Senate Bill 838

Sponsored by Senator BATES

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Health Evidence Review Commission to develop prioritized list of prescription drugs.

A BILL FOR AN ACT

Relating to prescription drugs; amending ORS 414.025, 414.325, 414.690 and 741.340; and repealing ORS 414.316.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.690 is amended to read:

414.690. (1) The Health Evidence Review Commission shall regularly solicit testimony and information from stakeholders representing consumers, advocates, providers, carriers and employers in conducting the work of the commission.

(2) The commission shall actively solicit public involvement through a public meeting process to guide health resource allocation decisions.

(3) The commission shall develop and maintain [*a list*] **two lists** of health services**. One list shall exclude prescription drugs and one list shall be solely composed of the prescription drugs in the Practitioner-Managed Prescription Drug Plan. Each list of services shall be** ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served. The [*list*] **lists** must be submitted by the commission pursuant to subsection (5) of this section and [*is*] **are** not subject to alteration by any other state agency.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized [*list*] **lists** of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) May include statements of intent in its prioritized [*list*] **lists** of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.

(c) Shall consider both the clinical effectiveness and cost-effectiveness of health services, including drug therapies, in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall report the prioritized [*list*] **lists** of services to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year.

(6) The commission shall make its report during each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Represen-

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

tatives and the President of the Senate.

(7) The commission may alter the [*list*] **lists** during the interim only as follows:

(a) To make technical changes to correct errors and omissions;

(b) To accommodate changes due to advancements in medical technology**, drug therapies** or new data regarding health outcomes;

(c) To accommodate changes to clinical practice guidelines; and

(d) To add statements of intent that clarify the prioritized [*list*] **lists**.

(8) If a service is deleted or added during an interim and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission shall report to the Emergency Board to request the funding.

(9) The prioritized [*list*] **lists** of services [*remains*] **remain** in effect for a two-year period beginning no earlier than October 1 of each odd-numbered year.

SECTION 2. ORS 414.025 is amended to read:

414.025. As used in this chapter and ORS chapters 411 and 413, unless the context or a specially applicable statutory definition requires otherwise:

(1)(a) "Alternative payment methodology" means a payment other than a fee-for-services payment, used by coordinated care organizations as compensation for the provision of integrated and coordinated health care and services.

(b) "Alternative payment methodology" includes, but is not limited to:

(A) Shared savings arrangements;

(B) Bundled payments; and

(C) Payments based on episodes.

(2) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(3) "Community health worker" means an individual who:

(a) Has expertise or experience in public health;

(b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;

(c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;

(d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;

(e) Provides health education and information that is culturally appropriate to the individuals being served;

(f) Assists community residents in receiving the care they need;

(g) May give peer counseling and guidance on health behaviors; and

(h) May provide direct services such as first aid or blood pressure screening.

(4) "Coordinated care organization" means an organization meeting criteria adopted by the Oregon Health Authority under ORS 414.625.

(5) "Dually eligible for Medicare and Medicaid" means, with respect to eligibility for enrollment in a coordinated care organization, that an individual is eligible for health services funded by Title XIX of the Social Security Act and is:

(a) Eligible for or enrolled in Part A of Title XVIII of the Social Security Act; or

(b) Enrolled in Part B of Title XVIII of the Social Security Act.

(6) "Global budget" means a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to and quality of the health care delivered to members of the coordinated care organization.

(7) "Health services" means at least so much of each of the following as are funded by the Legislative Assembly based upon the prioritized [*list*] **lists** of health services compiled by the Health Evidence Review Commission under ORS 414.690:

(a) Services required by federal law to be included in the state's medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner's practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical equipment and supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state's medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(8) "Income" has the meaning given that term in ORS 411.704.

(9) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable instruments as defined in ORS 73.0104 and such similar investments or savings as the department or the authority may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(10) "Medical assistance" means so much of the medical, mental health, preventive, supportive, palliative and remedial care and services as may be prescribed by the authority according to the standards established pursuant to ORS 414.065, including premium assistance and payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of health services and for services described in ORS 414.710.

(11) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(12) "Patient centered primary care home" means a health care team or clinic that is organized in accordance with the standards established by the Oregon Health Authority under ORS 414.655 and that incorporates the following core attributes:

(a) Access to care;

(b) Accountability to consumers and to the community;

(c) Comprehensive whole person care;

(d) Continuity of care;

(e) Coordination and integration of care; and

(f) Person and family centered care.

(13) "Peer wellness specialist" means an individual who is responsible for assessing mental health service and support needs of the individual's peers through community outreach, assisting individuals with access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services and to provide direct services to assist individuals in creating and maintaining recovery, health and wellness.

(14) "Person centered care" means care that:

(a) Reflects the individual patient's strengths and preferences;

(b) Reflects the clinical needs of the patient as identified through an individualized assessment; and

(c) Is based upon the patient's goals and will assist the patient in achieving the goals.

(15) "Personal health navigator" means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

(16) "Quality measure" means the measures and benchmarks identified by the authority in accordance with ORS 414.638.

(17) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 3. ORS 414.325 is amended to read:

414.325. (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(b) "Mental health drug" means a type of legend drug defined by the Oregon Health Authority by rule that includes, but is not limited to:

(A) Therapeutic class 7 ataractics-tranquilizers; and

(B) Therapeutic class 11 psychostimulants-antidepressants.

(c) "Urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(2) The authority shall reimburse the cost of a legend drug prescribed for a recipient of medical assistance only if the legend drug:

(a) Is on the drug list of the Practitioner-Managed Prescription Drug Plan adopted under ORS 414.334;

(b) Is in a therapeutic class of nonsedating antihistamines and nasal inhalers, as defined by the authority by rule, and is prescribed by an allergist for the treatment of:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies; or

(c) Is prescribed and dispensed under this chapter by a licensed practitioner at a rural health clinic for an urgent medical condition and:

(A) There is no pharmacy within 15 miles of the clinic;

(B) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(C) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(3) The authority shall pay only for drugs in the generic form unless an exception has been granted by the authority through the prior authorization process adopted by the authority under subsection (4) of this section.

(4) Notwithstanding subsection (2) of this section, the authority shall provide reimbursement for a legend drug that does not meet the criteria in subsection (2) of this section if:

(a) It is a mental health drug.

(b) The authority grants approval through a prior authorization process adopted by the authority by rule.

(c) The prescriber contacts the authority requesting prior authorization and the authority or its agent fails to respond to the telephone call or to a prescriber's request made by electronic mail within 24 hours.

(d) After consultation with the authority or its agent, the prescriber, in the prescriber's professional judgment, determines that the drug is medically appropriate.

(e) The original prescription was written prior to July 28, 2009, or the request is for a refill of a prescription for:

(A) The treatment of seizures, cancer, HIV or AIDS; or

(B) An immunosuppressant.

(f) It is a drug in a class not evaluated for the Practitioner-Managed Prescription Drug Plan adopted under ORS 414.334.

(5) Notwithstanding subsections (1) to (4) of this section, the authority is authorized to:

(a) Withhold payment for a legend drug when federal financial participation is not available;

(b) Require prior authorization of payment for drugs that the authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession; and

(c) Withhold payment for a legend drug that is not a funded health service on the prioritized [*list*] **lists** of health services established by the Health Evidence Review Commission under ORS [*414.720*] **414.690**.

(6) Notwithstanding ORS 414.334, the authority may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(7) Notwithstanding subsection (3) of this section, the authority may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(8)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

(9) The authority shall appoint an advisory committee in accordance with ORS 183.333 for any rulemaking conducted pursuant to this section.

SECTION 4. ORS 414.325, as amended by section 8, chapter 827, Oregon Laws 2009, is amended to read:

414.325. (1) As used in this section:

(a) "Legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(b) "Urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515 and pursuant to rules of the Oregon Health Authority unless the practitioner prescribes otherwise and an exception is granted by the authority.

(3) Except as provided in subsections (4) and (5) of this section, the authority shall place no limit on the type of legend drug that may be prescribed by a practitioner, but the authority shall pay only for drugs in the generic form unless an exception has been granted by the authority.

(4) Notwithstanding subsection (3) of this section, an exception must be applied for and granted before the authority is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the authority.

(5)(a) Notwithstanding subsections (1) to (4) of this section and except as provided in paragraph (b) of this subsection, the authority is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs that the authority has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The authority may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the authority, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Evidence Review Commission on the funded portion of its prioritized [*list*] **lists** of services:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

(6) The authority shall pay a rural health clinic for a legend drug prescribed and dispensed under this chapter by a licensed practitioner at the rural health clinic for an urgent medical condition if:

(a) There is not a pharmacy within 15 miles of the clinic;

(b) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(c) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(7) Notwithstanding ORS 414.334, the authority may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(8) Notwithstanding subsection (3) of this section, the authority may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

(9)(a) Within 180 days after the United States patent expires on an immunosuppressant drug used in connection with an organ transplant, the authority shall determine whether the drug is a narrow therapeutic index drug.

(b) As used in this subsection, "narrow therapeutic index drug" means a drug that has a narrow range in blood concentrations between efficacy and toxicity and requires therapeutic drug concentration or pharmacodynamic monitoring.

SECTION 5. ORS 741.340 is amended to read:

741.340. The Oregon Health Authority, in developing and offering the health benefit package required by ORS 413.011 (1)(j), may not establish policies or procedures that discourage insurers from offering more comprehensive health benefit plans that provide greater consumer choice at a higher cost. The health benefit package approved by the Oregon Health Policy Board shall:

(1) Promote the provision of services through an integrated health home model that reduces unnecessary hospitalizations and emergency department visits.

(2) Require little or no cost sharing for evidence-based preventive care and services, such as care and services that have been shown to prevent acute exacerbations of disease symptoms in individuals with chronic illnesses.

(3) Create incentives for individuals to actively participate in their own health care and to maintain or improve their health status.

(4) Require a greater contribution by an enrollee to the cost of elective or discretionary health services.

(5) Include a defined set of health care services that are affordable, financially sustainable and based upon the prioritized [*list*] **lists** of health services developed and updated by the Health Evidence Review Commission under ORS 414.690.

SECTION 6. ORS 414.316 is repealed.
