2017 HOUSE HUMAN SERVICES

HB 1120

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1120
1/11/2017
26795

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to prior authorization program

Minutes: 1, 2, 3

Chairman Weisz: called committee to order.

Opened the hearing on HB # 1120

Testimony in favor of HB # 1120

Brendan Joyce, Adm. Of Medicaid Pharmacy Services for the Dept. of Human Services (Attachment 1)

20:56

Chairman Weisz: Questions from the committee?

Chairman Weisz: Just to be clear on your last section, this has nothing to do with past prescriptions it is if they currently have 4 concurrent at the present time then they would have to have prior authorization for the 5th. In the past they had prescription A, B, C, or D.

B. Joyce: We would just set up an edit in our system. When you think about a prescription. You go to the doctor you get 30 day supply, so imagine a calendar in the computer. They have drug numbers 1 2 3 4 already. That 30 day supply has to run and include the day of service that they would be getting this new medication, #5. So if you got 2 of them on the first of the month for 30 days and the other one you actually got two weeks later for a 30 day supply and they come in on the 20th of this current month there will only be 3 others that are concurrent. The 4th one is not longer concurrent, because it was only through the 15th and it is now the 20th. So they would have to have complete overlapping use of 4 and then when the new prescription comes in asking for this medication it would say prior auth. Required. Please call this number to talk to a child and adolescent psychiatrist to discuss the patient.

Chairman Weisz: Questions?

Representative Porter: On the back on page 2 of the bill starting on line 10 you have me confused. We are saying "The restrictions of subdivision b do not apply for individuals under twenty-one years of age, who have five or more" then it is redundant language starting on line 13. Shouldn't that be 5 or less concurrent prescriptions for psychotropic medications?

B. Joyce: I am just as confused. This is referring to subsection D. You can preauthorize these 6 classes if the person is under 21 and this would be the 5th or more concurrent prescription for psychotropic medications. It refers back to say you can preauthorize these 6 classes if says 5 or more. Maybe legislative council can make it plainer.

Chairman Weisz: Subsection B is where it establishes those from exempt from prior authorization. So now you are saying that that restriction of being exempt doesn't apply if there are 5 or more. So now you are taking away the exemption for the prior authorization for those 6. If there is 5 or more under D it lists the types that are really the only ones that count under the 5 or more.

B. Joyce: It includes some of the classes that are not part of the 6. There are more drugs that are psychotropic than those that are included in the 6. We took this language out of Wyoming's stuff and Wyoming took it from the national looking at these classes and trying to figure out all the psych drugs in kids.

Chairman Weisz: Then some of the list here under D are some of those currently under prior authorization?

B. Joyce: Yes. They have the ability to be under prior authorization, but maybe not currently. Some of them do.

Chairman Weisz: But these add up to some of the 5 concurrent ones. And then when that kicks in the list of 6 allows you to do prior authorization.

B. Joyce: Yes. They can be on different drugs for different things such as: a sedative, lorazepam for anxiety, Prozac, an ADHD drug like Concerta. Then if they want to add one more drug like lithium they can do it, but they must consult with a pediatric psychologist.

Representative Porter: On the last line then, "through its agent". Who would be the agent?

B. Joyce: That is going to be up to the discussions here. We have a contract with Seattle Children's Hospital and gotten some quotes. I am not sure what is in the executive budget. The costs for what Wyoming does are really not that bad. There could be other options like the State Hospital if they have a pediatric psychiatrist it could be done by them. Often times people tend to look at experts. An expert is what, someone that doesn't live here sometimes? So we are looking to the legislature to give us direction.

Representative Porter: That brings up my last question. In section 1 on lines 10 and 11 you talked about the situation happening a lot. A potential cost savings to the state. On line 18 you talked about an RFP that would come with a cost, but we don't have a fiscal note on this bill to tell us what the costs and to lay out accounting of what this bill actually does. Is

there a reason why we don't have a fiscal note to show us what is going on in regards to your testimony?

B. Joyce: That would just be part of our normal operations for the computer system, so it wouldn't have any cost associated with it. Chairman Weisz asked if we could already do this. We are trying to do some of this a little bit, but we want it clarified if it is safe what we are doing. Typically, you don't see too many generic lobbyists in the Capital complex, so there is not usually much complaining if we are restricting generic access. We are also limited by a very complicated upper limit process. We can spend more on generics than on brand named drugs.
B. Joyce: It says we can preauthorize the generic, so we think it needs to be spelled out to do the opposite just to be sure.
(Continued with his testimony)

DUR Board will be reviewing these things as we bring them data.

Chairman Weisz: it is not necessarily about cost?

B. Joyce: We could have a set of steps instead of just doing whatever was ordered because it is not safe. A 62 year old grandma was a first time user of a med and it was ordered at 5 times what it should be for a first time user. We would like to be able to have a set of steps for them to do before they get that amount of the drug. Sometimes it is not Grandma that is taking them. We could stop this because of our limit, but not because it was too high a dosage.
(continued with his testimony)

Chairman Weisz: Any questions from the committee?

Chairman Weisz: this doesn't go back, correct?

B. Joyce: If they were already on 4 meds and then they ordered another one, they have to have prior authorization.

Representative Porter: on back page 2 line 10 confused . Is the wording correct?

B. Joyce: Lawyers wrote this, so sometimes the language is difficult to understand.

Chairman Weisz: Are some of those under prior authorization now.

Representative Porter: Who would be the agent?

B. Joyce: You would be deciding how that would work. It could be with State Hospital Doctors or whatever you decide.
Representative Porter: Section 1
No fiscal note on this bill. Why?

B. Joyce: Edit wouldn't have any cost. We are trying to do some of this already, but we want to be sure we are ok in doing it. Federal upper limits are really difficult in generic to work with. When we use a brand instead of a generic depends on what the federal upper level is. The feds put on a max limit which is that is the maximum allowable cost. So if you put on the federal upper level at $4 and the brand is $8, but post rebate it is $1. The generic is $4 at the max rate and $3.50 after rebate. We still have to pay for that brand. We can go ahead and do that, but every time we pay $8 vs. $4 that $4 works toward the calculation for the aggregate max that we can pay for all drugs that have a federal upper limit. We have calculations of when we do prefer a brand over a generic that those $4 don't eat away too much at the cushion that we have with our own mac pricing that we do. Back to your question. How much we can do this will depend on the federal upper limit in the aggregate calculations. We will be able to save some, but Iowa actually took CMS to court to try to do this as often as possible, like every single drug they could possibly do it on. They said post rebate which is the net cost for us and for you federal government. Post rebate it is better for us to do this. You should let us do this all of the time. They lost in court to CMS to where they have to comply with the federal upper limit which of course means that all of us have to. The savings, there is one drug we can save $20,000/month. It is like $80,000 a month, so we can save 25% on one drug. At some point we will get to that federal upper level max and as I said, we try to do some of this already. We just want to clear it here so we don't get sued. We already have the savings banked for that, so that's why we don't have a fiscal note from a savings side of things. On the contract out it is kind of up to the legislature. Do you want us to contract out? If so, a fiscal note will come. If you want us to absorb within the psychiatrists we have in our current human service centers or state hospital we can do it that way and there is no fiscal impact, so that is the reason for no fiscal note.

Representative Porter: In your testimony I don't remember hearing any amount of discussion on the through the agent component on what it would cost us, what it would do for us, what it would save us.

B. Joyce: There is nothing. I did not say anything. I can get that for you.

Representative Porter: OK

Chairman Weisz: How many people do you think you would have to consult with?

B. Joyce: For those that are already these classes of medications it is 2% or less of those patients, so I would have to pull up some data. I am trying to go off of memory. It was10 people or less.

Chairman Weisz: That would be doing 5 or more?

B. Joyce: I could give you March data. We just always use the same month, so within that month there were 10 people that would have fallen into this category. That is similar to other states. I can supply the links to the Wyoming program and get the costs as well.

Chairman Weisz: Further questions from the committee.

Chairman Weisz: Further testimony in support of HB 1120??

Chairman Weisz: Any one in opposition to HB 1120

37:00
Courtney Koebele, Exe. Director of ND Medical Assoc.
(Attachment 2)
We urge a do not pass on HB 1120.

Chairman Weisz: Are there any questions from the committee?
Chairman Weisz: Further testimony in opposition to HB 1120?

David Boeck, Protection and Advocacy Project
I am delivering the testimony for Carlotta McCleary, Exe. Dir. Of NDFFCMH
(North Dakota Federation of Families for Children's Mental Health and Mental Health America of North Dakota)
(Attachment3)
47:02

D. Boeck: This peer to peer consultation is a consultation between the physician who has a history and has the records and knows the child and if he disagrees with the constulting physician, he can alter what the child's physician wants. Our strongest objection is the removal of the carve out. We believe it should be kept in place.

Chairman Weisz: Are there any questions from the committee?

Chairman Weisz: Further testimony in opposition to HB 1120?

Seeing none. Hearing closed for HB 1120.

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1120
1/18/2017
27096

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kopplé

Explanation or reason for introduction of bill/resolution:

Relating to prior authorization program

Minutes: "Click to enter attachment information."

Chairman Weisz: called the committee to order for HB 1120

This bill was to put something together that both the mental health and the doctors can agree with. What the amendment does is basically change the carve out for the mental health. What you see listed was the original mental health carve out that we did. This bill attempted to move the stimulant medication out of the carve out. The amendment in front of us put that back in so that again would be part of the carve out. The stimulant medication used for the treatment of attention deficit disorder and hyperactive disorder will not be removed. In other words, it won't be required for prior authorization. The other change is in the language on page 2 starting on line 17 and 18. This language was ok with both the doctors and the mental health association that prior authorization will be needed for over 5, but they will get prior authorization. The department will grant authorization to exceed the limits after prescriber requesting authorization consults with a pediatric psychiatrist approved by the department. To be clear, this doesn't require approval by the pediatric psychiatrist. They have to consult with them, but at that point if they decide to go ahead, they have prior authorization. Both groups were more than happy with that change.

Representative Porter: A question that I had on that new language. When they presented the bill they were talking about an agent or contract. Did they come up with what the process would be for that component of approval by the department? If they are a practicing Board Certified pediatric psychiatrist are they granted automatic approval?

Chairman Weisz: They have to consult, but even if the consulting pediatric psychiatrist says no, they will still get approval if they decide to go ahead.

Representative Porter: Is that language necessary then that says it is approved by the department or can it be a period after the word psychiatrist. Because it just puts up a barrier for those consulting.

Chairman Weisz: I am not sure I understand the barrier part, but I mean the idea being you can't just pick and choose who you want, because you know you will probably not even consult. You know, my friend in wherever we can chat and say hi how is the weather and go on. The department says who you can consult with, you make the phone call and have the discussion and then they can continue on if indeed they decide that child still needs that medication they can do it. They can change their mind, but it is their option.

Representative Porter: That's why I question why the word "approved" needs to be there, because they can't stop it anyway.

Chairman Weisz: They could under the current, but if we adopt the amendment they can't
Representative Porter: What we are saying is that you can't exceed those limits unless you consult a pediatric psychiatrist.

Chairman Weisz: I think the argument is that while they have to approve it they want you to talk with someone they consider qualified to consult. That is where the department role comes in. Both sides seemed very comfortable with that.

Representative Porter: The other question I had is when you use the word pediatric psychiatrist. Do we need to put Board Certified? They certainly could be someone that just had a one-year fellowship, but never took the boards and calls himself in another state a pediatric psychiatrist, but that wouldn't be someone who did a full residency and passed the national exam.

Chairman Weisz: That discussion did not come up, but that certainly would not be an issue. We could certainly add that to be clear what we are talking about.

Vice Chairman Rohr: Do they exist in ND?

Chairman Weisz: Yes.

Vice Chairman Rohr: What kind of documentation is kept then? Regarding that consultation. Who keeps it?

Chairman Weisz: Certainly the psychiatrist is going to keep it in his records of consults.

Vice Chairman Rohr: Then it has to be done?

Chairman Weisz: Yes.

Representative McWilliams: If I understand this correctly, the child or a young person that is working with a doctor and is under 5 medications and needs a 6th one or what have you. The doctor then has to make a telephone call, hope that he gets in touch with somebody. If not, hope that that person gets in contact with him soon if they need that medication. Also he has to go make a note at the doctor's office and file that note just so that person can get the medication they need. Doesn't this still take it outside the patient and add more tasks for the doctor? He is already overburdened?

Chairman Weisz: I guess we are looking at children that are already receiving five psychotropic medications which can be prescribed by general practioner who doesn't have the specialized training in psychiatric conditions.. It is only Medicaid. It has nothing to do with private. It is just that maybe you should consult with someone before you add that 6th or 7th or 8th medication. Frankly I was concerned when I heard that we are giving them 5. We are talking young children. That concerned me. These are not emergency medications if you are already on 5. There is a process where you can get prior authorization. We prior authorize a lot of drugs already within the Medicaid system. This is not anything new. It seems to me that this is kind of the minimal thing just to insure that that doctor who may not talk to somebody could give someone 6 or 7 or 8. That is the rational.

Representative Porter: I agree. I don't like to see any kid on any medication. I have a psychology background and I have done a bit of an internship in Central Hospital. I agree with you, but it seems like we are adding a little bureaucracy that doesn't need to be there.

Chairman Weisz: I guess if you want to say that prior authorization is a layer of bureaucracy you can, because the system to insure one that we have some cost containment on the Medicaid side and in some cases like this is to insure that they are doing a consult.

Clear that this doesn't require approval of the pediatric

Both groups were happy with the changes.

Representative Porter: A question on the new language. When they presented the bill they were talking about an agent. .Did they come up with a definition of agent?
Will they have automatic approval?

Chairman Weisz: Yes, the authorization is approved as long as there is consulting done. Regardless of what the consulting psychiatrist says.

Representative Porter: Do we need that in there then?

Chairman Weisz: The idea is that you have to use an approved consultant not just anyone. The authorization is not psychiatrist dependent upon what the approval of that consulted

Representative Porter: When you use the word pediatric psychiatrist should we add board certified psychiatrist?

Chairman Weisz: I think that could be added?

Vice Chairman Rohr do they exist in ND

Chairman Weisz: Yes

Representative McWilliams: Doesn't this still take it outside of the patient and add to the work load of the doctor? Sometimes they won't be able to get a hold of the consulting psychiatrist and have to wait for them before they can get the medication.

Chairman Weisz: We are talking about a child taking 5 medications prescribed by a regular doctor. If you are going to add more they should consult with an expert, a pediatric psychiatrist first. We are already paying for 5

Representative McWilliams: It just seems like we are adding a layer of bureaucracy that we don't need.

Chairman Weisz: The system to insure we have some cost containment on the Medicaid side and in some cases it is to insure that they are doing the consult.

Representative Schneider: I appreciate this amendment and you doing this. I think the statistic that we got that foster care children who are wards of the state have 17x more likelihood of having more than 5 psychotropic medications was a red flag. I think this will at least give us some assurance that an outside person with expertise in that area is looking at it. I think it is a good amendment.

Representative Porter: I would move to accept the amendment with the insert after "a" to insert "Board Certified Pediatric Psychiatrist"

Chairman Weisz: We have a motion. .Do we have a second?

Representative Skroch: second

Voice vote

Carried

Chairman Weisz: any more amendments?

Representative Devlin: Maybe it is not so much an amendment, but the language in line 10 and 11 about generic drugs or brand name drugs that cost the state money when the brand name is less than the generic. We did get some input from the president of the ND Psychiatric Society that said that it would create problems for them. They would keep sending stuff in and it would keep getting rejected and the department said they would post it on the website which ones they were going to use. There was some questions whether that was the right approach, so I don't know if you want to deal with that or not. I don't have an amendment.

Chairman Weisz: Upon further investigation they decided it didn't matter.
In the beginning they want generics and now want name brands. We have name brands that are cheaper than generics. I can't speak for them, but they both said they were comfortable with that. Why would you oppose a name brand drug if it was cheaper?

Chairman Weisz: Committees wishes?

Representative Porter: I move a do pas as amended.

Representative P. Anderson: seconded
Chairman Weisz: Further discussion on the bill?
Seeing none. The clerk will call the roll on a do pass as amended on HB 1120.

Roll call vote taken: Yes 12 No 2

Chairman Weisz: Would wants to carry this bill?

Representative Porter: Will carry it.

1/19/17 DO

17.8071.01001
Title.02000

Adopted by the Human Services Committee

January 19, 2017

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1120

Page 1, line 16, remove "and"

Page 1, line 17, remove the overstrike over "~~; and~~"

Page 1, line 18, after "~~f.~~" insert "(6)"

Page 1, line 18, remove the overstrike over "~~Stimulant medication used for the treatment of attention deficit disorder and~~"

Page 1, remove the overstrike over line 19

Page 2, replace lines 17 and 18 with "The department shall grant authorization to exceed the limits after a prescriber requesting authorization consults with a board certified pediatric psychiatrist approved by the department."

Renumber accordingly

Date: 1-18-17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1120

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: add "Board Certified Pediatric Psychiatrist"

Recommendation: ☑ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Skroch

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. P. Anderson		
Vice Chairman Rohr			Rep. Schneider		
Rep. B. Anderson					
Rep. D. Anderson					
Rep. Damschen					
Rep. Devlin					
Rep. Kiefert					
Rep. McWilliams					
Rep. Porter					
Rep. Seibel					
Rep. Skroch					
Rep. Westlind					

Voice vote carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1-18-17
Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1120

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 17.8071.01001

Recommendation: ☐ Adopt Amendment
☑ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☑ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. P. Anderson

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson	✓	
Vice Chairman Rohr	✓		Rep. Schneider	✓	
Rep. B. Anderson	✓				
Rep. D. Anderson	✓				
Rep. Damschen	✓				
Rep. Devlin		✓			
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel		✓			
Rep. Skroch	✓				
Rep. Westlind	✓				

Total (Yes) 12 No 2

Absent _____

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1120: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). HB 1120 was placed on the Sixth order on the calendar.

Page 1, line 16, remove "and"

Page 1, line 17, remove the overstrike over "~~; and~~"

Page 1, line 18, after "~~f.~~" insert "(6)"

Page 1, line 18, remove the overstrike over "~~Stimulant medication used for the treatment of attention deficit disorder and~~"

Page 1, remove the overstrike over line 19

Page 2, replace lines 17 and 18 with "The department shall grant authorization to exceed the limits after a prescriber requesting authorization consults with a board certified pediatric psychiatrist approved by the department."

Renumber accordingly

2015 SENATE HUMAN SERVICES

HB 1120

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1120
2/15/2017
Job Number 28407

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	for Mary Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to the prior authorization program.

Minutes: **Testimony attached #** 1,2,3,4

Chair J. Lee brought the hearing to order, all members were present.

Dr. Brendan Joyce (0:25-12:25) testified in favor, please see attachment #1. Requested amendments.

Senator Piepkorn: Can you briefly describe how the Prior Authorization Program works?

Dr. Joyce went over the different members of the board that are a part of prior authorization.

"The program looks at which drugs are more cost effective, packets are put together that have drug information and all the classes, then recommendations are made by the Department on what drugs need authorization. After authorization is complete the Department begins to implement those authorizations. The pharmacists will have to follow specific criteria regarding the authorizations of these drugs."

Dr. Joyce described how there is a case in Texas of Pfizer vs Texas regarding the release of Medicaid data to lawmakers which is related to this.

Chair J. Lee: I hope they win; this is the most convoluted system.

Senator Heckaman: What's the magic about 5 prescriptions?

Dr. Joyce: We looked at numbers for impact, when you move to 4 prescriptions it's like 100 kids, but at 5 it was 12-24. It seemed like a good threshold.

Senator Piepkorn: Why is North Dakota the only state without the ability to authorize?

Chair J. Lee: Because the legislation has tied their hands.

The committee went over the bill with Dr. Joyce. (see attachment 2)

Chair J. Lee: Do you see a lot of limitation to section D? Do think there is adequate ability for a specialist to visit the prescriber to determine whether or not prior authorization should be in placed or not?

Dr. Joyce: The department feels the language in section D is appropriate.

Chair J. Lee: The rub is with deletion of lines 18-19 on front page?

Dr. Joyce: That's the primary difference from the original bill.

Chair J. Lee: Can you explain Lock In?

Dr. Joyce: Lock In is a federal program with all states take advantage of. If a patient is doctor shopping, where they go to different doctors to get more pills. The state is allowed to manage their care by requiring them to get a single pharmacy and single physician to give them their care. The prescriber can write referrals for them to go elsewhere, they just have to know about it.

V-Chair Larsen: What's the timeframe for that?

Dr. Joyce: I don't manage the program so I don't know exactly, but they get a warning that you should manage your care or we will do it for you. If they don't change within 6-12 months, then we start monitoring them. Then they can get reviews every six or 12 months after that to see if they can be removed.

Carlotta McCleary (32:10-37:30) testified in favor, please see attachment #3.

Senator Piepkorn: When Garret was running out of meds, the one you wanted was not Medicaid eligible, could you have paid for it out of pocket? Could you not buy it, or would Medicaid just not pay for it?

Carlotta McCleary I'm not sure, we did have private insurance that was access first. But the way it was set up was that Medicaid was first than private insurance.

Senator Piepkorn: So in case of an emergency you could have paid for it?

Carlotta McCleary: I believe so.

Chair J. Lee described the importance of not making legislation based on particular instance, and how it is important to make legislation based on a common problem.

Courtney Kobele Exec. Dir. NDMA (40:50-42:18) testified in favor, please see attachment #4.

Courtney Kobele expressed her concern with prior authorization and how there is a problem with opioid addiction. Almost every meeting within that last six months had discussion of drug addiction regarding opioids.

"I do want to agree with Dr. Joyce, I think we have the best PDMP. I think we have the best PDMP program in the nation. It's a wonderful tool and it has really cut back on a lot of our prescribers. It has more requirements for them to sign up on PDMP and use it. It's a great program. I feel removing this prior authorization carve out it's a double negative. It's very important to keep those in place."

Chair J. Lee: It isn't removing the carve out except for the stimulant medication use for the treatment of ADD, and ADHD. Everything else remains in place. I find it hard to imagine the people you represent don't understand that one addition to the list of those that are not able to be prior authorized a terribly challenging thing?

Courtney Kobele: It's a slippery slope. We're taking away this carve out, the next session they will take out another one, and so on and so forth.

No opposition or neutral testimony.

Chair J. Lee closed the public hearing.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1120
2/21/2017
Job Number 28525

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to the prior authorization program.

Minutes:

Chair J. Lee: Opened committee work. Walks through proposed amendments. Discuss House deleted provision prior authorization. On the bottom of page 1, line 20 just talks about children and things would continue not prior authorized for all of those individuals. The question we need to discuss, is the fact the House deleted the provision that would have permitted prior authorization for adults. I believe you have the original bill, which had over struck lines 18 and 19. Everything else is the same. We asked about the department to grant authorization to exceed the limits, at the very end of the bill. That was OK with the department. Please look at Dr. Joyce testimony, he talked about at the beginning bottom of page one, significant abnormalities in utilization patterns of stimulant meds between adults and children. There are two main categories of stimulants. Ritalin type and amphetamine type products. Both are listed as controlled substances by the DEA. Amphetamine products are reported to be abused. Amphetamines are speed. So you need to keep this in mind. It was reported that 60-70% children are prescribed the methylphenidate product, which is non-addictive one, but 60-75% of adults are prescribed an amphetamine product. ND is the only state not allowed to prior authorize stimulants for any portion of the Medicaid population. Chart at end, 50 can prior authorize and 1 can't; that's ND. The potential for abuse is there. With all the discussions about substance abuse and entry level, etc. it sounds to me that is easy to say 'that isn't working for me and I want this kind instead'. Dr. Joyce, can you come up?

Senator Piepkorn: What do you think is going on 60-70% children vs adults? What's happening?

Dr. Brenden Joyce, Pharma administrator for Medicaid: We have looked at the data. Variety of things going on. One of the main issues is the pediatricians and psychiatrists or PA or NP's tend to take care of the kids. they take care of kids. Doctors get a lot of training in ADHD. It is one of the higher prevalence diseases for children. You have a whole lot of specialist, and they tend to prescribe methylphenidate products. For the adults, you get your general practice Adderall. On the psychiatrist side I am not worried. You get a whole lot of self-directed care. It's also interesting when you see patients that are ADHA, that they say is life long, so you would expect something that works as a kids as you grow up; why does it

not remain the same all the way through? It gets switched over based on whatever reasons they are asking for. There is definitely an abused aspect. Happening when you look at medicine profile of the patients. I have been doing this since 2001, and I know what a patient profile looks like for those who are diverting and doctor shopping and pharmacy hopping. We see drug cocktails that we see can be used as well. (7.11)

Senator Piepkorn: The physicians may not be necessarily abuse the prescription process. Bu are they thinking it is working and patient is continuing on, and no real harm being done. Why is the process continuing?

Dr. Joyce: I hate to speak for the prescribers. I do have some thoughts, but it is tough thing to change. Complacency is the word. If you are not aware, you won't know until you know. Maybe you haven't checked the prescription monitoring program lately. If they paid attention, they would see that they are on a bunch of other stuff. They haven't told me about their pain issues.

Senator Anderson: Do you have any numbers or estimates about the money we might save if we did it one way or the other? If we go to conference committee, we need ammunition.

Dr.Joyce: That may not be where the ammunition comes from. If you assume that the market is going to stay the same, the cost for the drugs is equal. It wouldn't be a cost saving aspect. We will hopefully be preventing what happened with OxyContin and other things years ago, to where it continues spiraling to the abuse side of things. Potentially, we are the only one of 51 Medicaid programs that can't touch these medications. There could be a new stimulant med that comes out in the future and it is no more effective than the ones we now have now. There could be a new one that comes out that costs 20x more. We've seen the drug companies and price however they wish and what the market will pay. Especially true when the government is paying. We wouldn't be able to touch it, based on law. If we get the ability to prioritize, we could at least prefer the products that are more tried and true, lots more evidence, and lots more experience. If someone has not ever been on ADHD drugs before, why would you want to try this one? Try the cheap ones first.

Senator Anderson: Previously, you said line 18-19 was not needed.

Dr. Joyce: Previously we had separated it out to saying that 18 and above or 21 and above, and then 20 and under. They took out the deferential between the two which would only be prior authorizing the stimulants, there is no need for both of those, because there is no difference between the two age groups any more. (11.48)

Senator Anderson: In line 9-11 some language there you don't want to lose. It says generic drug or brand name equivalent for which cost is less than generic.

Dr Joyce: That is correct. That is in both sections.

Senator Anderson: If it's a brand name drug, because your rebate is greater, does the patient pay the 3 bucks, where they would not if it was generic drug?

Dr. Joyce: Yes, that can happen. We could look at rebranding system, but it can be done. Could do something to exempt co pays for those that we prefer the brands. The program that we did was to allow the DAW9 to be billed. It is a special code that pharmacists submit, the says the plan prefers the brand drug. Not that doctors prefer the drug to be a brand, but that Medicaid prefers. We have the underlying program in place, and we would piggyback off that to exempt for co pays.

V-Chair Larsen: Is there a study of increase of Adderall, is there a study that the people who are not on Medicaid. Are they not using because of price?

Dr. Joyce: That would be interesting. We may be able to get something from the prescription drug monitoring program to try to see. As far as knowing payer, there is an indicator on the

PMP that talks about the payer but not accurate. The birth date may be accurate, but that payer is manually entered. Nothing would be with a fast turnaround.

Chair J. Lee: Discussions about sub abuse in general and what has led to new policy in most Emergency Rooms. ER's issuing narcotics for pain meds, and it's impossible to control because they patient says I have dental pain. It's been a ruse, and the ER's are already making changes in the way they are handling people. Not like appendicitis, where you can see why there may be pain. I think we need to look at pediatricians and specialist involved with children. That is a different deal. Kids are prior authorized, too, right?

Dr. Joyce: The chart doesn't break up. That just if they can do any prior authorization. 8 states where they can only do it on adults. (17.15)

Chair J. Lee: We're not looking at children, and that is important. We are trying to make some reasonable attention provided for those adults with ADHD and ADD. It is now a large population. If we can find a way to intervene in what could be a problem situation. Prior authorization is not a terrible thing and there is a conversation with the prescriber and the payer and the doctor during all of this about what is most appropriate. If the Dr. is dedicated to getting a particular drug, they will get it in the end.

Dr. Joyce: We're thanked once in a while for having a process in place, because often times the prescriber does not want to be the bad guy. Children come in get testing and diagnosis, and get good diagnosis. They have all the standardized tests and everything. With the adults, you are not getting all that testing; just patient coming in and saying they cannot pay attention, etc. There are tests for adults, and that can be part of the process. We need them to show they are accurately diagnosed, and then get the drugs that are equivalent.

Chair J. Lee: Throw out thought look towards idea over striking that to original adults have the review. It is important for their health. This isn't a big money saver spender thing. Are we going to have a way to intervene, if appropriate, that might head off and then follow up so they do not get addicted. Since sect 2 for children in that line about brand equivalent which only talks about for underage. Maybe we should have it in there for adults. Would you be able to confirm for us that it enables to do it for adults, too?

Dr Joyce: They would have to be in both sections.

Chair J. Lee: Even if we did not have the rest of this stuff, we would need to have that one, regardless if we overstruck 18 and 19?

Dr. Joyce: Yes.

Senator Heckaman: I'm going to oppose that on the fact that when I look through the testimony that we had, both groups that testified on behalf of two organizations each, they said they like the way the House bill came out. I have to rely on the, too.

Chair J. Lee: What we have from Carlotta MCCleary, focus on children. And children are not affected by this. That is important to know as well. clearly focuses on children, doctors, and psychiatrists. The doctors and psychiatrists still have the ability the dispense as needed. This deserves additional attention. We need to get language in about being more cost effective. I am not pushing this one out because we have time on is one.

Senator Anderson: We could ask him to bring generalized answer without specific personal identification about what happens issue when they are not responsive. If that was a long ago thing. If you could bring us an answer to that, it would be helpful.

Chair J. Lee: Recess until the afternoon. (23.16)

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1120
3/7/2017
Job Number 28828

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to the prior authorization program.

Minutes: No attachments

Chair J. Lee: The House took out the part that would have permitted prior authorizations for adults for the ADD and ADHD medications. At that point the usage flips from 25% of patients on Adderall, the addictive one and 75% on the non-addictive drug for children. Once they reach the age of 21 it flips and its 75% requesting the addictive drug. I just have a hard time imagining why it wouldn't be a good idea for the fairly small number of adults to have prior authorized medication. The potential for this to lead in to an addictive behavior is real.

Senator Anderson: On this bill here, you're right, the whole section wouldn't be necessary if that line is taken out. Dr. Joyce would like to see us reinstate that. **I move that we remove the overstrikes on lines 18-19 on page 1.**

Chair J. Lee: Dr. Brendan Joyce that was the purpose to say that those 240 adults that are affected by this, would need prior authorization to receive the potentially addictive drugs. There is no difference in the efficacy of the drugs. There is a suspicion that it will be abused. Senator Anderson would be amending overstrike lines 18-19 page 1.

V-Chair Larsen: I second the motion.

Senator Heckaman: I'll oppose the amendment, given that was one of the changes the house made.

Chair J. Lee: What it does is make the bill useless, because without that change they don't need section 1, because the children one is already there. Section 3a and section 3b are the same, that's what Dr. Joyce told us.

Senator Clemens: I was looking at the way the bill is now, these preauthorizations cause a lot of heartache and time to physicians.

Chair J. Lee: The response is instantaneous, less than 24 hours, and often less than an hour. Then it goes back to the pharmacy and its dispensed. If the doctor says dispensed as written, it's dispensed as written anyway.

Senator Clemens: Why do we want these preauthorized?

Chair J. Lee: These people are likely to be using it inappropriately. Instead of using the non-addictive drug, suddenly at 21, they can choose the amphetamine.

Senator Clemens: Evidently that's not working.

Chair J. Lee: You don't want to prevent 240 people from getting speed when they could be getting a medication that is equally effective?

Senator Clemens: I'm just stating my opinion.

Chair J. Lee: Prior authorization doesn't mean they don't get it; the physician has to say why they need speed instead of the non-addictive drug. If the other drug was good for them at 17, there's no reason it wouldn't be good at 21.

Senator Kreun: Why can't they stay on Ritalin?

Chair J. Lee: They could.

Senator Clemens: This is a big problem with doctors prescribing these dangerous drugs?

Chair J. Lee: It's not so much dangerous as addictive. You and I have a formulary; we have certain drugs we can use, under the PERS program.

A discussion about Medicaid followed (7:45-9:50)

Senator Heckaman: Do you know the reason this got amended? There must be a reason they changed it.

Chair J. Lee: The House has always been receptive to any pharmacy manufacturer who came in and said you're interfering with the ability of doctors to prescribe for their patients.

Senator Heckaman: I'm not sure anybody in the Department would know what's best for the patient either.

Chair J. Lee: They visit with the physician about that, they don't make an arbitrary decision. We are prior authorized. If it's working in 49 states and D.C., maybe it will work here.

Senator Anderson: Sometimes the physicians get pressure from their patients to prescribe a particular drug. Sometimes the physicians like it when we say you can't have that without prior authorization, it gives the physician more ammunition; that backs the physician up a bit, in some cases it helps them.

Chair J. Lee: If the doctor really thinks it's the best drug, they'll get it.

Senator Kreun: related story about worker's compensation and pain medication.

Chair J. Lee: We have a motion to adopt an amendment to over strike lines 18-19 on page 1, so that we would have prior authorization for ADHD and ADD drugs for adults only.

Motion passes 4-2-1.
V-Chair Larsen: I move do pass as amended.
Senator Kreun: Second.
Motion passes 4-2-1.
Senator Anderson will carry.
Hold vote for Sen. Piepkorn. Sen. Piepkorn recorded his vote on a separate recording, please see Job Number 28882.
Final vote 5-2-0 on amendment.
Final vote 5-2-0 on motion to Do Pass as Amended.
Chair J. Lee: Closed the meeting.

CA
3/7/17

17.8071.02001
Title.03000

Adopted by the Senate Human Services Committee

March 7, 2017

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1120

Page 1, line 16, after the semicolon insert "and"

Page 1, line 17, overstrike "; and"

Page 1, line 18, remove "(6)"

Page 1, line 18, overstrike "Stimulant medication used for the treatment of attention deficit disorder and"

Page 1, line 19, overstrike "attention deficit hyperactivity disorder"

Renumber accordingly

Date: 3/7 2017

Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1120

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: remove overstrikes on lines 18-19, page 1

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Anderson Seconded By Sen. Larsen

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman		X
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens		X			
Senator Curt Kreun	X				

Total (Yes) 5 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/7 2017

Roll Call Vote #: 2

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1120

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Larsen Seconded By Sen. Kreun

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman		X
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens		X			
Senator Curt Kreun	X				

Total (Yes) 5 No 2

Absent 0

Floor Assignment Sen. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1120, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1120 was placed on the Sixth order on the calendar.

Page 1, line 16, after the semicolon insert "and"

Page 1, line 17, overstrike "; and"

Page 1, line 18, remove "(6)"

Page 1, line 18, overstrike "Stimulant medication used for the treatment of attention deficit disorder and"

Page 1, line 19, overstrike "attention deficit hyperactivity disorder"

Renumber accordingly

2017 CONFERENCE COMMITTEE

HB 1120

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1120
4/4/2017
29915

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for the introduction of bill/resolution:

Relating to the prior authorization program

Minutes: 1, 2

Chairman Seibel called the committee to order.
Attendance was taken.
Clerk read the title

Representative Seibel: I understand that there is an amendment. Who you like to explain your amendment to us?

Sen. H. Anderson: Explained the senate amendment.
(Attachment 1)
The most significant part of the amendment is on page 1 lines 18 and 19. The department had asked to include those items in the ability to do prior authorization. The exemptions were overstruck. We just want to be sure that the House had considered the issues relative to the fact that there are two types of medication usually used for attention deficit disorder. The methylphenidate at 70% works well for the kids, but when these kids get to be 18 they will provide meds that are 70 %amphetamines which are much easier to abused, sold, etc. We just want to be sure you considered that difference which is really the reason that the dept. wanted to include those. I am going to pass out a couple of sheets here that will highlight what we are talking about. This is prescribers on this graph. It shows that the number goes above 180 for that one prescriber and the next highest one is 45. That is the next highest prescriber in the whole state is 45. It makes you wonder if that one prescriber is making a business of the med or not, but the ones that want the easily abused drug go to that prescriber. If we look at the one which is a more difficult to abuse product, the Vyvanse. On this sheet that same prescriber is number 9. (You have to take my word for it because we are disclosing any names here.) So that is one example of why the department wants to ask the question of the prescribers, "Why are you using this particular product?" That is where the review comes in. It might be that that would give us the impetus to say that you shouldn't be using those abuse able drugs. As far as the cost is concerned it is kind of a wash. The department is looking at trying to reduce the abuse. Obviously if we quit prescribing the ones that are abused it would save us money, but we don't know if that is going to happen. We

just want to ask the prescriber whether they are using the most appropriate product for these patients. That was the reason we restored that.

Chr. Seibel: Are there any questions?

Representative Schneider: I did listen to the floor videos of both yours Senator Anderson and Senator Lee as well and I appreciate what you are trying to do, but I am going to pass out the AMA s position on prior authorization and some of the detrimental features of it. I think if we are looking in to abusive prescriptions or trying to control drugs, this is not the vehicle to be doing that. I don't think we had any testimony from people that have been turned over for criminal prosecution at all on this issue. Prior authorization has a lot of negative with it. When we heard testimony on carving out exceptions and the reasons for that and I find that it is substantiated with the position of not only the AMA, but a bunch of other groups that are named in this article. I think we are just guessing that this is an abuse situation and if we need to do that there are other ways to do it. The negatives far outweigh the positive intent that both of you have expressed, so I would be in favor of keeping the bill as it is.

Chairman Seibel: Senator Lee

Sen. J. Lee: We have had this discussion about prior authorization for as long as I have been here. The medical associations don't like it because they see it as interfering with their ability to do whatever they want to do. There is more to every picture than just that. There is the need to not only watch for cost containment. Our prior authorization under Medicaid is very quick response. No one will be denied access to the medication they need. They can say dispense as written. The physician can do that. The pharmacist is just going to say can you just explain why this one is better. There is absolutely no evidence that was presented that suggests just because someone turns 21 speed is going to be better for them than the drug they were given when they were children. There are about 240 adults that would be effected by this because that it the number that is currently covered by Medicaid that have this. We are not talking a big population and we are not depriving anybody of the kind of care that they need to have, but the prescription drug monitoring program is used to evaluate whether this is the right drug. If it is, they will get it., if it is not they may not. There is no evidence that anything changes just because they turn 21, so that they need the other stuff.

Representative Seibel: Any other comments or questions?

Sen. H. Anderson: If you listen to my testimony on the floor, one of the things I said was that sometimes with practitioners it just takes somebody who asks them about the alternative to help them with their patient. If they have a patient that is demanding a particular drug by telling them that this is the only thing that works, they will have the information that tells them that the one they are on is the most effective drug and we should stick with this one. Not all practitioners are adverse even though the policy of the AMA and the ND Medical Association kind of has a standard. If you have a practitioner like this one appears to be soliciting that kind of patient, it is not going to change that, but at least we can affect the average.

Representative Schneider: Your discussions are important, but I don't think the bill was intended for the purpose that it is now being used after the Senate's action. I think that if we need to study that or if we have got someone who is abusing this or something that doesn't

look quite right, we have the criminal means to do something about that. I think that in the house, our testimony indicated that there are still real problems with delays. Some of them were fairly extreme and involved doctors from out of state. I appreciate that you are trying to reform one specific group within the pharmaceutical sphere, but I think it does damage over all to impose the prior authorization. There is a whole list of organizations that oppose this. (Attachment 2). The testimony that we had would not support the change we see in the senate. If we need to make some changes elsewhere, this bill is probably not the vehicle.

Sen. J. Lee: We all are subject to formularies in our health coverage. This is no different. My pharmacist that lives across the street calls the Medicaid card the gold card, because they have privileges that we don't. I am not interested at all in denying anyone appropriate medical care, but I don't think it should be more gold plated than the one for public employees. I would have one question if you would allow it Mr. Chairman. In stating that there are big delays, Dr. Brendan Joyce is here and I would like to have him comment on what that is if you would let him.

Chairman Seibel: Dr. Joyce you can come up.

Dr. Brendan Joyce, Administrator of Pharmacy for Medicaid Services
I cannot speak directly to any testimony. I am aware of the testimony that was given on both sides, but I cannot speak to that testimony directly. Our prior authorization program began roughly in about 2005. That was when our contract started. We did some ourselves for 2003 to 2005 just myself in the office. We basically just did a few products. There is a part of the contract that says that they have to respond to prior authorization requests within 24- hours. In 2003 it was put into law that anyone that has not been on the medication before can get 5 days of that medication without prior authorization to allow them to go through the process of prior authorization. Obviously with the 24 hour response rate and the fact that 90 +% get responses within 4 hours, we rarely use the 5 day provision. Our goal is that 98-99% get it within the same business day.

Representative Schneider: Just because it is in their contract, how do we know exactly how long it takes for them to respond.

Dr. Joyce: I can go on the computer and see kind of a spreadsheet that tells me the amount of time it has taken. It gives me direct access to everything about the process for each request and I also receive quarterly reports.

Representative Schneider: Would that be the same time frame regardless of where the doctor is?

Representative Seibel: Are there any more questions? I don't believe the house wants to move off of its position at this time. We can adjourn and schedule another conference committee.

Committee is adjourned.

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1120
4/10/2017
29999

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to the prior authorization program.

Minutes:

Chairman Seibel: Called the committee to order.
Attendance taken.

Chairman Seibel: Does anyone want to say anything?

Sen. Anderson: The senate would like the department to preauthorize the amphetamine replacement drugs because they are the easiest ones to abuse. They are more likely to be marketed than the alternatives.

Representative Seibel: Our feeling was that after we met last time that there may be a bad actor or two out there, but we thought this was going a bit far to deal with one bad actor, so we feel that we would like to hold fast to our position.

J. Lee: I wasn't looking at it as one bad actor, but a chance to get our arms around the drug

This gives them the extra tool to make sure that this is an appropriate medication for you. There are only 240

Representative Westlind: Is there an alternative drug to the speed drug?

Sen. J. Lee: I guess I wouldn't look at this as one bad actor, but a tool when we are so anxious to get our arms around the whole issue of diversion of prescription drugs as well as things such as illegal drugs. To not provide this tool that hurts no one. The person getting the prescription gets a 5- day supply while that maximum 24- hour period goes by during which this would be reviewed with the prescriber. I understand exactly that for 240 adults that suddenly need speed. That is what this is all about. Amphetamines are speed. I am just not quite getting it. I am not going to fall on my sword on this one, but I just don't understand why you wouldn't want to give these physicians the extra tool.There are two types of drugs. There is one that is used mainly on children that works well on adults as well,

but for some reason it seems that when someone turns 18 they need to be switched off of that and on to the amphetamines.

Sen. Anderson: When kids get ADHD drugs they are prescribed methylphenidate. That is the preferred drug. For some reason when they get to 21 they are asking their doctors to give them the amphetamines.

Representative Westlind: Sen. Lee, is there an alternative drug that can replace this one? Can they be given something else instead of the so called speed to deal with their problem?

Sen. Lee: Senator Anderson is the pharmacist and so I am going to allow him to do the detail work. What we were told in our committee and what we heard actually in our first meeting is that there are two types of drugs. One of them is primarily used for children, but when they get to be adults all of a sudden it is a flip over from 20% - 80% one way to 20% - 80% the other way. When they are at the adult age they think they have to have the speed. Absolutely there is another drug and medically there has not been determined to be any difference in the efficacy between those two drugs.

Sen Anderson: When kids receive ADHD drugs they are 65-70% prescribed methylphenidate which is actually the preferred drug for the ADHD. When they hit 18 years old, then it reverses. Then they are using amphetamines 65-70% of the time. The efficacy is the same, but for some reason once they get to be adults they want amphetamines. They are asking their doctors for that and the methylphenidates are just as effective and harder to abuse.

Representative Westlind: Do they want the speed because they get a higher high. Why do they want this and why does it differ just from being a minor to being an adult?

Sen. Anderson: That is exactly the reason. It is easier to abuse and it is marketable. No one wants to by methylphenidate, because it works differently. It is absorbed slower, you don't inject it. It is our opinion that these people ask for the amphetamine products because they are either abusing or marketing them. You can't go out and prove that in every case, but that looks like what is happening. There is no other reason to switch your preference from one to the other.

Sen. J.Lee: Parents would prefer that their kids stayed on the methylphenidate
but once they kids are able to make their own decision, they ask for the amphetamine.
They are not being denied, it just has to be reviewed.

Representative Schneider: I have already stated my position, but I think we are making some assumptions that are not appropriate. We are assuming that they are drug dealers and abusing their drugs. I think this is like going after a flea with a sludge hammer. If we do have someone that is prescribing many of these meds than we need to deal with them and not just punish everyone that is taking this medication. This is not the right process or the right vehicle to use here in this particular way.

Sen. Lee: I think the organizations that were brought up in the first meeting were all national organizations. I would assume that they do not necessarily know what the ND law is and the

protections that have been put into place here. Any insurance company that I know about has either a formulary or a preferred drug list. We can't get this medication the way Medicaid patients can and I don't think it should be any different. I think we should all have equal access to all drugs.

Chairman Seibel: I know the ND Medical Assoc. opposed this bill until we amended that section out of it. We are going to stand hard by that.

Sen. Anderson: There are some other things in this bill that we don't want to lose. My personal opinion is that I don't want to take the risk that they won't have enough support on the floor and Sen. Lee can't speak there. I think we are ready for a motion.

Chairman Seibel: I will entertain a motion.

Sen. Clemens: When this amendment was in our committee I opposed it at that time because I felt that just adding to more preauthorization is not going to be advantageous and I like the idea of the physicians have that little bit of leeway to make the decision about what is in the best interest of their patient. I make a motion that the senate recede from their amendment on lines 18 and 19 of the bill.

Chairman Seibel: Is there a second?

Senator Anderson: I will second it.

Chairman Seibel: Is there any further discussion? If not, the clerk will call the roll on Senator Clemens motion to recede from the senate amendments.
Roll call vote taken Yes 5 No 1 Absent 0

Meeting adjourned.

Date: 4/10/2017
Roll Call Vote: 1

2017 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1120 as (re) engrossed

House "Enter committee name" Committee

Action Taken

- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☒ **SENATE recede from Senate amendments**
- ☐ **SENATE recede from Senate amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen. Clemens Seconded by: Sen. Anderson

Representatives	4/4	4/10		Yes	No	Senators	4/4	4/10		Yes	No
Rep. Seibel	✓	✓		✓		Sen. H Anderson	✓	✓		✓	
Rep. Westlind	✓	✓		✓		Sen. J. Lee	✓	✓			✓
Rep. Schneider	✓	✓		✓		Sen. Clemens	✓	✓		✓	
Total Rep. Vote						Total Senate Vote					

Vote Count Yes: 5 No: 1 Absent: 0

House Carrier Rep. Seibel Senate Carrier Sen. H. Anderson

LC Number 17.8071.02001 . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

HB 1120, as engrossed: Your conference committee (Sens. Anderson, J. Lee, Clemens and Reps. Seibel, Westlind, Schneider) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ page 960 and place HB 1120 on the Seventh order.

Engrossed HB 1120 was placed on the Seventh order of business on the calendar.

2017 TESTIMONY

HB 1120

HB 1120
1-11-17
att. 1

Testimony
House Bill 1120 – Department of Human Services
House Human Services Committee
Representative Weisz, Chairman
January 11, 2017

Chairman Weisz, members of the House Human Services Committee, I am Brendan Joyce, Administrator of Medicaid Pharmacy Services for the Department of Human Services (Department) and I am here to support House Bill 1120 that was introduced at the request of the Department.

Currently, subsection 3 of section 50-24.6-04 of the North Dakota Century Code restricts the Department from prior authorizing six drug classes (antidepressants, antipsychotics, anticonvulsants, antiretrovirals for HIV, antineoplastics, and stimulants used for the treatment of Attention Deficit Hyperactivity Disorder (ADHD)). However, the Department is allowed to prior authorize brand medications in these classes when the generic is less expensive. Through House Bill 1120, the Department proposes to allow prior authorization of generics when the brands are less expensive (net of rebates). This situation is becoming more and more common and can account for potentially extreme cost differentials in all drug classes, including the six classes affected by this portion of the North Dakota Century Code.

Second, through this bill, the Department proposes to allow prior authorization of stimulants used for the treatment of ADHD for adults 21 and over. Through the ND Medicaid drug utilization review work over the past biennium, the Department has noticed some significant abnormalities in the utilization patterns of stimulant medications between adults and children. There are two main categories of stimulants: methylphenidate type products such as Ritalin®, and amphetamine type

products such as Adderall®. Both categories are listed as controlled substances by the Drug Enforcement Agency (DEA), but amphetamine products are reported to be abused (used for non-medical purposes) more often than methylphenidate products.

The Department has noticed through utilization review that 60-70% of children on stimulant medications are prescribed a methylphenidate product. However, 65-75% of adults are prescribed an amphetamine product. This complete reversal in utilization exists despite the literature showing that there is no age related difference in efficacy for the products.

Also, less than 20% of prescriptions for children on amphetamines are for short acting medications, while this reaches 43% for adults. There is no literature to support this difference. This data helps explain why the Department is requesting the ability to prior authorize stimulant medications for ADHD for adults.

Third, the Department is asking for the ability to utilize a successful approach used by multiple states in validating the appropriate use of five or more psychotropic medications in children. During the past four years, it has come to light nationally that foster children on Medicaid are more likely to be on psychotropic medications than non-foster care children on Medicaid. This is no different in North Dakota. Department staff have participated in national and state workgroups during the past four years and have explored many different approaches being used throughout the nation. Please note, while Foster Care differences helped bring this issue to national awareness, the focus is no longer just on foster care children, but instead all children on Medicaid.

The Department believes that the one approach that best serves the patients is what is used in Wyoming Medicaid (and other states). Simply put, Wyoming Medicaid requires a prior authorization process for a child's fifth concurrent prescription for a psychiatric medication. This prior authorization process includes a phone consultation between the prescriber and a child and adolescent psychiatrist to discuss the treatment of the patient.

There are ongoing studies and reviews in this area (e.g. Office of Inspector General (OIG) is currently evaluating data from North Dakota and four other states) and North Dakota remains one of the only states unable to do any prior authorization at any level on these medications. Again, as it states in the bill, the Department is asking for the ability to prior authorize the fifth (or greater) concurrent psychiatric medication for children. Since this approach would not be an overall prior authorization for a drug category, we would not be incorporating any of the currently exempted classes into our preferred drug list for supplemental rebates.

This concludes my testimony on HB 1120. I would be happy to answer any questions.

HB 1120
att. 2
1-11-17

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

House Human Services Committee
House Bill 1120
January 11, 2017

Chairman Weisz and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.
The North Dakota Medical Association is opposed to House Bill 1120. The North Dakota Psychiatric Association also opposes 1120. This organization is the professional membership organization for North Dakota's psychiatrists..

NDMA's opposition reflects concern that prior authorization would interfere unfairly in the patient-physician relationship and the ability of a patient's physician to assure that the patient is receiving appropriate medical care, and that a prior authorization program may be more costly to implement than the anticipated savings. Administrative costs and extra patient visits may offset any potential savings realized under the program. Restricting access to physician-prescribed medications, particularly new and more effective treatments, may cause patients to suffer medically and require more costly treatment in the long-run.

The department needs to make a better case that the drugs are being diverted and be more aggressive about getting law enforcement involved when it is suspected. It is the physician's obligation to not prescribe medications if there is a suspicion that there is diversion. The North Dakota Prescription monitoring program (PDMP) is one of the best in the United States. The NDPDMP is a secure and HIPAA compliant online database of controlled substances (C II – V) that is used to improve patient therapy and the state's ability to identify and inhibit medication diversion in an efficient and cost effective manner that should not impede the appropriate

utilization of these drugs for legitimate medical purposes. Prescription records are gathered from all outpatient pharmacies, assisted living facilities, nursing homes, practitioner's offices, and most Indian Health Service (IHS) facilities in the Aberdeen Area. It is now mandatory for all prescribers to be signed up for the PDMP and there are Board of Medicine guidelines for utilizing it.

ND Medicaid is punishing all patients for just a few bad apples. Prior authorization is not an adequate way to control the diversion problem and still protect individuals with a legitimate need for the medications. This is a comment I received from the president of the ND Psychiatric Society:

> Although it makes sense to convert to brand-name with less expense, it shifts the burden to the clinic providers to re-send the prescriptions without compensation for their time for the extra effort. The provider only receives notices like "need to do pre-authorization" when the pharmacy cannot get the old prescription approved. ND Medicaid needs to post on their web-site when they are going to a brand-name preferred medication, so when the provider gets denials, instead of going for pre-authorization for generics that will be denied because brand name is covered, (a waste of everyone's time) they post what the preferred brand is. A lot of effort goes into guessing, being turned down repeatedly, and it drives prescriber/pharmacies/patients nuts- and the patient usually call the physician's office, not ND Medicaid with their frustration.

Although there's a national concern about multiple prescriptions, it still begs the question of what the review process will be -what is the exact process? It does create another dis-incentive for people to work with the most ill children.

Perhaps one alternative may be educational programs under the Drug Utilization Review (DUR) Program. Federal law is quite clear in requiring each state to institute a drug use review program to ensure that covered outpatient drugs are appropriate, are medically necessary, and are not likely to result in adverse medical results. The DUR program must include prospective drug review, retrospective drug use review, assessment of drug data against predetermined standards, and educational programs. The state has broad discretion in implementing educational programs

through the DUR Board, accredited health care educational institutions, state medical societies or state pharmacists associations, or other organizations. The state must "provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems with the aim of improving prescribing or dispensing practices." The DUR Board is required by the federal law to provide ongoing interventions for physicians and pharmacists. *See* 42 USC 1396r-8(g).

Under the guidance of the DUR Board, the Department could develop materials identifying their concerns regarding certain categories of drugs, and provide the materials to physicians and pharmacists through direct mailings or educational forums in cooperation with those professional organizations.

For these reasons, the North Dakota Medical Association and the ND Psychiatric Association urge a DO NOT PASS on HB 1120.

HB1120
Att. 3
1-11-17

Testimony
Human Services Committee
Representative Robin Weisz, Chairman
January 11, 2017

Chairman Weisz and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). NDFFCMH is a parent run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families. MHAND's mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

We have concerns about HB 1120. NDFFCMH and MHAND continue to be supportive of the current law regarding the carve out for mental health medication. It is our belief that the prescribing of mental health medication must be between the individual and their doctor. We are also concerned with delays in appropriate treatment that a drug utilization review process would require. We know the sooner people receive the appropriate treatment the better. For example, with depression, we know that the longer it goes untreated, the worse the depression gets. The longer the depression lasts, it is more difficult to get back to the baseline, with some people never returning to baseline due to the length of time with untreated symptoms. There could also be additional negative consequences. Anything that delays the stabilization of the individual can lead to a decrease in family and other social interactions, an increase in hospitalizations, an increase in out-of-home placements, increased encounters with law enforcement, increased risk for suicide, or a decrease in school attendance and academic achievement.

My husband Mike and I have three children. Our son Garrett has some neurological damage and has since been diagnosed with autism. His psychiatric condition was extremely fragile. We took him to the University of Minnesota. Garrett was being treated by the head of pediatric neurology and head of pediatric neuropsychology, and the head of pediatric psychiatry. When Garrett needed changes in medication, we could not take him off of medication he was on and simply put him on another. He had to remain on the medications he was on and then the new ones had to be added. And then they would attempt to slowly withdraw the others. Medication changes were extremely dangerous for him because of Garrett's complex medical situation. This was an unusual situation. We have been told that the drug utilization review process is quick and it responds right away, most of the time that day. Yet when my son needed it, the system failed. Garrett was given a particular prescription for a brand-necessary medication from his doctors at the University of Minnesota. This means that his doctors did not want him taking any generic medications. Furthermore, this particular medication was not part of the carve out.

One day when we tried to fill his prescription, the pharmacist indicated that it had been denied by Medicaid. Instead of wanting Garrett to be on a brand-necessary medication, Medicaid wanted him to be on a generic. The pharmacist said we needed to have the doctor call the pharmacy. Garrett was running out of his medication. This medication was one that he had been on for over a year. This particular medication needed to be administered every two hours. If he went longer than the two hours, he became extremely aggressive-- often hurting our other children or damaging property in our home. Our doctors at the University of Minnesota called Medicaid and filled out their forms and sent it in. We went back to the pharmacy and it was still denied. So the Doctors again called Medicaid (they called numerous times, in fact) and never received a call back. My husband and I also placed calls to Medicaid and they never got back to

us. This had gone on for two weeks. By Friday of week two we still did not have it approved. Meanwhile, my son had completely run out of his medication. Against his doctors' medical advice, we had to change what he received and give him the generic. We were scared to death and we prayed that no further harm would come to him. Thankfully the medication did not cause any harm and he was okay; he tolerated the change in medication. By the way, we never did receive that call.

The decision to change my son's medication was made by a pharmacist at the North Dakota Department of Human Services-- not his pediatric neurologist and his pediatric psychiatrist. It was expressly against our doctors' medical advice and the risks were significant. We are concerned that this bill will also put the pharmacist in charge of deciding how to transition individuals from one medication to the next. How could a pharmacist at the Department of Human Services possibly know how to address Garrett's complex needs? This is an example of why we believe the mental health carve out is essential. Decisions must be maintained between the doctor and their patient.

Thank you for your time and I will be happy to answer any questions you may have.

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HB 1120
Attach #1
2/15

Testimony
Engrossed House Bill 1120 – Department of Human Services
Senate Human Services Committee
Senator Lee, Chairman
February 15, 2017

Chairman Lee, members of the Senate Human Services Committee, I am Brendan Joyce, Administrator of Medicaid Pharmacy Services for the Department of Human Services (Department) and I am here to support Engrossed House Bill 1120 that was introduced at the request of the Department.

Currently, subsection 3 of section 50-24.6-04 of the North Dakota Century Code restricts the Department from prior authorizing six drug classes (antidepressants, antipsychotics, anticonvulsants, antiretrovirals for HIV, antineoplastics, and stimulants used for the treatment of Attention Deficit Hyperactivity Disorder (ADHD)). However, the Department is allowed to prior authorize brand medications in these classes when the generic is less expensive. Through House Bill 1120, the Department proposes to allow prior authorization of generics when the brands are less expensive (net of rebates). This situation is becoming more and more common and can account for potentially extreme cost differentials in all drug classes, including the six classes affected by this portion of the North Dakota Century Code.

Second, prior to the House amendments, the Department's original proposed language would have established prior authorization of stimulates used for treatment of ADHD for adults 21 and over to assist in finding solutions to address the substance use issues facing the State. Through the ND Medicaid drug utilization review work over the past biennium, the Department has noticed some significant abnormalities in

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the utilization patterns of stimulant medications between adults and children. There are two main categories of stimulants: methylphenidate type products such as Ritalin®, and amphetamine type products such as Adderall®. Both categories are listed as controlled substances by the Drug Enforcement Agency (DEA), but amphetamine products are reported to be abused (used for non-medical purposes) more often than methylphenidate products.

The Department has noticed through utilization review that 60-70% of children on stimulant medications are prescribed a methylphenidate product. However, 65-75% of adults are prescribed an amphetamine product. This complete reversal in utilization exists despite the literature showing that there is no age related difference in efficacy for the products.

Also, less than 20% of prescriptions for children on amphetamines are for short acting medications, while this reaches 43% for adults. There is no literature to support this difference. This data helps explain why the Department is requesting the ability to prior authorize stimulant medications for ADHD for adults.

Again, the original bill only requested the ability to prior authorize stimulant medications for adults, not children. In surveying Medicaid agencies nationwide (see table below), North Dakota is the only state not allowed to prior authorize stimulants for any portion of the Medicaid population.

Survey: State Medicaid Ability to Prior Authorize Drug Classes

	Antineoplastics	Antiretrovirals	Antipsychotics	Antidepressants	Anticonvulsants	Stimulants
Can	40	37	47	47	45	50
Cannot	7	10	4	3	4	1

Third, the Department is asking for the ability to utilize a successful approach used by multiple states in validating the appropriate use of five or more psychotropic medications in children. During the past four years, it has come to light nationally that foster children on Medicaid are more likely to be on psychotropic medications than non-foster care children on Medicaid. This is no different in North Dakota. Department staff have participated in national and state workgroups during the past four years and have explored many different approaches being used throughout the nation. Please note, while Foster Care differences helped bring this issue to national awareness, the focus is no longer just on foster care children, but instead all children on Medicaid.

The Department believes that the one approach that best serves the patients is what is used in Wyoming Medicaid (and other states). Simply put, Wyoming Medicaid requires a prior authorization process for a child's fifth concurrent prescription for a psychiatric medication. This prior authorization process includes a phone consultation between the prescriber and a child and adolescent psychiatrist to discuss the treatment of the patient.

There are ongoing studies and reviews in this area (e.g. Office of Inspector General (OIG) is currently evaluating data from North Dakota and four other states) and North Dakota remains one of the only states unable to do any prior authorization at any level on these medications. Again, as it states in the bill, the Department is asking for the ability to prior authorize the fifth (or greater) concurrent psychiatric medication for children. Since this approach would not be an overall prior authorization

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for a drug category, we would not be incorporating any of the currently exempted classes into our preferred drug list for supplemental rebates.

This concludes my testimony on Engrossed HB 1120. I would be happy to answer any questions.

HB 1120
Attach #2
2/15

17.8071.01000

Sixty-fifth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1120

Introduced by

Human Services Committee

(At the request of the Department of Human Services)

A BILL for an Act to amend and reenact subsection 3 of section 50-24.6-04 of the North Dakota Century Code, relating to the prior authorization program.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 3 of section 50-24.6-04 of the North Dakota Century Code is amended and reenacted as follows:

3. a. ~~Except~~For individuals twenty-one years of age and older, except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert, ~~or~~ brand name drugs with a generic equivalent drug for which the cost to the state postrebate is less than the brand name drugs, in the aggregate, or generic drugs with a brand name equivalent drug for which the cost to the state postrebate is less than the generic drug, the department may not prior authorize the following medication classes:

   ~~a.~~ (1) Antipsychotics;

   ~~b.~~ (2) Antidepressants;

   ~~c.~~ (3) Anticonvulsants;

   ~~d.~~ (4) Antiretrovirals, for the treatment of human immunodeficiency virus; and

   ~~e.~~ (5) Antineoplastic agents, for the treatment of cancer~~; and~~

   ~~f. Stimulant medication used for the treatment of attention deficit disorder and attention deficit hyperactivity disorder~~.

   b. For individuals under twenty-one years of age, except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert, brand name drugs with a generic equivalent drug for which the cost to the state postrebate is less than the brand name drugs, in the aggregate, or generic drugs with a brand name equivalent drug for which the cost to the state postrebate is less than the

generic drug, the department may not prior authorize the following medication classes:

(1) Antipsychotics;

(2) Antidepressants;

(3) Anticonvulsants;

(4) Antiretrovirals, for the treatment of human immunodeficiency virus;

(5) Antineoplastic agents, for the treatment of cancer; and

(6) Stimulant medication used for the treatment of attention deficit hyperactivity disorder.

c. The restrictions of subdivision b do not apply for individuals under twenty-one years of age, who have five or more concurrent prescriptions for psychotropic medications.

d. Prior authorization for individuals under twenty-one years of age is required for five or more concurrent prescriptions for antipsychotics, antidepressants, anticonvulsants, benzodiazepines, mood stabilizers, sedative, hypnotics, or medications used for the treatment of attention deficit hyperactivity disorder. Prescribers requesting authorization to exceed the limits shall consult with the department or through its agent.

HB 1120
Attach #3
2/15

Testimony
Human Services Committee
Senator Judy Lee, Chairman
February 15, 2017

Chairman Lee and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). NDFFCMH is a parent run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families. MHAND's mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

We support HB 1120 as amended by the House Human Services Committee.

We had concerns about HB 1120 as it was originally drafted. NDFFCMH and MHAND continue to be supportive of the current law regarding the carve out for mental health medication. It is our belief that the prescribing of mental health medication must be between the individual and their doctor. We are also concerned with delays in appropriate treatment that a drug utilization review process would require. We know the sooner people receive the appropriate treatment the better. For example, with depression, we know that the longer it goes untreated, the worse the depression gets. The longer the depression lasts, it is more difficult to get back to the baseline, with some people never returning to baseline due to the length of time with untreated symptoms. There could also be additional negative consequences. Anything that delays the stabilization of the individual can lead to a decrease in family and other social interactions, an increase in hospitalizations, an increase in out-of-home placements, increased encounters with law

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enforcement, increased risk for suicide, or a decrease in school attendance and academic achievement.

My husband Mike and I have three children. Our son Garrett has some neurological damage and has since been diagnosed with autism. His psychiatric condition was extremely fragile. We took him to the University of Minnesota. Garrett was being treated by the head of pediatric neurology and head of pediatric neuropsychology, and the head of pediatric psychiatry. When Garrett needed changes in medication, we could not take him off of medication he was on and simply put him on another. He had to remain on the medications he was on and then the new ones had to be added. And then they would attempt to slowly withdraw the others. Medication changes were extremely dangerous for him because of Garrett's complex medical situation. This was an unusual situation. We have been told that the drug utilization review process is quick and it responds right away, most of the time that day. Yet when my son needed it, the system failed. Garrett was given a particular prescription for a brand-necessary medication from his doctors at the University of Minnesota. This means that his doctors did not want him taking any generic medications. Furthermore, this particular medication was not part of the carve out.

One day when we tried to fill his prescription, the pharmacist indicated that it had been denied by Medicaid. Instead of wanting Garrett to be on a brand-necessary medication, Medicaid wanted him to be on a generic. The pharmacist said we needed to have the doctor call the pharmacy. Garrett was running out of his medication. This medication was one that he had been on for over a year. This particular medication needed to be administered every two hours. If he went longer than the two hours, he became extremely aggressive-- often hurting our other children or damaging property in our home. Our doctors at the University of Minnesota called Medicaid and filled out their forms and sent it in. We went back to the pharmacy and it was still

denied. So the Doctors again called Medicaid (they called numerous times, in fact) and never received a call back. My husband and I also placed calls to Medicaid and they never got back to us. This had gone on for two weeks. By Friday of week two we still did not have it approved. Meanwhile, my son had completely run out of his medication. Against his doctors' medical advice, we had to change what he received and give him the generic. We were scared to death and we prayed that no further harm would come to him. Thankfully the medication did not cause any harm and he was okay; he tolerated the change in medication. By the way, we never did receive that call.

The decision to change my son's medication was made by a pharmacist at the North Dakota Department of Human Services-- not his pediatric neurologist and his pediatric psychiatrist. It was expressly against our doctors' medical advice and the risks were significant. Before HB 1120 was amended, we were concerned that the bill would also put the pharmacist in charge of deciding how to transition individuals from one medication to the next. How could a pharmacist at the Department of Human Services possibly know how to address Garrett's complex needs? This is an example of why we believe the mental health carve out is essential. Decisions must be maintained between the doctor and their patient.

The changes made to HB 1120 alleviated those concerns. We understand the concerns regarding children on five or more medications. We feel it is imperative that it be a pediatric psychiatrist that consults with physicians regarding this issue. We feel that a pediatric psychiatrist would have the expertise that is necessary for consulting on pediatric psychiatric issues.

Thank you for your time and I will be happy to answer any questions you may have.

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2/15

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HB 1120
Attach #4
2/15

NDMA Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

NORTH DAKOTA PSYCHIATRIC SOCIETY

Senate Human Services Committee

House Bill 1120

February 15, 2017

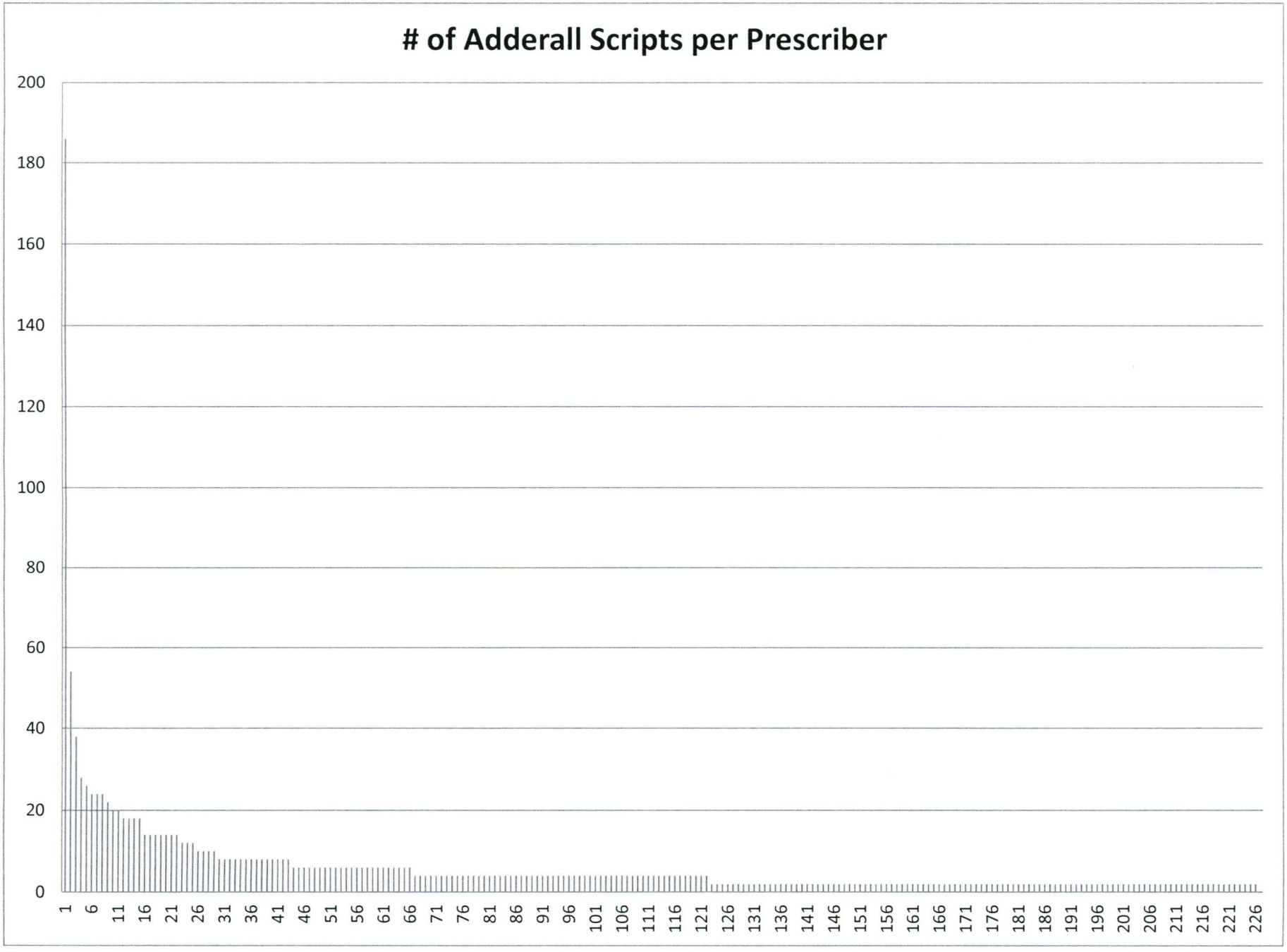
Chairperson Lee and Committee Members, I'm Courtney Koebele and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students. I also represent the North Dakota Psychiatric Association - the professional membership organization for North Dakota's psychiatrists.

NDMA and NDPS were opposed to HB 1120 as originally filed. The opposition reflects concern that prior authorization would interfere unfairly in the patient-physician relationship and the ability of a patient's physician to assure that the patient is receiving appropriate medical care, and that a prior authorization program may be costlier to implement than the anticipated savings. Administrative costs and extra patient visits may offset any potential savings realized under the program. Restricting access to physician-prescribed medications may cause patients to suffer medically and require more costly treatment in the long-run.

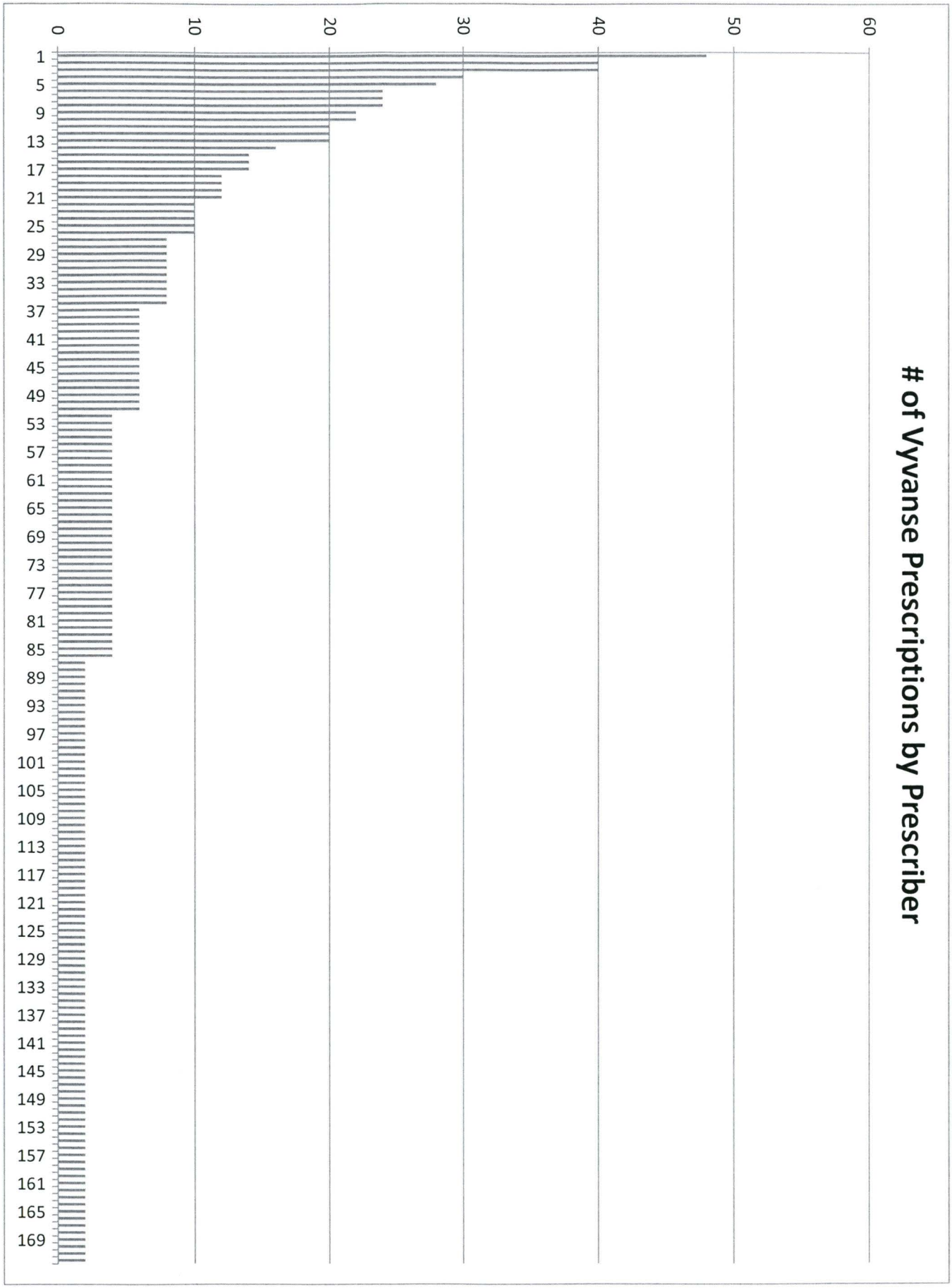
NDPS also had concerns about the original language in the bill which stated that prescribers requesting authorization to exceed the limits shall consult with the department or through its agent. We were concerned that the consultation with the department might be with someone who is not medically trained for these complicated cases.

However, with the House Human Service Committee's amendments, the bill is in acceptable form. For these reasons, the North Dakota Medical Association and the ND Psychiatric Association urge a DO PASS on amended HB 1120.

4/4/17 Att. 1 H.B 1120



Att. 1
4/4/17
HB 1120



Att. 2
HB 1120
4/4/17

Health Care Coalition Calls for Prior Authorization Reform

For immediate release: Jan 25, 2017

CHICAGO – Responding to unreasonable hurdles for patients seeking care, a coalition including the American Medical Association (AMA) and 16 other health care organizations today urged health plans, benefit managers and others to reform prior authorization requirements imposed on medical tests, procedures, devices and drugs.

The coalition, which represents hospitals, medical groups, patients, pharmacists and physicians, says that requiring pre-approval by insurers before patients can get certain drugs or treatments can delay or interrupt medical services, divert significant resources from patient care and complicate medical decisions. Concerns that aggressive prior authorization programs place cost savings ahead of optimal care have led Delaware, Ohio and Virginia to recently join other states in passing strong patient protection legislation.

Given the potential barriers that prior authorization can pose to patient-centered care, the coalition is urging an industry-wide reassessment of these programs to align with a newly created set of 21 principles. Prior authorization programs could be improved by applying the principles' common-sense concepts grouped in five broad categories:

- Clinical validity,
- Continuity of care,
- Transparency and fairness,
- Timely access and administrative efficiency, and

- Alternatives and exemptions.

"Strict or bureaucratic oversight programs for drug or medical treatments have delayed access to necessary care, wasted limited health care resources and antagonized patients and physicians alike," said AMA President Andrew W. Gurman, M.D. "The AMA joins the other coalition organizations in urging health insurers and others to apply the reform principles and streamline requirements, lengthy assessments and inconsistent rules in current prior authorization programs."

The data entry and administrative tasks associated with prior authorization reduce time available for patients. According to a new AMA survey, every week a medical practice completes an average of 37 prior authorization requirements per physician, which takes a physician and their staff an average of 16 hours, or the equivalent of two business days, to process.

The AMA survey illustrates that physician concerns with the undue burdens of preauthorizing medical care have reached a critical level. Highlights from the AMA survey include:

- Seventy-five percent of surveyed physicians described prior authorization burdens as high or extremely high.
- More than a third of surveyed physicians reported having staff who work exclusively on prior authorization.
- Nearly 60 percent of surveyed physicians reported that their practices wait, on average, at least 1 business day for prior authorization decisions—and more than 25 percent of physicians said they wait 3 business days or longer.
- Nearly 90 percent of surveyed physicians reported that prior authorization sometimes, often, or always delays access to care.

The AMA survey findings indicate there is a real opportunity to improve the patient experience while significantly reducing administrative burdens for both payers and physicians by reforming prior authorization and utilization management programs.

The AMA and other coalition organizations welcome the opportunity to work collaboratively with health plans and others to create a partnership that lays the foundation for a more efficient prior authorization process. In addition to the AMA,

the coalition includes the: American Academy of Child and Adolescent Psychiatry, American Academy of Dermatology, American Academy of Family Physicians, American College of Cardiology, American College of Rheumatology, American Hospital Association, American Pharmacists Association, American Society of Clinical Oncology, Arthritis Foundation, Colorado Medical Society, Medical Group Management Association, Medical Society of the State of New York, Minnesota Medical Association, North Carolina Medical Society, Ohio State Medical Association and Washington State Medical Association.

# # #

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About the American Medical Association
The American Medical Association is the premier national organization dedicated to empowering the nation's physicians to continually provide safer, higher quality, and more efficient care to patients and communities. For more than 165 years the AMA has been unwavering in its commitment to using its unique position and knowledge to shape a healthier future for America. For more information, visit ama-assn.org.

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