happen as we move forward.

Any other questions from people on the phone or on the committee?

Okay. Again, the email address is hcapdpmailbox@hca.wa.gov. So if you have questions or comments that you can think of after today's meeting, please submit those to this mailbox and we will have somebody respond back to you once we get an answer. Again, we will write out answers to all of the questions that were asked today and try to respond to the comments that were given and we will post those online. We're hoping to have one kind of area where information will be posted. So if you need to get updates on the progress of what's happening and we will send out the link to that through the Washington mailbox, the same that you got this meeting [inaudible]. Stay tuned and watch for regular updates.

I think we are done unless there are any more questions.

Po Karczewski: I just want to say that it sounds like a wonderful idea from the [inaudible] and community health center because the multiple formularies is really ridiculous. So I realize it is a heck of a lot of work, but it seems like the results will be a lot easier for [inaudible].

Donna Sullivan: Thank you. We've got another question.

Tracy [inaudible]: Tracy [inaudible] with Lilly. Just to follow onto the question about contracts with manufacturers for supplementals. So for classes that are not currently managed via PDL I'm assuming those will then move into a position where they are going to be managed by PDL?

Donna Sullivan: Yes. We will be expanding. The Washington preferred drug list now is about 35 to 40 classes depending on how you slice and dice it. We will be adding drugs for Medicaid. So Medicaid will use, you know, will still use DERP. We'll still have the evidence-based reviews from the Drug Effective Review Project. We will still maintain the Washington PDL to the extent that Medicaid… that the drug classes align. Medicaid will follow that Washington PDL, but we will add

additional classes to the Medicaid preferred drug list. So it will be kind of like a Venn diagram where everybody is using the Washington PDL with some aspects, or at least the recommendations that come from the P&T Committee and then the DUR Board will be making recommendations for additional drug classes that will be on the Medicaid only PDL.

Lisa Chew: Any other questions or comments?

Donna Sullivan: Going once. Twice. Lisa, it does not look like anybody here in the room has any more questions. Unless there is someone on the phone, last call. Okay. I think we are good.

Lisa Chew: I think we are adjourned then. Okay. Thanks.

Donna Sullivan: Thanks everybody for coming.