# MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1470

2005 HOUSE HUMAN SERVICES

HB 1470

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1470

House Human Services Committee

❑ Conference Committee

Hearing Date February 2, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| # 1 | x | | 4-4417 |
| | | | |
| | | | |
| Committee Clerk Signature | | | |

Minutes:

**Chairman Price** opened the hearing on HB1470.

**Rep. Devlin, Dist. 23:** Appeared in support of HB 1470. See attached Testimony.

**Rep. Weisz:** Can you explain the Fiscal Note.

**Rep. Devlin:** I haven't seen the FN yet, however, I did project that the dept. would have a billion dollar FN, but I was wrong. It's only 5 million dollars. I have also made the comment on this issue, whatever the FN the dept. has on this, will never reflect the cost in many other areas, you have less hospitalization, people are able to return to work, people able to function in their home. People in nursing homes, less people going to emergency, all of these has increased savings, decreased costs to the dept. and we never see those things. This is an area that has been a source of frustration with me for every session since I have been here.

**Rep. Weisz**: The bill is only changing two small areas, we already have our authorization in drug review board, the FN seems to imply that we are starting from scratch.

**Rep. Devlin:** I guess you would have to ask the dept. that question. We have seen death by FN so many times, we can recite by chapter and verse. But I do agree with your statement.

**MR682**

**Dr. Terry Johnson:** St. Alexius Medical Center

I am here to address the part of this bill having to do with not restricting drugs for mental health problems. See attached testimony.

Rep. Porter: Have you found in current prior authorization program guidelines that the dept. has, where you felt that you needed medications that were available to other patients, that wouldn't have been available to a Medicaid patient?

T. Johnson: Not very often. The dosages that should be used were not available, so we work around that.

Chairman Price: We had testimony yesterday some other behavioral type drugs. SSRI category the normal practice, should a patient be on more than one at a time?

T. Johnson: Sometimes, yes, the more complex patients. We have to be very careful.

Chairman Price: Do you have any idea of the numbers of populations would be on SSRI ?

T. Johnson: On more than one? My specialty is in the treatment of Resistant Depression area, and I get referrals from other Drs. I see a very small percentage, in relation to the primary care population would be less often, but I do have some of them on multi antidepressants.

Chairman Price: What about one being a typical at a time.

T. Johnson: Some where there are cases when combining two medications together works better than going to a higher dose of just the one. You have to have the knowledge of how to dispense this and the interaction levels and also if someone would be trying to abuse them.

**Chairman Price :** 6% of the population?

**T. Johnson:** That's is probably not to high.

**Chairman Price:** I want to emphasize that for each episode, that someone under goes, the severity increases, is that correct?

**T. Johnson:** That seems to be a general rule, not always true, Once I get the patient's illness on a level, I want to make sure that they are able to continue their medication to keep them healthy. When I have had patients that could not afford medication on their own, they have wound up in the hospital setting at times.

**Bruce Levi, Ex. Director, ND Medical Assn.**

I think for the reasons Dr. Johnson expressed, NDMA does also support HB 1470. Mr. Thomas handed out a report from the Medicaid working group that met over the summer. They recognized that Dr's. do have the primary responsibilities for insuring that Medicaid prescription drug cost containment program support the provision of medical necessary care is ultimately provided. This provides less costs for everyone in the long run. Dr. Johnson clearly illustrated the these are complex decisions. There is always an ongoing study regarding these prescriptions. MA stand point, we are looking toward all sides, the Senate has called for establishment of a preferred drug list (SB2284). The MA realizes how this legislation will effect cost containment and supports HB 1470.

**CET Pulver, Mental Health Assn.** Testimony Attached ( Sherry Spear)

**Rep. Devlin**: Ms. Spears came to me yesterday and indicated she had a death in the family, so she could not appear herself today.

**Chairman Price**: Any opposition?

**John Savageau, RPH, Chairman DUR Board.**

I want to clear one thing up. There is no intention to restrict anit-psycotrophic's to people. There never has been, there never will be. I am confused of the statements regarding this. going to a What I am opposed to in this bill, is some of the language.

See attached handout.

**Rep. Potter:** Would you have suggestions on how you would like to have it worded?

**J. Savageau:** Would like it struck out. Does this language mean that if a generic drug becomes available, does the state have to still keep paying for the higher price drug? That makes no sense to me. I feel that PDL is not the answer, as some have suggested. The language in this bill sets up the DUR Board to fail. When you lose the opportunity to go to the generic drug, that goes on from year to year. The state has to have the same opportunity to use generic as the general public.

**Chairman Price:** Any others in opposition?

**Neutral:**

**Dr. Brendan Joyce: Administrator, Pharmacy Services**. See Attached Testimony.

**Chairman Price:** On page 2, line 30: "Prior Authorization" so your wanting to take out the other language "otherwise restrict", to get around the limits?

**Dr. Joyce:** Yes, however, but if the Legislature wanted Pharmacies to prior authorize, you need to encourage to be able to go with the generic?

**Chairman Price:** If you do that, how would you go to the generic drug?

**Dr. Joyce:** To allow the Board to go with generic.

**Chairman Price:** Any questions regarding the Fiscal Note?

**Jamie Starr, Acct. Medical Services Division.**

In regards to the Fiscal Note, $450,000 is actually $433,000 for a 6 month, and then took that times 4, which is 1.7 million.

**Dr. Joyce**: I want to clarify, I was using the 6 month figures.

**Chairman Price:** Anyone else to testify, if not, the hearing is closed.

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1470

House Human Services Committee

☐ Conference Committee

Hearing Date February 2, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 1 | | x | 1540-2050 |
| | | | |
| | | | |
| Committee Clerk Signature | | | |

Minutes:

**Chairman Price** reopened discussion on HB 1470.

**Rep. Devlin**: I move the amendments to HB 1470 as presented.

**Rep. Nelson:** Second

**Rep. Devlin**: Move the 2nd Amendments as presented.

**Rep. Porter:** Second.

**Chairman Price** called for vote.

**Rep. Devlin**: Move a Do Pass as Amended.

**Rep. Porter:** Second

**Vote: 11-0-1 Carrier: Rep. Devlin**

# FISCAL NOTE

**Requested by Legislative Council**
03/31/2005

Amendment to: Engrossed HB 1470

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | | | | | | |
| **Expenditures** | | | | | | |
| **Appropriations** | | | | | | |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would amend and reenact subsection 2 of section 50-24.6-02 and section 50-24.6-04 of the NDCC relating to the membership of the drug use review board and the prior authorization program and to provide an expiration date.

The fiscal impact of the bill is estimated to be less than $5,000.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

| | | | |
|---|---|---|---|
| **Name:** | Brenda M. Weisz | **Agency:** | DHS |
| **Phone Number:** | 328-2397 | **Date Prepared:** | 03/31/2005 |

# FISCAL NOTE

**Requested by Legislative Council**
02/07/2005

Amendment to: HB 1470

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | | | | | | |
| **Expenditures** | | | | | | |
| **Appropriations** | | | | | | |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would amend and reenact subsection 2 of section 50-24.6-02 and section 50-24.6-04 of the NDCC relating to the membership of the drug use review board and the prior authorization program.

This fiscal note includes a revision to the original fiscal note request dated 1/18/05, regarding prior authorization savings and also includes the effects of the amendments.

The fiscal impact of the bill is estimated to be less than $5,000.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

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|---|---|---|---|
| **Name:** | Debra A. McDermott | **Agency:** | Human Services |
| **Phone Number:** | 328-3695 | **Date Prepared:** | 02/08/2005 |

# FISCAL NOTE

**Requested by Legislative Council**
01/18/2005

Bill/Resolution No.: HB 1470

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

| | 2003-2005 Biennium | | 2005-2007 Biennium | | 2007-2009 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Other Funds | General Fund | Other Funds | General Fund | Other Funds |
| **Revenues** | $0 | $0 | $0 | ($1,209,818) | $0 | ($1,519,484) |
| **Expenditures** | $0 | $0 | ($402,129) | ($1,209,818) | ($646,944) | ($1,519,484) |
| **Appropriations** | $0 | $0 | $0 | $0 | $0 | $0 |

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

| 2003-2005 Biennium | | | 2005-2007 Biennium | | | 2007-2009 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |
| $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

This bill would amend and reenact subsection 2 of section 50-24.6-02 and section 50-24.6-04 of the NDCC relating to the membership of the drug use review board and the prior authorization program.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

For 2005-2007 the department would potentially receive federal title XIX revenue related to prior authorization activities of $1,473,081; this amount would be offset due to potential savings of $2,682,899 from prior authorization activities resulting in a net savings of $1,209,818.

In 2007-2009 the department would potentially receive federal title XIX revenue related to prior authorization activities of $1,660,339; this amount would be offset due to potential savings of $3,179,823, from prior authorization activities resulting in a net savings of $1,519,484.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The department would incur insubstantial salary and operating expenditures as a result of adding one member to the drug use review board. Other operating expenditures relate to the contract for prior authorization in the amount of $1,100,000 ($550,000 general funds) for 2005-2007 and $1,133,220 ($566,610 general funds) for 2007-2009.

Medical assistance grants would increase due to removal of limitations on drugs used to treat mental illness. The estimated increase in expenditures for 2005-2007 would be $1,419,622 of which $498,287 would be general funds; for 2007-2009 the increase is estimated to total $1,727,002 of which $635,019 would be general funds.

As a result of this bill, medical assistance grants would also decrease due to savings achieved by the prior authorization of prescriptions for certain classes of drugs. For 2005-2007 the potential savings would amount to $4,133,897 of which $1,450,998 would be general funds; for 2007-2009 the savings could total $5,028,978 of which

$1,849,155 would be general funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

For 2005-2007, there would be no affect on appropriations.

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|---|---|---|---|
| **Name:** | Brenda M. Weisz | **Agency:** | Human Services |
| **Phone Number:** | 328-2397 | **Date Prepared:** | 01/31/2005 |

Adopted by the Human Services Committee
February 2, 2005

**House Amendments to HB 1470 - Human Services Committee 02/03/2005**

Page 2, line 5, overstrike "who is"

Page 2, line 6, remove "appointed by the executive director of the department" and overstrike "from a list of"

Page 2, line 7, overstrike "nominees provided" and replace "to the executive director" with "appointed"

Page 2, line 30, replace "The" with "Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert and an AB-rated generic equivalent drug for which the cost to the state postrebate is less than the brand name drug, the"

Renumber accordingly

1) Amd 1 - 11-0-1
2) amd 2. 11-0-1

**Date:** 2/2/05 **Roll Call Vote #:** 3 - Do Pass as Amd

## 2005 HOUSE STANDING COMMITTEE ROLL CALL
## BILL/RESOLUTION NO. HB 1470

**House** Human Services **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number 50557.0301-0400

Action Taken DP as Amd

Motion Made By **Rep.** Devlin Seconded By **Rep** Porter

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chairman C.S. **Price** | ✓ | | Rep.L. **Kaldor** | ✓ | |
| V Chrm.G. **Kreidt** | ✓ | | Rep.L. **Potter** | ✓ | |
| Rep. V. **Pietsch** | ✓ | | Rep.S. **Sandvig** | ✓ | |
| Rep.J.O. **Nelson** | ✓ | | | | |
| Rep.W.R. **Devlin** | ✓ | | | | |
| Rep.T. **Porter** | ✓ | | | | |
| Rep.G. **Uglem** | ✓ | | | | |
| Rep C. **Damschen** | ✓ | | | | |
| Rep.R. **Weisz** | AB | | | | |
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**Total** **Yes** 11 **No** 0

**Absent** 1

**Floor Assignment** **Rep.** Devlin

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

## REPORT OF STANDING COMMITTEE

**HB 1470: Human Services Committee (Rep. Price, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1470 was placed on the Sixth order on the calendar.

Page 2, line 5, overstrike "who is"

Page 2, line 6, remove "appointed by the executive director of the department" and overstrike "from a list of"

Page 2, line 7, overstrike "nominees provided" and replace "to the executive director" with "appointed"

Page 2, line 30, replace "The" with "Except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert and an AB-rated generic equivalent drug for which the cost to the state postrebate is less than the brand name drug, the"

Renumber accordingly

2005 SENATE HUMAN SERVICES

HB 1470

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1470

Senate Human Services Committee

❑ Conference Committee

Hearing Date March 8, 2005

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 1 | x | | 2065-end |
| 1 | | x | 00-0020 |
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| Committee Clerk Signature | | | |

Minutes:

Chairman Lee opened the public hearing on HB 1470. All members were present.

Representative Bill Devlin, District 23, Finley was a sponsor of this bill and introduced it. It relates to the membership of the drug use review board and the prior authorization program.

See written testimony (Attachments 1, 1A, 1B, 1C)

**Testimony in favor of the bill**

Terry M. Johnson, M.D., speaking for himself as a psychiatrist at St. Alexius Medical Center.

See written testimony (Attachment 2)

Chairman Lee: Did you find that you were unduly restricted in the last two years and if you procedurally you found it to be challenging?

Johnson: It hasn't been too bad, I've generally been able to get the medicines I've needed for my patients. Occasionally when there are problems, I call up Brandon Joyce and complain to him, and we usually get good results.

Sherry Spear: Representing herself and family members. She is a fourth generation advocate for people with mental illness. I encourage the committee to support 1470 because I can tell you, if you've ever had to take somebody to the emergency room because they were given Haloperidol which is an older anti psychotic, and the muscle spasms in their neck and chest are so painful that they think they're having a heart attack. If you've ever had to take someone to the emergency room to get Ativan because they were given Prosac and it exacerbated an underlying anxiety disorder and those kinds of things, people would know that there is no one size fits all. This is an area of medicine we're still trying to unravel the mysteries of the brain. We don't even fully understand why the medications that work, why they even work. This is truly an area where it's as much an art as a science and we do ask that you allow physicians to prescribe what they feel is appropriate for the complex set of issues the individual has and to not allow prior authorization of anti psychotics and antidepressants because it truly does put up a roadblock and a barrier to access.

Dave Peske, with the North Dakota Medical Association. We're in support of the bill as it came from the House.

**Neutral Testimony**

Dr. Brendan Joyce, Administrator of Pharmacy Services for the Department of Human Services. See written testimony. (Attachment 3)

Chairman Lee gave a short overview of the drug utilization review board to new committee members.

Joyce: The types of medications are going to change a lot on Part D. We're looking to see which medications are shifting, for instance, the furosemide which is a very old lasix, for diuretic for

blood pressure. Currently, that's the top volume of claims for North Dakota Medicaid. But its use, because of the population shift, our average age is going from 42 to 24 for the Medicaid population. So our population is shifting. ADHD is another big one. Mood stabilization for kids. Antihistamines and proton pump inhibitors, both of those the UR board said 'we don't want to do anything for 14 and under.'

Chairman Lee: Do you know when you might have the information available so the committee can review the information before we act on it?

Joyce: Probably this week.

**Testimony in Opposition to the bill**

Linda Wurtz, Associate State Director for Advocacy and Communication with AARP of North Dakota. We are opposed to 1470 and would hope you would let your prior authorization system work.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1470

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 23, 2005

| Tape Number | Side A | Side B | Meter # |
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| 1 | x | | 0-3290 |
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| Committee Clerk Signature | | | |

Minutes:

Chairman Lee reopened discussion on HB 1470. All members were present.

This bill deals with prior authorization and membership of the drug utilization review board. The only drugs that are currently requiring prior authorization are antihistamine type drugs and stomach acid reducing drugs like Prilocec. This bill changes the membership and carves out psychotropic drugs and cancer drugs. So there are two new areas here. I have had people express concern with the direct appointment of members to the board rather than recommended by the Governor as is currently the case. The other concern is whether we would choose to carve out the psychotropic drugs and cancer drugs.

The committee discussed the logic of choosing members of the board. They also discussed the use of formularies, prior authorization, utilization review and carving out certain drugs. It was agreed that the committee was not interested in depriving Medicaid recipients of the proper medication for any medical condition. But in the same sense, as all of us have to have some kind

of formulary used by our physicians when we're going to have a prescription chosen for us, it doesn't seem unreasonable that Medicaid patients, who are receiving them through taxpayer dollars, would have the same kind of criteria. We're not asking for a less rich program for them, just an equivalent program. Right now they have a richer program than we do.

There was some concern that if prior authorization was used for Medicaid prescriptions and a prescription was denied, if the Medicaid recipient would have recourse. It was assured that there was an appeal process in place. There was also concern that there would be a delay in getting the drug of choice if prior authorization was used, but that if physicians would have prior authorization in mind, they would more likely think about generics.

It was agreed that if we're trying to contain costs, that Medicaid patients should be subject to the same rules that the rest of us have when dealing with the insurance companies. Senator Brown stated that with the new Medicaid Part D thing, the DUR board is not going to get to any other drugs besides the antihistamines and antacids in the time available. Part D has to take effect January 1, 2006 and plenty of work has to be done prior to that. There will be a lot of change to the department in the next year and a half. If we pass this, it won't make a lot of difference because they're not going to get to the psychotropic or cancer or HIV drugs to prior authorize in that time.

Chairman Lee agreed but thought it would be a lot harder to remove any kind of section of law that carves out a certain thing if we want to examine it in the future, than it is to leave it out in the first place and talk about adding it back in again in two years. She thought that there was so much transition taking place in the next two years, with part D drug benefits going in and the fact that the DUR board has just gotten itself planted and up and running. She would like to be

able to see them continue that and the department be able to respond to the changes in part D and we can come back in two years if we decide we want to do that again we can do it. There's no question that we want everyone to get the appropriate medication, she just doesn't want to tie the hands of the department. They approve containing costs but want to follow the correct procedure to not hurt Medicaid recipients.

Senator Warner moved DO NOT PASS, seconded by Senator Dever.

Sen. Lyson: I'm going to vote for this because I'm not smart enough not to, because I don't know what I'm doing. The portion of changing the board a little bit may be a great idea, but I think they can live with it the way it is.

Sen. Brown: I'm not going to vote for the do not pass. I think we could have lived with this. I'm not convinced and it's a bit of a change from two years ago. I think if we were to change this bill, it might help the DUR process.

VOTE: 4 yeas, 1 nay, 0 absent

Carrier: Senator J. Lee

Chairman Lee: We do have several small amendments that need to be addressed.

Sen. Lyson: In the likelihood that it does pass, we should put the amendments on in the conference committee.

Chairman Lee: Would you like to reconsider and do those two amendments? Page 2 line 30.

Senator Warner moved to reconsider our actions by which we gave the do not pass recommendation to HB 1470, seconded by Senator Lyson

Voice vote: Motion passed.

Senator Warner moved DO PASS to amend House Bill 1470 per proposed amendment

(attachment 1), seconded by Senator Lyson.

VOTE: 5 yeas, 0 nays, 0 absent

Senator Warner, moved DO NOT PASS as amended, seconded by Senator Lyson.

VOTE: 4 yeas, 1 nay, 0 absent Carrier: Senator Judy Lee

Date: 3-23-05
Roll Call Vote #: 1

## 2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB 1470

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Sen Warner Seconded By Sen Dever

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | ✓ | |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | | ✓ | | | |
| Sen. Stanley Lyson | ✓ | | | | |
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Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen. J. Lee

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

Date: 3-23-04
Roll Call Vote #: 2

## 2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB1470

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Reconsider amendment

Motion Made By Sen Warner Seconded By Sen Lyson

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | | | Sen. John Warner | | |
| Sen. Dick Dever - Vice Chairman | | | | | |
| Sen. Richard Brown | | | | | |
| Sen. Stanley Lyson | | | | | |
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Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

voice vote 4 yeas. 1 nay

Attachment 1

**Proposed Amendments to HB 1470**

Page 2, line 30, replace "and" with "or", remove "an"

Page 2, line 31, replace "drug" with "drugs, in the aggregate"

Renumber accordingly

3/23/05

Date: 3-23-05
Roll Call Vote #: 3

## 2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. HB 1470

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amendment

Motion Made By Warner Seconded By Lyson

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | ✓ | |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | ✓ | ✓ | | | |
| Sen. Stanley Lyson | ✓ | | | | |
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Total (Yes) 5 No Ø

Absent Ø

Floor Assignment _____

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

Date: 3-23-05
Roll Call Vote #: 1

**2005 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**BILL/RESOLUTION NO.** HB 1470

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do not Pass as amended

Motion Made By Sen Warner Seconded By Sen Lyson

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Sen. Judy Lee - Chairman | ✓ | | Sen. John Warner | ✓ | |
| Sen. Dick Dever - Vice Chairman | ✓ | | | | |
| Sen. Richard Brown | ✓ | ✓ | | | |
| Sen. Stanley Lyson | ✓ | | | | |
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Total (Yes) 4 No 1

Absent 0

Floor Assignment Sen J. Lee

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

## REPORT OF STANDING COMMITTEE

**HB 1470, as engrossed: Human Services Committee (Sen. J. Lee, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1470 was placed on the Sixth order on the calendar.

Page 2, line 30, replace "and an" with "or"

Page 2, line 31, replace "drug" with "drugs, in the aggregate"

Renumber accordingly

2005 TESTIMONY

HB 1470

Good Morning, Chairman Price and members of the House Human Services Committee, it is a pleasure to appear before you today. For the record I am Representative Bill Devlin, District 23, from Finley. District 23 is a rural district comprising all of Griggs and Nelson counties along with parts of Steele, Benson and Eddy counties. I am here to introduce HB 1470 that makes some changes to the Drug Utilization Review Board and also makes changes to the prior authorization process in our state.

I know the legislature wanted an independent DUR Board that wasn't under the control of the legislature or the department. We expected the medical professionals on the board, particularly the doctors, to make the best decisions possible as independent members. We were then and are today very concerned about interfering with the doctor-patient relationship.

Under the scenario we use to appoint members to the board we expected that the medical professionals in our state organizations would pick who they wanted on the board. What we are trying to do in section one of the bill is to say that the state medical association and state pharmaceutical association will each pick their four members and not send a list in to be picked by the department. The department still has the right to pick two doctors and two pharmacists, however I am certainly open to changing that. At the time of the drafting I felt the department needed at least those four people to provide a historical basis for decision-making and continuity.

There is an error in subsection f. It was my attempt to also change the person representing the pharmaceutical industry to be picked by them and not from a list. We will need an amendment for that section, if the bill moves forward.

Section E. is a new position, which adds a consumer advocate appointed by the governor. A number of other states have added that position and I feel that it would be a vital addition to the process to have a consumer advocate on the board. I think it is good public policy.

Section 2 is where the major changes to the process are called for in HB 1470. It adds a carve-out for many of the mental health drugs as well as prescriptions for HIV and cancer. In my search of what other states do, I have found that nearly 30 states have least one or more of the areas exempted with many states having all three exempted.

The rapid development of new and better drug therapy to treat those medical conditions literally means the difference of life and death for many patients. In every report that I have read on the subject, it has been shown that the use of the latest drug therapy saves the state money in the long run. There are fewer hospitalizations, less repeat treatment, less trips to the emergency rooms and the latest drug therapy often allows a patient to return to work or other normal activities more quickly.

Dr. Linda Gorman of the Washington based no-profit research and education organization, who Rep. Price and I heard at a CSG meeting in Denver reported in a report that I have attached to my testimony that: "State officials tend to overreact to costs, downgrading patient outcomes and delaying access to new treatments in an effort to control budgets".

She went on to say that in Tennessee lawmakers estimated savings of 10% from formulary controls and cut public mental health funding accordingly. Expected savings never appeared, although the quality of care declined for mentally ill patients.

She also noted that an Illinois study on treating refractory schizophrenia with the newer drug, clozapine, found the state was able to discharge 243 of 518 patients, thus saving about $20 million per year. Many other independent reports make similar findings.

A Kaiser Foundation report on the Michigan PDL said it resulted in substandard care for patients in the Medicaid program and added additional cost implications.

According to the National Mental Health Association, Medications comprise only 3 percent of the costs for treating mental illness and some experts say they may account for more than 50 percent of the positive treatment outcomes. The national association also says for every $1.00 invested in mental health early treatment and prevention programs yields a savings of $2.00 to $10.00 thus highlighting the fact that investment lowers health care costs. Conversely, cutting access to the proper medication and services increases overall costs.

I have also attached a article entitled "New Medicines for Mental Health Help Avert a Spending Crisis". The article reports some facts that were originally in "Health Affairs" and also appeared in a " Wall Street Journal from Dec. 31, 2003. Much of the article was based on a report in the "Journal of Clinical Psychiatry" also published in the same month. It supports what I am saying here today.

As several of you know, our oldest son is an economist in Boston. He sent me an article from "Business Week" that reported much of the same information. The author, Gary S. Becker, a Nobel laureate who teaches at the University of Chicago said that forecasts for increased spending on drugs do not take into account the ability of new drugs to cut total medical costs and improve the quality of life for our people.

He also noted the fact that although antidepressant drug expenditures tripled from 1990 to 2000, hospital stays declined so much that the total spending per depressed person fell. He also pointed out that the drugs enormously improved the quality of patients' lives since most people who were suffering from serious depression can now function reasonably well at work and home.

He concluded his article by saying; "New Drugs have the potential to cut the growth of Medicaid spending sharply. It is crucial to take much better advantage of this potential." I couldn't have said it any better myself.

By taking this action, none of us will ever have to face a family member who's lost a loved one while we had the proper drug therapy available but didn't allow it to be used because of cost. The state shouldn't try to balance our budget on the backs of the most vulnerable citizens of our state.

There are a number of other medical professionals and advocates here today who will provide the committee with the expert medical information they will need to make an informed decision, about the importance of the carve-out language. I would be happy to answer any questions.

1470

#1

Page 2, line 5, overstrike "who is"
Page 2, line 6, remove "appointed by the executive director of the department" and overstrike "from a list of"
Page 2, line 7, overstrike "nominees provided", remove "to the executive director", and insert immediately thereafter "appointed"

**Devlin, William R.**

**From:** Patrick B Goodman MD [pgoodman@mohs.org]
**Sent:** Monday, January 31, 2005 4:52 PM
**To:** Devlin, William R.
**Subject:** house bill no. 1470

Dear Sirs:

As a practicing psychiatrist in the Bismarck area, I understand that this bill will amend a section to a allow physicians to decide on medication decisions without prior authorization. This includes medication for mental illnesses, HIV, and cancers. I support this strongly since I believe all of my decisions involve weighing out finances as part of the process. Patients can respond to certain medications regardless of the cost of medication and I believe that physicians can make good decisions outside of administrative perspectives. I don't believe that patients fit into standard boxes/guidelines or even flowcharts are hard to apply to mental health patients. I chose medications based on symptoms, cost, and side effects, and previous responses/reactions.

Do you believe most physicians use good judgement? I do.

Sincerely,

Patrick B. Goodman MD

House Bill 1470 Testimony
February 1, 2005

Chairman Price and members of the House Human Services Committee, my name is Janet Sabol from Minot. I am in favor of HB 1470 because it exempts antipsychotic, antidepressant, or other medications used to treat mental illness from prior authorization. It is critical because well-accepted research has demonstrated that mental health consumers who have illnesses such as schizophrenia, bipolar disorder, major depression and severe anxiety disorder need access to a full array of medications to attain the best health outcomes. People with psychiatric disorders often have co-existing disabilities. Depression and anxiety are common among people with schizophrenia and bipolar disorders. Having multiple diagnoses makes it even more difficult to treat the illnesses and more important that all types of medications are at their disposal.

Science has developed our understanding of mental illness and made it possible for people coping with mental illness to lead full and productive lives when appropriate treatment and supports are available. The word "recovery" has become a common and attainable goal for many mental health consumers who would have been considered "hopeless" less than a decade ago. The newest and most effective medications are a critical component of services that have enabled them to succeed as members of their communities.

Dr. David Satcher, former U.S. Surgeon General, stated, **"There is no health without mental health."** Each year one in five Americans has a diagnosable mental illness, yet fewer than half of adults get help. There are many reasons for not seeking help including the continued stigma of having a mental illness and medications with side effects that are

enumerated on TV and in print that are unpleasant and sometimes dangerous. Weight gain is a common side effect that puts many mental health consumers' health at further risk of diabetes and cardiovascular disease. Even though there is no cure, 80-90% of mental disorders are treatable through medications and other therapies.

I understand that controlling costs is an important objective in all aspects of health care but mental disorders can be as disabling as cancer and heart disease. Their cost to society, including costs in lost productivity, is second only to cardiovascular disease. Limiting medication options can have costly results and also forces clinicians to compromise the best treatment for the patient. Ineffective treatment of mental illness causes some individuals to discontinue medications leading to expensive hospitalizations and other outcomes. Changes in treatment, motivated by cost concerns, are not only disastrous for the person who is ill but also for the taxpayers' bottom-line. The consequences of failing to provide effective medications for individuals will result in increased deaths, homelessness, incarceration in jails, prisons and juvenile justice systems and immeasurable suffering.

Medications used to treat mental illness each have unique characteristics and are not interchangeable compounds. As a person who has coped with depression for over 35 years and tried nearly all of the antidepressants, I understand the importance of having the newest and best medications available to treat the illness. For 20 years, one medication after another was tried with limited success in treating the symptoms. In 2000 a combination of five drugs kept the illness under control so that I could function "normally". Unfortunately, through the years the illness had become more difficult to treat and I had had to quite working as a professional in 1993. Just last fall, continued stress made the combination of

drugs ineffective and another drug was added until a newly marketed antidepressant was offered. I took the step of discontinuing four meds and replacing them with the new one that is not only effective but has better side effects—less drowsiness, less dry mouth and, for once, the opportunity to lose weight from exercising and appropriate diet. I just found out I am paying over 50% for this drug because it is on the non-formulary list for ND Blue Cross Blue Shield coverage, whereas the other medications were on the formulary and I paid 20%. Blue Cross Blue Shield suggests I try other alternatives—drugs I have already tried and did not effectively treat my depression. Why should I be limited to an arbitrary list of medications that are ineffective in my body when my quality of life can be improved immensely by a different medication?

Through my work as a volunteer state coordinator for NAMI: The Nation's Voice on Mental Illness, I have had contact with many mental health consumers whose lives have been literally turned around by use of the new, cutting-edge medications. Some people have been able to begin working, go off disability, return to college or accomplish other goals. Protecting access to all psychiatric medications is critical to ensuring that North Dakota citizens receive the right treatment. Without the exemption of prior authorization of psychiatric medications, the health of citizens seeking treatment under Medicaid will be at risk.

Your support of HB 1470 will be much appreciated by people coping with mental illnesses.

Janet Sabol
2205 Crescent Drive
Minot, ND 58703
701-852-8202
naminwnd@min.midco.net

## The Fact is That Psychotropic Drugs Are Not Like Other Drugs:

- The normal patient response time for psychotropic drugs is from three to six weeks. And the time it takes to eliminate the effects of these drugs is similarly lengthy. Most other medications have a response time of hours or even minutes.
- Psychotropic drugs are far more likely to induce idiosyncratic treatment responses in patients than are other medications. They also may differ in the way they affect a patient's particular symptoms. All people with schizophrenia are not alike in the way their disease manifests itself.
- Psychotropic drugs are associated with a considerable number of adverse side effects, especially when medical co morbidities, treated or untreated, are present. Although two drugs may be judged to have the same effectiveness in treating the patient's particular psychosis, they may have different reactions with other medications the patient is taking.
- Compliance is a significant issue when treating a person with mental illness with drugs, and all of the preceding factors contribute to making compliance more difficult.

## Restriction of Access to Medications Discriminates Against People with Mental Illness:

- Because of the unique nature of psychotropic drugs, the burden placed on people with mental illness will be disproportionately large if access to the appropriate medication is delayed or denied.
- This inequitable burden is arguably discrimination and creates the potential for challenges to the system that has created it.

## Restriction of Access to Medications Impairs Clinical Decision Making and Patient Care:

- The special complications for clinical decision making created by psychotropic drugs demand that interference with physician choice be minimized.
- Restrictions imposed by formulary management will interfere with clinical choices necessary to provide the most appropriate medical care, i.e., the most tolerable and effective treatment for each individual patient.

## Effective Psychotropic Drugs Are Essential to Maintaining People with Mental Illness in the Community:

- Patients who do not receive the appropriate psychotropic drugs are often unable to function as members of the general community and may require hospitalization.
- Failure to provide adequate access to psychotropic drugs may create an ADA issue (Olmstead) because the state will not be providing the necessary services for all individuals that will keep them from unnecessary institutionalization.

## Negative Fiscal Impact Created by Restriction of Access to Medications:

- Studies have shown that restricting access to drugs often fails to achieve the intended goal of cost containment because unanticipated problems are created that necessitate greater utilization of the overall health system.
- In fact, comprehensive analyses have clearly shown that:
  #There is a strong relationship between formulary restrictions and increased resource use;
  #Restrictive formularies are often associated with as much as twice the utilization of health care services as nonrestrictive formularies; and
  #Nonrestrictive formularies are almost always associated with the lowest use of overall health care resources.
- Initiatives to reduce Medicaid pharmacy expenditures must take into account the effect of 1) reduced federal financial participation for decreased state expenditures on pharmaceuticals and 2) increased state expenditures for more costly hospitalizations, emergency room visits, and physician/clinic visits.

Lewin Group: "Health Plan Benefit Barriers to Access to Pharmaceutical Therapies for Behavioral Health: Findings" SAMHSA *Managed Care Tracking System*, October 6, 1998.
Soumerai, McLaughlin, Ross-Degnan, et al: "Effects of a Limit on Medicaid Drug-Reimbursement Benefits on the Use of Psychotropic Agents and Acute Mental Health Services by Patients with Schizophrenia." *New England Journal of Medicine* 194;331:650-655

**Testimony**
**House Human Services Committee**
**Chairperson Clara Sue Price**
**Mental Health Association in North Dakota**
**February 1, 2005**

Madam Chair and members of the House Human Services Committee, my name is Chet Pulver and I'm representing the Mental Health Association in North Dakota. I've been asked to read testimony prepared by our director of public policy and advocacy, who regrets not being here today. I'll be happy to forward any questions you may have on and she will respond as quickly as possible. The testimony is as follows:

Over the past 40 years I've observed four generations struggle with severe mental illnesses and have seen the huge impact the newer, more effective medications have on people's lives. My grandmother's 29 years with schizophrenia were marked by periodic hospitalizations involving electro shock therapy and drugs that were mostly sedating. While at home she'd argue day and night with the voices that tormented her.

Today, we have medications that give back to people the control they once had over their minds and lives. And, our organization feels very strongly that these medications – and those being developed -- should be made available immediately, and not withheld for any period of time from those who desperately need them.

Suffering should not be prolonged by forcing someone to try and "fail" on a medication that was not, in a doctor's best judgement, the best choice in the first place. We are opposed to requiring that a doctor prove a drug is not "effective" before they can receive authorization to prescribe what they know to be the best therapy for an individual's full range of symptoms..

For some individuals requiring mental health drugs, trying and "failing" on a medication can mean dying or suffering irreversible brain damage. Brain image scans show the percentage of gray matter loss annually when a person is psychotic. This means that while the condition is left untreated, they are suffering brain damage. This can result in lose of cognitive abilities that will never be regained. Early diagnosis and treatment are absolutely critical for the best prognosis. Enabling doctors to prescribe the best, most appropriate, therapy the first time, every time, is paramount.

Requiring prior authorization restricts the physician's ability to use their best judgement, can force prolonged suffering, have a negative impact on outcomes and diminish a person's hope for recovery.

The language in the law which requires that a doctor prove a medication "has not been effective" also raises the following questions: What is the definition of "effective"? And, who decides? In some areas of medicine we have diagnostic tools that are clear indicators of effectiveness. Blood tests, for example, tell us how effective a drug is for lowering cholesterol. But there are no such diagnostic

tools available for measuring the effectiveness of antidepressants or antipsychotics.

We believe "effectiveness" should be based – not just on a reduction in the prominent, primary symptoms – but also on achieving the highest level of functioning and quality of life. Side effects such as sedation, weight gain (which can be 100 lbs or more), sexual dysfunction, inability to concentrate, flattening of emotions and so on, can affect a person's ability to work and interact with others.

People deserve the best therapy for their range of complex symptoms. And only a doctor and his patient can determine what that is.

Thank you, Madam Chair and Committee members, for allowing the Mental Health Association to present comments today.

TESTIMONY BEFORE HOUSE HUMAN SERVICES COMMITTEE

REGARDING HB 1470

FEBRUARY 1, 2005

Chairman Price, members of the committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Department of Human Services. I appear before you to provide testimony regarding HB 1470.

Section 1 includes some minor changes to the appointing process of members and adds a member. We would also appreciate any guidance on the identification of potential consumer representatives.

Section 2.3 includes language to exempt certain mental health, cancer, and AIDS / HIV drugs from prior authorization (PA). As a reminder, mental health drugs account for roughly 50% of our drug spend. Also, exemptions from PA are a slippery slope. It is difficult to define exactly what should be exempted. Overall, most states trust the practicing physicians and pharmacists on the DUR Board to make the appropriate decision. The fiscal note reflects the result of preventing limitations on these exempted categories of drugs. The Department does not require prior authorization of any of these medications, but we do have quantity limits, and the fiscal note is based on the termination of those limits.

I would be happy to answer any questions you may have.

HB 1474 TO
2/1/05

JOHN SAVAGEAU RPH
CHAIRMAN DUR BOARD

CONCERN: PRIOR AUTHORIZATION LANGUAGE

POINT 1. Healthcare costs are growing at a multiple rate of inflation. Within healthcare cost, drug cost(s) and utilization are a major Component of the increase in healthcare cost.

POINT 2. SECTION 50-24.6-04 SUBSECTION 3
Remove language that states " restrict single-source or brand name antipsychotic, antidepressant etc"

POINT 3. Remove Language that states "or other medications used to treat mental illnesses etc"

Result: By not removing this language, the DUR Board and states efforts to reduce It's overall drug expenditures will be limited.

Comment: "Going to a PDL is not the answer, as some have suggested" —

#2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1470

Page 3, line 1, after "disorder" insert "except for quantity limits that may be no less than the pharmaceutical manufacturer's package insert and an AB-rated generic equivalent drug for which the cost to the state post-rebate is less than the brand name drug"

Renumber accordingly.

HB 1470

# REPORT OF THE

# MEDICAID WORKING GROUP

**AUGUST, 2004**

**MEDICAID WORKING GROUP**
**AUGUST 2004**

## PREFACE

The Medicaid Working Group resulted from ongoing discussions with Governor John Hoeven regarding North Dakota's Medicaid program. The working group was formed by representatives of a number of professional, service, and advocacy organizations for the purpose of providing the Governor, the Department of Human Services (DHS), and policymakers with recommendations on how to improve the Medicaid program in North Dakota.

The working group members all have some connection to the Medicaid program as providers of service or otherwise. Special thanks to DHS and ND Health Department staff who provided information requested by the working group. All costs associated with the working group were incurred by professional, service, and advocacy organizations involved in the effort.

In many respects, the recommendations are specific in nature as to need or purpose, but may not include all details as to how each recommendation may be implemented. The working group felt strongly that the Governor, DHS, and policymakers should be allowed maximum flexibility in implementing the recommendations, consistent with the working group's goal of addressing the long-term sustainability of the Medicaid program in North Dakota.

We are at a crossroads in North Dakota with respect to our state's Medicaid program – fewer federal resources, increased cost shifting to other payers resulting from under funding of Medicaid, the need for an enhanced information systems infrastructure, more enrollees and greater needs of Medicaid recipients, growing cost pressures on service providers -- all these factors and more contribute to the need to address the long-term sustainability of the Medicaid program. The Working Group believes these recommendations can begin to address these issues while improving the quality of life for the recipients.

While the working group deliberated for about a year, one of the key recommendations is to foster improved Medicaid management through the expansion of the current Medical Care Advisory Committee. If this recommendation is implemented, the Advisory Committee is a logical vehicle for continuation of the important process of initiating improvement in the Medicaid program.

The working group expresses its appreciation to Governor John Hoeven, DHS staff, and our legislative participants, Sen. Judy Lee and Sen. Richard Brown, for their leadership in encouraging this collaborative effort.

**MEDICAID WORKING GROUP**
**MEMBER AND STAFF LISTING**

**MEMBERS:**

| | |
|---|---|
| Susan Bosak | MeritCare |
| Sen. Richard Brown | ND Legislature |
| Janis Cheney | AARP ND |
| Joe Cichy | ND Dental Association |
| John Doherty | MeritCare |
| Karen Hagel | PrimeCare health group & ND Medical Group Management Association |
| Dr. Patricia Hill | ND Pharmacists Association |
| Kathy Hogan | Cass County Social Services |
| Janelle Johnson | Community Health Care |
| John Johnson | Options |
| Galen Jordre | ND Pharmacists Association |
| Betty Keegan | AARP ND |
| Kim Krohn, M.D. | Minot Center for Family Medicine |
| Karen Larson | Community Health Care |
| Sen. Judy Lee | ND Legislature |
| Bruce Levi | ND Medical Association |
| James M. Moench | ND Disabilities Advocacy Consortium |
| Barb Murry | Pride Inc. & ND Association of Community Facilities |
| Bruce Murry | Protection and Advocacy |
| Shelly Peterson | ND Long Term Care Association |
| Rod St. Aubyn | Noridian |
| Al Stenehjem | ND Mental Health Association |
| Chip Thomas | ND Health Care Association |
| Mike Tomasko | PrimeCare health group & ND Medical Group Management Association |
| Dan Ulmer | Noridian |
| Mary Wakefield | UND Center for Rural Health |
| Les Wietstock | Towner County Memorial Hospital |
| John Windsor, D.O. | ND Medical Association |
| Tim Yellow | Indian Health Services |

**STAFF SUPPORT**:

| | |
|---|---|
| Rod Backman | Covenant Consulting Group |
| Dr. John Baird | ND Health Department |
| Barb Fischer | ND Department of Human Services |
| Celeste Kubasta | ND Office of Management and Budget |
| Dave Zentner | ND Department of Human Services |

# MEDICAID WORKING GROUP
# FINDINGS AND RECOMMENDATIONS

The Medicaid Working Group (MWG) was formed in August of 2003 for the purpose of providing recommendations, to the Governor and the Department of Human Services (DHS), to improve Medicaid in North Dakota. The group's Charter is as follows:

**"To provide information, from the perspective of providers and consumers of health care working together, that the Governor and Department of Human Services may use in developing the '05-'07 budget for Medicaid. To be useful, the information provided should present ways the group had concluded Medicaid services could be most effectively delivered, recognizing the limitations of resources."**

The Medicaid program in North Dakota is approaching a $1 billion biennial state/federal appropriation. The provision of Medicaid benefits is complex. It requires an appropriately high level of management, administration, operation and advisory oversight that befits a program of such major significance to the overall state budget in North Dakota and, more importantly, to the approximately 53,000 eligible North Dakotans who benefit from the program (in the year ended 6-30-03 there was a monthly average of 53,134 eligible individuals with an average of 38,324 recipients served per month) see appendix C. The challenge for our state's policymakers is to put recipients first in assuring the long-term sustainability of the state's Medicaid program.

## I. Medicaid Management

- Expand Medical Care Advisory Committee
  *Expand the role and composition of the federally-mandated Medical Care Advisory Committee to report directly to the Governor or the Governor's designee at least annually on all aspects of the Medicaid program, and to report to legislative leaders or committees at their request.* The composition of the Committee should be expanded from its present form to include appropriate representatives of hospitals, clinics and other service providers. In addition to its current scope of responsibilities, the role for this Medical Care Advisory Committee should include a consultative role in development of the executive biennial budget for Medicaid, and also include:

  (a) An annual review of the Medicaid fee schedules and program expenditures with a report of its findings and recommendations as needed to DHS, Legislative Council's Budget Section, and the Governor.

(b) An annual review of program administration, including program case management (including the current lock-in program), vendor relationships, and quality assurance programs and measures.

(c) An annual review of enrollment, service utilization and other program trends.

(d) An annual review of clinical performance profiles of providers and recipients, with assistance from the state's peer review organization or similar entity.

(e) Identification of state and federal rules and regulations unnecessary to operating an efficient and effective Medicaid program.

(f) An annual cost/benefit analysis of the current mandatory and optional services.

(g) An assessment of current behavioral health policies and procedures.

*Narrative:* Timely and appropriate access to quality health care is essential to the health and well being of the North Dakotans enrolled in the Medicaid program. To ensure this access, it is vital that the DHS receive meaningful, participatory input and advice from providers including long term care, home and community based service providers, health professionals, hospital and clinic administrators, Medicaid recipients, and others regarding Medicaid policy development and program administration.

Federal law requires DHS to have a Medical Care Advisory Committee for the purpose of advising the DHS about health and medical services, including participating in policy development and program administration (42 CFR, Section 431.12). However, the purpose and composition of the committee under the federal mandate is currently narrow in scope. In addition, the current committee does not meet often and provides limited input on a department-driven agenda.

The Medical Care Advisory Committee should be given a broader mandate and composition to focus on all aspects of the medical assistance program, including consideration of innovative approaches to care delivery. States have considerable discretion under current law to administer their Medicaid programs through state plan amendments and seeking waivers; however, the waiver/amendment has been viewed more as an insurmountable barrier to change in North Dakota. The Medical Care Advisory Committee can be structured in a manner that provides a positive force for addressing challenges, ensuring access for Medicaid recipients, and achieving long-term financial sustainability for the program.

## II. Medicaid Budget Process and Payments

- Develop Actuarially-Based Budget and Payments
  *Develop actuarially-based methodologies for setting Medicaid payment rates and developing agency budget recommendations, performing and reviewing data analyses, tracking program service utilization, and determining the effectiveness of quality and cost containment initiatives.* These methodologies should lead to development of the underlying basis for:

  (a) An actuarially-based executive budget process resulting in recommendations to the Legislative Assembly;

  (b) A fair and equitable payment system that funds services to appropriate levels, helping to ensure quality services can be delivered.

  (c) Periodic payment adjustments that reflect inflation, technology and overhead costs;

  (d) Establishment of service priorities (benefits and eligibility) actuarially linked to funding sources, including analyses of the relative level of spending by sector compared to other states; and

  (e) Consideration for implementing insurance concepts, including stop loss insurance.

- Address Expected FMAP Decrease
  *For the 2005-07 budget cycle, address the expected decrease in FMAP (Federal Medical Assistance Percentage) in North Dakota by considering the allocation of additional funds, including federal funds made available to North Dakota pursuant to the Jobs and Growth Tax Relief Reconciliation Act of 2003.* (FMAP is the process that the federal government uses to allocate Medicaid funds to the states. It bases the federal percentage on the economic growth of each state. States with per capita personal income growing faster than average will see their federal share decrease; conversely states with slower growth will see their share increase. Because North Dakota has seen better than average economic growth we are expecting a decrease in the Federal share. The current FMAP in North Dakota is 68.31%; however, the enhanced FMAP which ended on June 30, 2004, was 71.31%. The percentage dropped to 68.31% on July 1, 2004, and will further decline to 67.49% for the 2005 fiscal year beginning on October 1, 2004. ) Other FMAP strategies include:

  (a) In consultation with the state's Congressional Delegation, the executive branch should lead in developing a private/public sector federal Medicaid advocacy strategy. Consideration should be given to advocating for bold change in the Medicaid structure as encouraged by the National Conference of State Legislatures and other organizations.

  (b) DHS should forgo implementation of proposed new service limits and co-payments and exercise existing budget authority to spend available FMAP funds to meet its budget obligations.

- Consider Other Budget-Related Initiatives
  Other initiatives that should be pursued include:

  (a) Develop a payment system whereby providers will not be compensated less than their cost.

  (b) Investigate taking full financial advantage of the federal disproportionate share program.

  (c) Investigate taking full financial advantage of federal SSI provisions applied to Medicaid recipients.

  (d) Continue the North Dakota Healthy Steps program (SCHIP) as a separate program directed to maximize coverage for the uninsured with maximum federal financial support.

*Narrative:* For the future, North Dakota faces significant funding challenges in the Medicaid program that will directly impact the ability of the state to assure continued access to community, long term and acute care for Medicaid recipients. The willingness of providers to accept Medicaid recipients is threatened by confusion regarding eligibility and inappropriate presentation for care, low reimbursement rates that do not recognize all costs of providing care, and continued delays in claims payments, increased paperwork, new service limitations and other administrative burdens.

The executive budget process for the Medicaid program should result in budget recommendations that are actuarially sound and reliable. Currently, DHS sets payment rates based on expenditures from the prior complete year that is then trended forward based on price and utilization factors used in the Department's budget request. Various considerations may be left out of the equation, including the current health status of the Medicaid population and other major factors. The budget process should be taken to a higher level of financial sophistication, to assure legislators, participating hospitals, long term care, home and community based service providers, clinics, physicians, other health professionals, and taxpayers that the program is actuarially sound.

Payment schedules for all providers should cover the provider's cost of service delivery and should also be actuarially linked to benefit coverage and program eligibility thresholds. The current fee schedules do not account fully for the direct and indirect costs incurred. Many Medicaid providers receive payments significantly below their standard rates and in some cases below their actual cost. Adjustments that are made are piecemeal, with no apparent underlying payment philosophy, policy or framework.

In addition, as North Dakota's economy grows, federal funding support for North Dakota's Medicaid program will decrease significantly under the current FMAP financing structure, providing a new challenge in the need for additional funding to maintain the current level of recipient benefits or benefit reprioritization and provider payments in 2005-07. At the same time, health related expenditures continue to grow faster than the growth in per capita Gross Domestic Product, even though state funds supporting DHS have not kept pace with the growth in the number of recipients. See appendix C for Eligibles, Recipients and expenditures by year.

## III. Medicaid Administrative Functions

- Enhance Administrative Support Systems
  *After thorough analysis, implement options in a timely manner for building better administrative support systems, including assurance of an adequate DHS infrastructure of technology and personnel. The options considered should include outsourcing current administrative functions to experienced entities subject to adequate protections for maintaining Department control of medical and utilization information.*

  (a) In developing a new CMS-certified Medicaid Management Information System (MMIS), a request for proposal/bid process to qualified entities should be employed in assisting the Department to define, develop, implement and operate its administrative support systems.

  (b) Standards should be adopted for the promptness and accuracy of Medicaid claim payments. The claim processing function should be included in any request for proposal/bid process.

- Explore Risk Sharing or Capitated Service Delivery Options
  *Explore options for Medicaid service delivery including direct contracting with systems and/or consortia and other third party payors as appropriate for Medicaid acute care service, and expansion of managed care, risk-sharing, or capitated service delivery arrangements. These options would require DHS to provide service providers with access to information to evaluate the benefits of such arrangements.*

- Provide Access to Fee Schedules and Administrative Assistance
  *DHS should enhance its provider service function. Medicaid fee schedules should be readily available through electronic means to providers for budgeting and other purposes. Other provider services should include a Medicaid website for referrals, preauthorizations and claim follow-up and, if problems cannot be resolved, Medicaid should make available a representative that can be called upon for assistance. The current appeals process should be reviewed.*

*Narrative:* Medicaid program administration should be efficient and encourage participation by providers. However, the current MMIS is not adequate to support existing and future program administration demands, and unacceptable claims delay is currently a disincentive for provider participation in the Medicaid program. DHS is facing major capital challenges to upgrade its claims management capability, and is currently working with a consultant to identify MMIS options.

Sufficient financial resources, including access to necessary technologies, should be available for program administration, in a manner appropriate to the $1 billion biennial state/federal appropriation for the Medicaid program. The technical advantages available to commercial insurers should be available to the management and administration of the state's Medicaid program. DHS must have the management, administrative, and technology tools necessary to perform its role and functions appropriately.

## IV. Medicaid Benefits and Eligibility

- Establish a Single Point of Entry (SPE).
  *To address the confusion and lack of consistent information, DHS should establish a single point of entry for community and long term care services. The SPE should provide the public with consistent and accurate information about:*

  (a) Services available and how to access,
  (b) Funding options,
  (c) Screening and uniform assessment.

- Strike an Appropriate Balance in Pursuing the Long-Term Sustainability of the Program
  *In pursuing the long-term sustainability of the state's Medicaid program, strike an appropriate balance between the needs of recipients, the state's ability to pay, and health care providers ability to absorb the cost of providing service, including:*

  (a) An initial review of the current benefit and eligibility program by the Medical Care Advisory Committee to determine appropriateness of the current level of mandatory and optional services, and capacity for coordinating care.

  (b) A recognition that current Medicaid benefits will not be enhanced unless there is a change in commitment by either the state or federal government; new benefit commitments and changes in eligibility thresholds should not be made until an actuarial assessment and cost-benefit analysis have been completed and funding sources identified.

- Consider Wellness, Disease Management and Self-Care Initiatives
  *Consider wellness, disease management, and self-care initiatives*, including:

  (a) Review and expand as appropriate the current lock-in case management program, and

  (b) Consider appropriate initiatives developed by the Governor's Healthy North Dakota program's Third Party Payor Committee that support and promote healthy lifestyles of Medicaid recipients.

*Narrative:* The aging of North Dakota's population suggests increasing demands for health care services in the next five to ten years, especially specialized services by an older population with increased health care needs. Providers will see increasing numbers of clients with several chronic diseases. These clients will require improved coordination of care.

A lack of consistent information is a problem. In addition to multiple sources of information, there also appears to be differences in the various regions of the state and differences between rural and urban access to both services and information. Another issue that arose was the inability for some sources of information or services to be of assistance if they did not cater to the specific need presented. There are many levels of systems entry from simply receiving

information and referral (211 or Senior Info-line) to preliminary screening and finally comprehensive assessment. If there is to be one single point of entry for screening or assessment for all levels of care, it will need to be adequately funded.

Closely related to this issue is the need for an initial uniform assessment process. As individual's assessed needs change, there is a need for the money to follow the individual, to the most appropriate, least restrictive setting.

On the acute care side, Medicaid recipients should access benefits at the appropriate level of care. However, while the extent of the problem may vary by facility, there exists a substantial misuse of the emergency room as a point of presentation by Medicaid beneficiaries.

North Dakota's eligibility thresholds are more restrictive than surrounding states, while Medicaid program benefits in North Dakota are comparable with surrounding states. While enrollment in North Dakota's Medicaid program is at an all time high, claim trends are more stable.

The Medicaid program should use incentives to encourage positive health and lifestyle choices by Medicaid recipients. There is a wellness/prevention component in the Medicaid program. The program includes preventative / wellness services, including nutrition counseling (morbid obesity), tobacco cessation counseling and medications, the Health Tracks program for children, care management for pregnant women, and wellness services provided in the Altru managed care plan.

DHS should be the lead agency for educating and informing the public about Medicaid services and access. Coordination to ensure consistent information is presented is critical. DHS should partner with other public service interests including local public health units to promote healthy lifestyles as an important way to improve health and to reduce costs. In addition, efforts should be made to work with the financial, provider, insurance and legal communities to better inform the public on how to properly plan for LTC needs and costs.

DHS & the ND Health Department should be encouraged to develop pilot projects in the area of disease management. The State agencies should also encourage local entities with flexibility so as to promote new and creative approaches to providing services.

## V. Medicaid Prescription Drug Benefits

- Ensure Access to Prescription Drug Benefits
  *Ensure beneficiary access to medically necessary prescription drugs without undue administrative burdens. Specifically, DHS should redirect its cost containment strategy from one of identifying drug categories for prior authorization to the establishment of an evidence-based preferred drug list. This effort should include revision of the statute (NDCC Ch. 50-24.6) creating the Drug Use Review Board.*

Bruce Levi - HB1470

*Narrative:* As an optional Medicaid benefit in North Dakota, outpatient prescription drugs constitute over 28% of all mandatory and optional medical services. While Medicaid has experienced increases in drug payments in excess of 10% per year in fiscal years 2001 and 2002, payments actually dropped by 2% in fiscal year 2003. Medicaid credits new initiatives implemented in 2002 for "stabilizing and limiting" the growth in prescription drug costs. These initiatives included a $3 copayment imposed on brand name drugs, which resulted in the greater use of generic products.

Physicians have the primary responsibility for ensuring that Medicaid prescription drug cost containment programs support the provision of medically necessary care. While costly, prescription drugs improve the quality of life for many Medicaid recipients and are less costly than hospitalization, surgery or other therapies. Therefore, choice of drugs should be based on clinical criteria and not solely on cost.

The provider response to the current prior authorization program implemented by the new Medicaid Drug Use Review Board is mixed. Providers are increasingly opposed to the administrative burdens imposed by "piece-meal" cost containment efforts which equate to additional financial responsibilities for providers.

While there was reduction in prescription drug spending in 2002-03, expenditure growth is projected in the low double digits for the immediate future. With respect to cost containment programs, thirty states have implemented or plan to implement a preferred drug list (PDL) to control Medicaid fee-for-service prescription drug spending – lists of preferred prescription medications that recipients generally may receive without first obtaining prior authorization from a state. North Dakota has not implemented a PDL program, but the topic of PDLs with supplemental rebates is being considered by the Legislative Council's interim Budget Committee on Health Care. The Department has expressed the view in testimony to the interim committee that supplemental rebates allow a program to offer more medication choices, thereby reducing the administrative burden by decreasing the number of prior authorizations.

## VI. Housing, Assisted Living and Other Community Based Services

These recommendations for benefit enhancements should be considered only in recognition of the previous recommendation that changes in government commitments should be made before additional benefit commitments are made

- The State needs to develop a long term plan for housing for the elderly and disabled.

  (a) Develop plan to address changing demographics.

  (b) Consider funding assistance for assisted living arrangements.

*Narrative*: Helping the elderly and the disabled to live as independently as possible in the community of their preference is a key component of a least restrictive environment. Core services are necessary to support independent living. Transportation, affordable housing and adequate support to remain in the setting (Home and Community Based Services) are three core services identified as critical, but not universally available.

Transportation is an issue that affects both housing and medical access. Without adequate transportation, a person may have to choose a more restrictive setting to access services and remain safe. While it sometimes is an issue in the cities, it is more of a problem in rural areas.

Affordable assisted living is in short supply in North Dakota. In recent years, entities in the cities have begun to offer assisted living accommodations; however, these facilities tend to be upscale and not affordable to many people. The success of these entities points to the appeal such living arrangements have for elderly persons. On the surface it appears that assisted living facilities of a more affordable level would see significant usage if they were available.

A serious shortage of services through the Individualized Supported Living Arrangement (ISLA) program and Qualified Service Provider (QSP) program results in people living with inadequate support or remaining institutionalized. Additionally, low salaries for support staff lead to a shortage of workers.

The State needs to develop a long term plan for housing for the elderly and disabled. Demographics of an aging population and longer life expectancies indicate that this problem will only accelerate in years to come and it is important to begin to plan for the future.

People of moderate income fall into a housing gap when their home is no longer appropriate yet they do not need nursing home services. DHS should consider a program to subsidize assisted living facilities to a cost level that is somewhat comparable to basic care. Such a move could stimulate private sector interest in providing such living arrangements to a larger percentage of the elderly by making it more affordable.

## CONCLUSION

In North Dakota an aging population, longer life spans and accelerating medical and long term care costs are all combining to create a challenge for Medicaid in the near future. In order to avert significant financial problems, best practices in administration and programming will be required We believe the recommendations in this report are all a part of and can assist with implementation of those best practices. We are also very concerned that actions need to be taken soon. The issues are urgent, but manageable if they are addressed in a timely fashion.

**APPENDIX A**

## MEDICAL CARE ADVISORY COMMITTEE

Pursuant to Title 42, Section 431.12 of the Code of Federal Regulations, the Department of Human Services is required to have a Medical Care Advisory Committee for the purposes of advising the department about health and medical services, including participating in policy development and program administration. The committee is to consist of physicians and other representatives of the health profession who are familiar with the medical needs of the low-income population and the resources available and required for their care; members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions and cooperatives; and the director of the State Department of Health (State Health Officer). North Dakota currently has a Medical Care Advisory Committee and the members are as follows:

July 31, 2004

MEDICAL CARE ADVISORY COMMITTEE MEMBERSHIP

Terry Dwelle, M.D.
State Health Officer
Bismarck, ND

Terry Johnson, M.D.
Archway Mental Health Services
Bismarck, ND

Lynn Blakeman
St. Vincent's Care Center
Bismarck, ND

Alison Fallgatter, DDS
Bismarck, ND

Amy Fleck, O.D.
Family Vision Clinic
Bismarck, ND

David Peske
ND Medical Assoc.
Bismarck, ND

Delores Farrell
Public Member
Bismarck, ND

Connie Glasser
Public Member
Bismarck, ND

Gary Bettig, M.D.
Medical Consultant
Medical Services, DHS
Bismarck, ND

Howard Anderson, R.Ph.
Turtle Lake, ND

**APPENDIX B-1**

## Overview of North Dakota's MR/DD Waiver Program

North Dakota received approval to begin implementation of its Home and Community Based Services Waiver program serving individuals with mental retardation and developmental disabilities beginning April 1,1983. North Dakota's MR/DD Waiver allows individuals to receive case management, homemaker, personal care, adult day health, habilitation, family support services, respite, family training-infant development and adult family foster care.

The populations that are served on this waiver are the following: individuals who have a diagnosis of mental retardation and developmental disability, require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), be financially eligible for Medicaid (for this waiver the eligibility is the aged, blind or disabled who meet requirements that are more restrictive than those of the Supplemental Security Income (SSI) program and the medically needy) and require home-based services which are no more costly than institutional services.

The Disabilities Services Division, Developmental Disabilities Unit, directly operates the waiver, however; the State Medicaid Agency (Medical Services) exercises administrative discretion in the administration and supervision of the waiver. The philosophy of the DD Unit regarding operational status of this waiver involves input from a variety of individuals who function as a team and who have different responsibilities for ensuring the operational functioning of the waiver program.

Based on the assurances North Dakota had provided the Centers for Medicaid and Medicare Services, our request for renewal of our waiver was approved for a 5-year period, effective April 1, 2004. Currently, there are approximately 2,600 recipients of waiver services.

## 1915(c) MEDICAID WAIVERS FOR HOME AND COMMUNITY BASED SERVICES FOR THE AGED AND DISABLED

A home and community-based services (HCBS) waiver is an agreement between the Centers for Medicare and Medicaid (CMS) and the State's Medicaid Agency. HCBS waivers enable the eligible individual to choose between institutional care or, if his/her needs can still be met, living in community. In 1981 the federal government acknowledged the Medicaid Program had a bias toward funding institutional care, such as nursing homes. HCBS waivers were developed as a means of countering that bias, with the stipulation that the cost of community support services cannot cost more than institutional care. The Waiver provides federal matching funds for needed services otherwise not available under the State's Medicaid Program. A maximum of $2,400 per recipient per month is allowed.

## ELIGIBILITY FOR AGED & DISABLED WAIVER

- Medicaid recipient, and
- Screened at nursing facility level-of-care, and
- At least 65 years of age OR disabled by Social Security Disability criteria, and
- Capable of directing his/her own care or legal authority, and
- Lives in own home/apartment (not dormitory or other group housing), and
- Has service/care need(s) that can be met within scope of this Waiver.

## SERVICES AVAILABLE UNDER AGED & DISABLED WAIVER

HCBS Case Management
Personal Care Service
Chore Service
Adult Day Care
Specialized Equipment
Respite Care
Adult Family Foster Care
Homemaker
Non-Medical Transportation
Environmental Modification
Training Family Members
Adult Residential Service

## PROVIDER REQUIREMENTS

Clients select their provider(s) from the "QSP LIST" issued by the Aging Services Division to the county social service office for each service provided in that county.

12/

# 1915(c) MEDICAID WAIVERS FOR HOME AND COMMUNITY BASED SERVICES
## TBI

A home and community-based services (HCBS) waiver is an agreement between the Centers for Medicare and Medicaid (CMS) and the State's Medicaid Agency. HCBS waivers enable the eligible individual to choose between institutional care or, if his/her needs can still be met, living in community. In 1994 North Dakota received approval for a Medical Waiver for TBI.

## ELIGIBILITY FOR TBI

- Receiving Medicaid, AND
- Screened in need of nursing facility level-of-care AND
- Disabled by social security criteria AND
- 18 years of age and over (does not have IEP) AND
- A diagnosis, which is not degenerative or congenital, of traumatic brain injury or acquired brain injury (e.g. anoxia, infections, CVA, aneurysms, tumors which are not expected to result in death, toxic chemical reactions) resulting in significant emotional, behavioral, or cognitive impairments AND
- Be capable of directing care as determined by inter-disciplinary team or, if not, legal party to act in their behalf AND
- Neuropsychological Evaluation

## SERVICES AVAILABLE UNDER AGED & DISABLED WAIVER

TBI Case Management
Personal Care Service
Chore Service/ERS
Transitional Care
Specialized Equipment
Respite Care
Prevocational Services
TBI Residential Care
Supported Employment
Non-Medical Transportation
Environmental Modification
Training Family Members
Substance Abuse Counseling
Behavior Management

## PROVIDER REQUIREMENTS

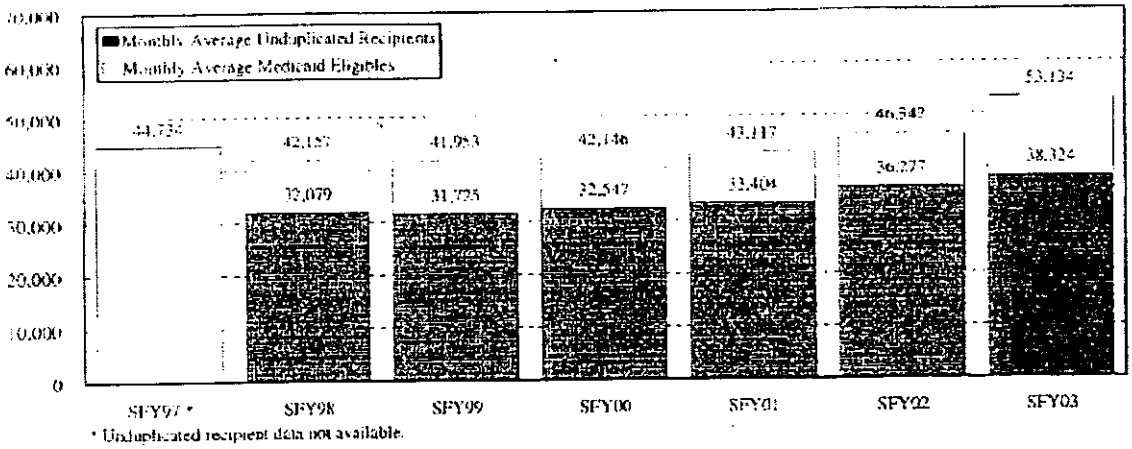
Clients select their provider(s) from the "QSP LIST" issued by the Aging Services Division to the county social service office for each service provided in that county.

APPENDIX C-1

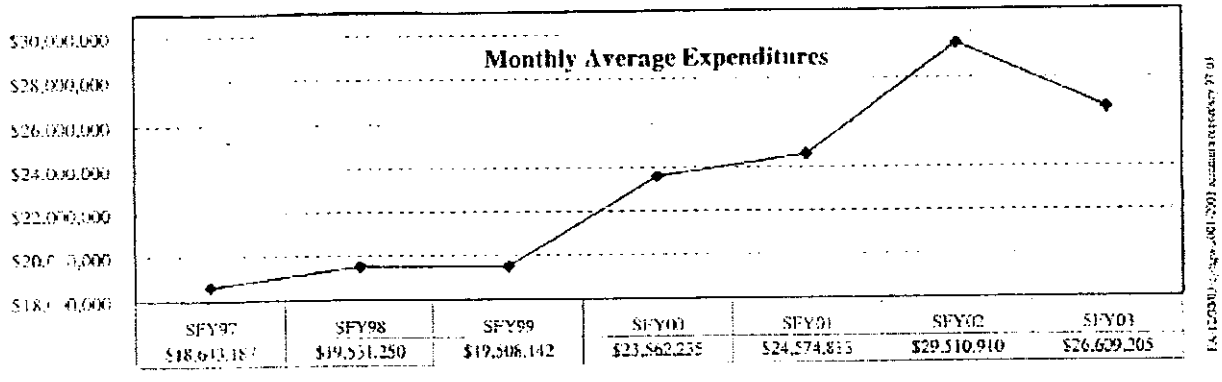
North Dakota Department of Human Services

# Medicaid

*Monthly Average Number of Eligibles, Recipients, and Expenditures by State Fiscal Year*



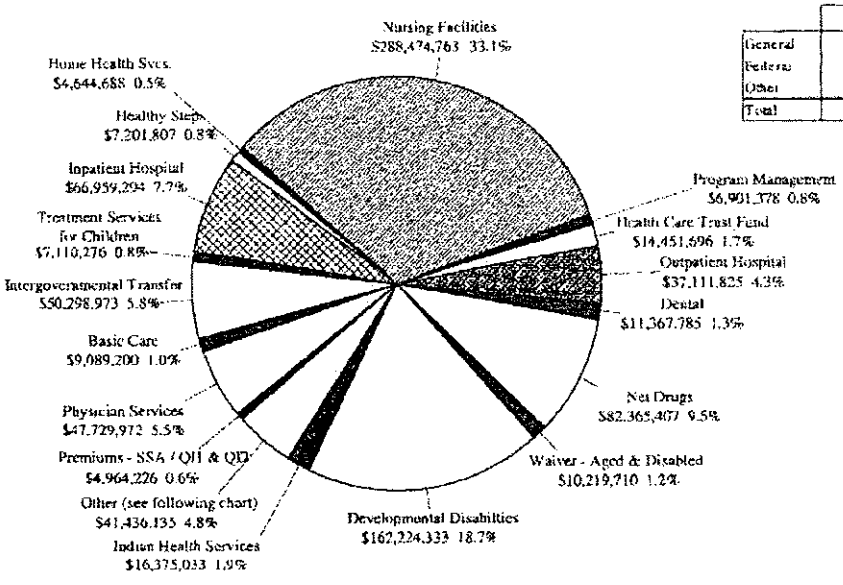

* Unduplicated recipient data not available.




| SFY97 | SFY98 | SFY99 | SFY00 | SFY01 | SFY02 | SFY03 |
|---|---|---|---|---|---|---|
| $18,613,187 | $19,551,250 | $19,508,142 | $23,562,235 | $24,574,833 | $29,510,910 | $26,609,205 |

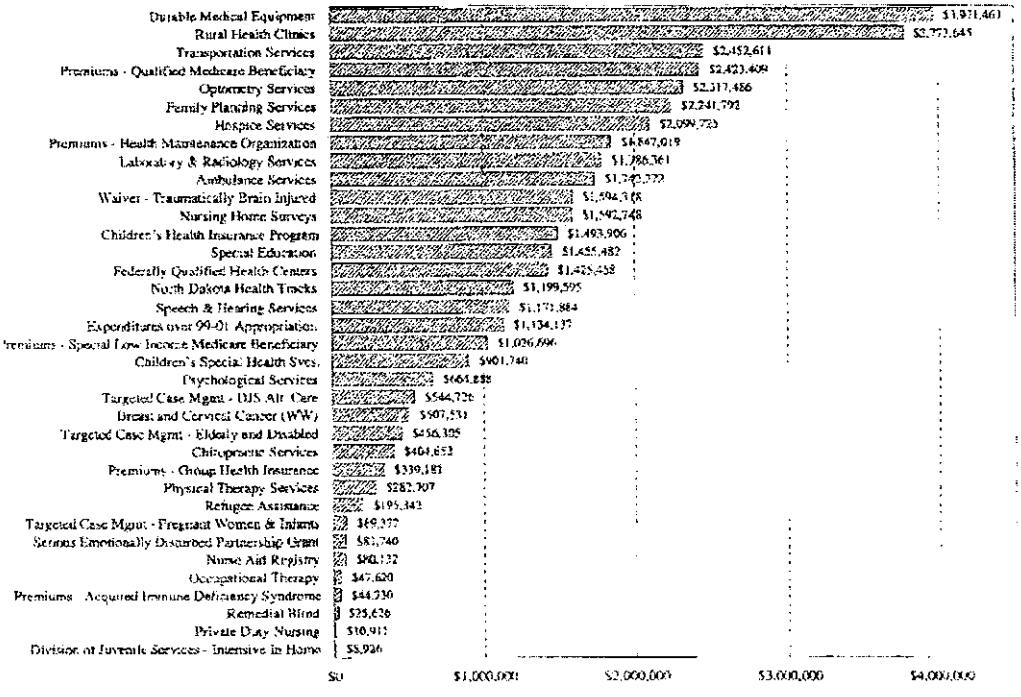
Source- DHS 2001-2003 Biennial Report

# Medical Services Expenditures
## 2001-2003 Biennium




| | Funding | Percent |
|---|---|---|
| General | $224,566,916 | 25.8% |
| Federal | $592,288,875 | 68.2% |
| Other | $52,070,710 | 6.0% |
| Total | $868,926,501 | 100.0% |

## Total of "Other" Expenditures ($41,436,135)
## Medicaid Division (Including DD Grants)
### 2001-2003 Biennium




Source- DHS 2001-2003 Biennial Report

Attachment 1

Good morning Senator Lee and esteemed members of the Senate Human Services Committee.

For the record, I am Representative Bill Devlin, District 23 of Finley. District 23 is a rural district made up of all of Griggs and Nelson Counties along with portions of Steele, Eddy and Benson Counties.

HB 1470 makes some changes to the Drug Utilization Review Board and also makes changes to the prior authorization process in our state. However, they are not costly changes as the department said there will be no fiscal note or it would be less than $5,000.

When we set up the DUR Board last session, the legislature wanted an independent DUR Board that wasn't under the control of the legislature or the department. In section one we make sure that the medical professionals in our state organizations would pick who they wanted on the board. We direct the state medical association and the state pharmaceutical association to each pick their four members and not send a list in to be picked by the department. The department still has the right to pick two doctors and two pharmacists to provide a historical basis for decision-making and continuity. We are also allowing PHARMA to pick their nonvoting member instead of sending in a list.

Section E. is a new position, which adds a consumer advocate appointed by the governor. A number of other states have added that position and I feel that it would be a vital addition to the process to have a consumer advocate on the board. I think it is good public policy.

Section 2 is where the major changes to the process are called for in HB 1470. It adds a carve-out for many of the new mental health drugs as well as new drugs for HIV and cancer. In my search of what other states do, I have found that nearly 30 states have least one or more of the areas exempted with many states having all three exempted.

The rapid development of new and better drug therapy to treat those medical conditions literally means the difference of life and death for many patients. In every report that I have read on the subject, it has been shown that the use of the latest drug therapy saves the state money in the long run. There are fewer hospitalizations, less repeat treatment, less trips to the emergency rooms and the latest drug therapy often allows a patient to return to work or other normal activities more quickly.

However, we also make it clear that we expect the department to use the generic equivalents, if available, and they have a right to limit quantities. They have those powers of decisions now and we agree to preserve them. If there are not generic equivalents available, we want the doctors and other medical providers to have every right to use the latest drug therapy which has the most likelihood to treat those diseases successfully.

I also have a small amendment dealing with that section, which I understand the department supports. It changes the word "and" to "or" in that section to insure the department has the right to use the generics or limit quantities or do both if they wish.

Chairman Lee, I know you have some new board members this session and I have attached several attachments dealing with the prior authorization process as well as the importance of carve-outs for mental health drugs. I won't go through all of them now but I hope your committee will have an opportunity to glance through them at their convenience.

Dr. Linda Gorman of a Washington based nonprofit research and education organization, who Rep. Price and I heard at a Council of State Governments meeting in Denver, reported in one of the attachments that "State officials tend to overreact to costs, downgrading patient outcomes and delaying access to new treatments in an effort to control budgets".

In the same report, Dr. Gorman discusses an Illinois study on treating refractory schizophrenia with the newer drug, clozapine. The study found the state was able to discharge 243 of 518 patients, thus saving about $20 million per year. Many other independent reports make similar findings.

I have also attached an article entitled "New Medicines for Mental Health Help Avert a Spending Crisis". That article reports some facts that were originally in "Health Affairs" and also appeared in a Wall Street Journal article from Dec. 31, 2003. Much of that article was based on a report in the "Journal of Clinical Psychiatry" also published in the same month. It supports what I am saying here today.

In another attachment, the National Mental Health Association reports that medications comprise only 3 percent of the costs for treating mental illness and some experts say they may account for more than 50 percent of the positive treatment outcomes. The national association also says for every $1.00 invested in mental health early treatment and prevention programs yields a savings of $2.00 to

$10.00 thus highlighting the fact that investment lowers health care costs. Conversely, cutting access to the proper medication and services increases overall costs.

As several of you know, our oldest son is an economist in Boston. He sent me an article from "Business Week" that reported much of the same information. The author, Gary S. Becker, a Nobel laureate who teaches at the University of Chicago said that forecasts for increased spending on drugs do not take into account the ability of new drugs to cut total medical costs and improve the quality of life for our people.

He also noted the fact that although antidepressant drug expenditures tripled from 1990 to 2000, hospital stays declined so much that the total spending per depressed person fell. He also pointed out that the drugs enormously improved the quality of patients' lives since most people who were suffering from serious depression can now function reasonably well at work and home.

He concluded his article by saying; "New Drugs have the potential to cut the growth of Medicaid spending sharply. It is crucial to take much better advantage of this potential." I couldn't have said it any better myself.

Chairman Lee and members of the Senate Human Service Committee by supporting this bill, none of us will ever have to face a family member who's lost a loved one while we had the proper drug therapy available but didn't allow it to be used because of cost. The state shouldn't try to balance the budget on the backs of the most vulnerable citizens of our state.

Chairman Lee and members of the Committee that concludes my testimony. I would be happy to try answer any questions. However, I will note there are a number of other medical professionals and advocates here today who will provide the expert medical information you will need to make an informed decision about the vital importance of the carve-out language to our most vulnerable citizens.

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1470

Page 2, line 30, replace "and" with "or"

Renumber accordingly.

http://washingtonpolicy.org/HealthCare/PBGormanTreatmentDenied.html

# New Study Finds State Drug Formulary Programs Adversely Impact the Most Vulnerable Patients

Seattle - A new study by Washington Policy Center Adjunct Scholar Linda Gorman, Ph.D. examines existing state drug formulary policies as lawmakers in Olympia consider creating a similar program in an effort to reign in rising public health care costs.

The study, titled **"Treatment Denied: State Formularies and Cost Controls Restrict Access to Prescription Drugs,"** examines formulary programs in Florida, Oregon, Michigan and other states for lessons that may help Washington lawmakers as they debate the merits of such programs.

Among the study's major findings:

· Adverse impact on vulnerable patients. The study found that state formulary drug programs have an adverse impact on the most vulnerable patient populations, particularly the poor, the mentally ill and people living with diabetes and HIV/AIDS.

· Reduced health care quality. The research found that centralized control of prescription drugs affects the quality of health treatment by shifting medical decision-making from patients and their doctors to state agency managers.

· "Fail first" policy. Formulary regulations in many states require mental patients to "fail" on older, cheaper drugs before they are allowed access to newer and more expensive treatments.

· Lack of performance measures. Formulary programs were often instituted without proper trials, evaluation or safeguards. They generally avoid traditional benchmarks that identify and measure performance shortcomings.

· Cost-driven health care. State officials tend to over-react to costs, downgrading patient outcomes and delaying access to new treatments in an effort to control budgets.

· "Off-label" ban. Formulary programs often forbid "off-label" uses of new drugs, barring doctors from using new treatments in the most effective way.

· Expected savings seldom materialize. In Tennessee lawmakers estimated savings of 10% from formulary controls and cut public mental health funding accordingly. Expected savings never appeared, although quality of care declined for mentally ill patients.

· Delayed access. The study found state formulary programs can cause treatment delays, suffering and death. Local newspapers reported a death associated with the Florida program, because a patient skipped doses while waiting for approval required by state formulary regulations.

The greatest impact of a Washington formulary program would be on the state's Medicaid program. About 293,000 people in Washington received prescription drug under Medicaid in 1997; roughly 17% were elderly, 33% were blind or disabled, 30% were children, and 20% were low-income adults.

Study author **Linda Gorman** found that although formulary programs were promoted as money savers, they tended to increase total health care expenditures. "By delaying access to therapies that are found in formulary programs, restricting access to needed drugs ensures that sicker patients will visit doctors and hospitals more frequently," **Gorman said.**

For example, an Illinois study on treating refractory schizophrenia with a new drug, clozapine, found that the state was able to discharge 243 of 518 patients, thus saving about $20 million per year. Yet clozapine is expensive, and may not qualify for Washington's formulary program. The Policy Center found that Oregon's Health Plan Drug Formulary, unlike a proposed formulary plan for Washington, specifically exempts drugs used to treat cancer, mental illness and HIV/AIDS. "The fact that these exemptions are allowed at all shows that government health care officials are perfectly aware that limiting drug choices can compromise patient care," **said the Center's research director, Paul Guppy.**

Dr. Gorman is available for media interviews.

The study is available free by calling **1-888-972-9272**, and on the Internet at **www.washingtonpolicy.org.**

Washington Policy Center is a non-profit, 501(c)(3) research and education organization.

1C

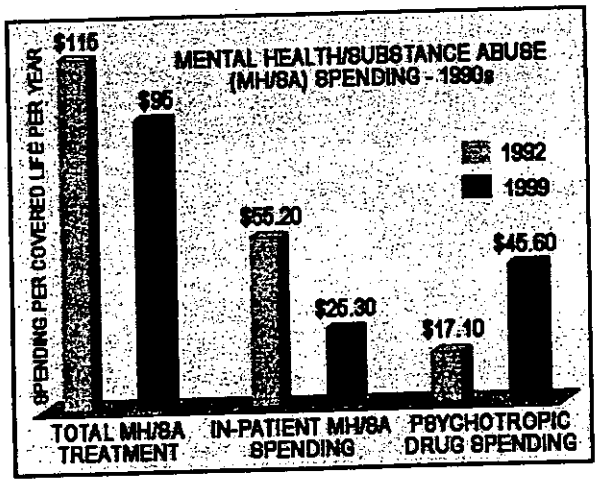
# New Medicines for Mental Health Help Avert a Spending Crisis

Advances in the treatment of depression and other mental illnesses over the last decade offer a dramatic illustration of how the discovery and use of new medicines improved patient care and helped contain treatment costs.

In the 1980s, the rising cost of mental health care was a growing concern for insurers and employers. Media reports highlighted this concern, stating that rapid increases in spending on mental health were expected to continue, threatening to put increased pressure on employer health costs and insurance premiums.[1,2]

However, a recent study published in *Health Affairs* finds that in the 1990s, as newer, better medicines were introduced for depression, schizophrenia and other disorders, this threat did not materialize. In fact, the study found that, as a percentage of total private insurance spending, mental health/substance abuse expenditures fell from 7.2 percent in 1992 to 5.1 percent in 1999.[3]

The study notes that "new medications such as selective serotonin reuptake inhibitors (SSRIs) and atypical antipsychotic medication have reduced the side effects associated with psychotropic treatment of depression and schizophrenia, allowing for improved compliance and perhaps a reduced need for inpatient care."




The study went on to say that while spending on pharmaceuticals for mental health and substance abuse disorders rose by 8.9 percent between 1992 and 1999, overall treatment costs for those disorders fell from $115 to $95 per member per year. The increase in spending on medicines was outweighed by a 15.6 percent decrease in hospital inpatient spending for mental health and substance abuse treatment.

Results of a second study on the costs of treating depression echo the findings of the *Health Affairs* research. "The cost of treating a depressed person fell throughout the 1990s, largely because of a switch from hospitalization to medication," the *Wall Street Journal* said in a December 31, 2003, story on the study. The study, published in the *Journal of Clinical Psychiatry* in December 2003, found that per-patient spending on depression fell by 19% over the course of the decade.[4] As a result, while 56% more people with depression received treatment in the 1990s, the total national costs for treatment rose only seven percent.

*Continued from page 1*

Depression is the most common mental illness, affecting 18.8 million Americans (9.5% of the population) every year.[5] A huge clinical and economic impact results from this disorder. Depression severely affects a person's ability to work productively and is the leading cause of disability in the U.S.[6] Recent estimates of the cost to the U.S. economy of lost productivity and absenteeism due to depression put the figure at $52 billion.[7]

*The cost of treating a depressed person fell throughout the 1990s, largely because of a switch from hospitalization to medications.*

Despite the recognized benefits of adequate treatment for mental health disorders, many patients – including those with insurance – still do not receive it. For example, in 2002 data reported by private health plans to the National Committee for Quality Assurance (NCQA), only 40.1% of insured patients (in plans reporting to NCQA) with depression "received effective continuation phase treatment," which includes six months of therapy with antidepressant medicines. It is estimated that with proper care of every American suffering from depression, employers would regain 8.8 million work days now lost to depression.[8] This gap between recognized standards of care and the care patients obtain highlights the opportunity to improve patients' lives and health care affordability with appropriate use of medicines.

*It is estimated that with proper care of every American suffering from depression, employers would regain 8.8 million work days now lost to depression.*

Introduction of innovative pharmaceuticals to treat depression, schizophrenia, and bipolar disorder illustrates the potential of new medicines to improve patient care and curb overall health care costs. As new pharmaceuticals become available it will be possible to achieve better clinical outcomes, fewer side effects, greater compliance, and lower costs.

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[1] LD Williams. "Getting Therapy for the High Cost of Mental Health Benefits: To Cope with Soaring Costs, More Companies Turn to Contractors who Provide Thrifty Mental Health Services," *Los Angeles Times*, 5 August 1990, Business, part D, p. 1.

[2] S Nohlgren, "Insurance Cost Crisis Expanding," *Saint Petersburg Times*, 30 April 1989, p. 1B.

[3] TL Mark and RM Coffey, "What Drove Private Health Insurance Spending on Mental Health and Substance Abuse Care, 1992-1999?," *Health Affairs*, 22 (2003): 1, 165-172.

[4] PE Greenberg, et al., "The Economic Burden of Depression in the United States: How Did It Change Between 1990 and 2000?" *Journal of Clinical Psychiatry*, 64 (2003): 1465-1475.

[5] National Institute of Mental Health Website, September 2002, <http://www.nimh.nih.gov/publicat/depression.cfm> (7 January 2004).

[6] Pharmaceutical Research and Manufacturers of America, ""How Much Do Managed Care Companies Spend on Prescription Medicines?" (Washington, DC: PhRMA 2003).

[7] PE Greenberg, et al., "The Economic Burden of Depression in the United States: How Did It Change Between 1990 and 2000?" *Journal of Clinical Psychiatry*, 64 (2003): 1465-1475.

[8] Pharmaceutical Research and Manufacturers of America, ""How Much Do Managed Care Companies Spend on Prescription Medicines?" (Washington, DC: PhRMA 2003).

Business Week article

MARCH 22, 2004

ECONOMIC VIEWPOINT

By Gary S. Becker

# New Drugs Cut Costs, And Medicare Can Help

Spending on medical care is forecast to keep growing fast during the next several decades. Health-care costs as a share of gross domestic product jumped from 5% in 1980 to more than 15% in 2003. They are projected to rise to almost a quarter of GDP by 2030. But through greater reliance on new drugs, it may be possible to slow the hike while greatly improving health if Medicare and other health-care plans are structured correctly.

Since Western European nations and Japan have also experienced large and continuing growth in medical spending, a common belief is that most of this jump stems from the aging of the population. However, a recent article by David Cutler, a leading health economist at Harvard University, shows that aging explains less than half of past and projected hikes in health-care costs in all Organization for Economic Cooperation & Development countries. Cutler concludes that about a third of the future growth in medical spending by the U.S. will be due to an aging population, with the rest resulting from a continuation of the trend toward greater medical spending at each age on new equipment and procedures.

**BUT HIS AND OTHER FORECASTS** may overstate future spending because they do not take into sufficient account the ability of new drugs to cut total medical costs and improve the quality of life. For example, a recent study in the *Journal of Clinical Psychiatry* reported that antidepressant expenditures increased from about $400 per depressed person in 1990, to $1,300 in 2000, but hospital stays declined by so much that total spending per depressed person fell. These drugs enormously improved the quality of patients' lives, since most people who were suffering from serious depression can now function reasonably well at work and home.

Frank R. Lichtenberg of Columbia University Graduate School of Business has shown that new drugs also made important contributions to the decline of adult mortality in the U.S. and more than 50 other nations after 1982. There is considerable evidence that men and women are willing to pay generously for still further progress in raising life expectancy and for improvements in the quality of their lives.

I believe that the contribution of more effective drugs will become even more important during the next several decades as progress accelerates in finding ways to treat Alzheimer's disease, cardiovascular disorders, cancers, AIDS, diabetes, nerve disorders such as Parkinson's disease, and other serious medical problems. Better understanding of DNA and the genome will stimulate the development of treatments and lead to new drugs that are tailored to individuals.

The share of drugs in future medical spending is likely to increase sharply. But even without full cures, drugs that greatly delay the onset and severity of major diseases will reduce expensive and unproductive time spent in hospitals, nursing homes, and under the care of family members.

Since costly medical care is concentrated at older ages, it is important to get a well-crafted system of drug coverage integrated into the Medicare system. Unfortunately, the law passed at the end of last year to include drugs has defects that should be corrected before it goes into full effect in 2006. Medicare will then pay all patient spending on drugs up to $250 per year for eligible persons who elect this coverage. It will pay 75% of drug expenditures from $251 to $2,250 but then pays nothing until spending reaches $5,100 -- the so-called donut in drug coverage. Thereafter, Medicare will pay 95% of all additional drug costs.

The drug deductible should be raised to $1,000, since the elderly mainly want coverage for expensive drugs that reduce lengthy hospital and nursing-home stays. The elderly poor already have all of their spending on drugs covered by Medicaid. Medicare should then pay about 50% of drug outlays from $1,000 to $3,000 before its share rises to 75% for spending up to $5,000, and increases further, to perhaps 95%, for all additional drug expenditures. These changes would raise the burden on Medicare patients with less than $3,700 in annual drug outlays. However, they would reduce the cost to patients who need them most: those who require expensive drugs for serious diseases and disorders. These changes could also help reduce overall health-care costs.

New drugs have the potential to cut the growth of medical spending sharply. It is crucial to take much better advantage of this potential.

Gary S. Becker, the 1992 Nobel laureate, teaches at the University of Chicago and is a Fellow of the Hoover Institution.

# Limiting Medicaid Patients' Access to Mental Health Medications Is Not Fiscally Responsible

More than half of mental illness specialty care programs surveyed found that **prior authorization barriers** and denials of drug coverage **caused problems** for patients, including hospitalization, missed dosages and increased side effects.

*International Patient Advocacy Association*

*1999 Study by the Michigan Mental Health Association and the Michigan Psychiatric Society*

Every $1.00 invested in mental health early treatment and prevention programs yields a savings of $2.00 to $10.00, thus highlighting the fact that investment lowers healthcare costs. Conversely, **cutting access to the proper medication and services increases overall costs**.

*National Mental Health Association*

*"Labor Day 2001 Report – Untreated and Mistreated Mental Illness and Substance Abuse Costs U.S. $113 Billion a Year"*

In the case of treating depression, **only 30% of patients respond to the first anti-depressant prescribed** to them, and 70% may eventually require a change in medications.

*Kaiser Commission on Medicaid and the Uninsured*

*"Case Study: Michigan's Medicaid Prescription Drug Benefit"*

**Medications comprise only 3% of costs for mental illnesses**, and some experts contend that they may be responsible for more than 50% of positive treatment outcomes.

*National Mental Health Association*

*NMHA Policy Positions on Restrictive Formularies*

Attachment 2

Testimony of
Terry M. Johnson, M.D.

For the
Senate Human Services Committee

Re: HB 1470

Rational for unrestricted use of psychotropic medications from the perspective of a busy practitioner.

I am speaking for myself as a psychiatrist practicing at St. Alexius Medical Center in Bismarck, who sees hundreds of psychiatric patients per month and who treats many of the treatment resistant mood disorders in the area as well as many other severe psychiatric problems in the adult population. The practice of psychiatry is both very challenging and exciting. We are able to successfully treat people with severe disorders such as schizophrenia and the most severe depression and bipolar disorders as well as many other psychiatric illnesses. The use of medications for these disorders has advanced greatly in the past 40 or 50 years since we started using chlorpromazine (Thorazine) and imipramine (Tofranil) to even more dramatic results as we moved into the newer generation of antipsychotics and antidepressants and antiepileptics (used as mood stabilizers). People who used to be warehoused in the State Hospital with no hope of improvement, suddenly were given hope. Schizophrenic patients on Clozaril and some of the other novel antipsychotics (Zyprexa, Risperdal, Geodon and others) are now sometimes able to go to college and/or get full time jobs with benefits. Not all of the seriously mentally ill are that fortunate, but many more than before are. For some a more realistic goal is for them to have a better life with their family and to stay out of the hospital and to be less tormented with voices, delusions and mood swings.

Following are some of the benefits and cost savings of having available the needed treatments for our patients:

- decreased utilization of other medical services
- decrease Emergency Room visits
- often decreases the severity or even existance of comorbid illnesses and physical pain
- decreased death through suicide or inadvertant death through associated problems
- decreased hospitalization
- increased productivity

Other issues to consider:

- Treating into remission and preventing relapse -- We have learned that our patients do the best, if their mood disorder is treated into full remission. With less than that they are more prone to relapse. We have also learned that the more they relapse the more treatment resistant they become and the more likely they are to keep relapsing. The more they relapse the more likely they are to relapse, and the longer they stay healthy or are in remission the longer tend to stay that way. If we are required to go through a progression, starting with the cheaper medications and then have them relapse to go to the next level of meds, we may be causing increased illness and morbidity and much more suffering and expense in the long run. If I can do what I determine to be the best treatment for the patient at the start, I have an increased liklihood of success and decreased liklihood of making their illness worse.

- Some patients need multiple medications to get the best results. I have patients I have worked with over months and years to find the right combination to keep them out of the hospital and decrease their suffering, and in some cases get them back to work. This is often with multiple medications, carefully combined, often along with some psychotherapy, and always taking into account their other comorbid illnesses and medications.

Treating psychiatric patients is very complex. Physicians and other practitions have many tools to use in treating these patients. The current array of medications are some of our most powerful tools. The best results, I believe, are attained when an experienced physician can take into account the multiple variables and wisely combine that with the treatments available and then determing the best treatment for that patient at that time. Some of the variables include

- the diagnosis (recognize that this is not usually black and white -- there are many variations, shades and blending of diagnoses that can make a difference in what treatment is chosen)
- comorbid conditions
- family history
- the patient's preconceived ideas about their illness or certain treatments
- compliance issues
- the psychological dynamics going on between patient, treater, family and others
- many more.

The bottom line is that medical/psychiatric treatment is a complex process, and to get the best results the practioner needs the ability to choose the best treatment for the situation, and not have roadblocks preventing that.

Thankyou.

Attachment 3

**TESTIMONY BEFORE SENATE HUMAN SERVICES COMMITTEE**
**REGARDING HB 1470**
**MARCH 8, 2005**

Chairman Lee, members of the committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Department of Human Services. I appear before you to provide testimony regarding HB 1470.

Section 1 includes some minor changes to the appointing process of members of the Drug Utilization Review (DUR) Board and adds a member. The Department hopes that these changes will encourage physicians to agree to serve on the board because we have continuously been short of the 6 physician members since the DUR Board was restructured.

Section 2.3 includes language to exempt certain mental health, cancer, and AIDS / HIV drugs from prior authorization (PA). As a reminder, mental health drugs account for nearly 50% of the Medicaid drug expenditures. Also, exemptions from PA are a slippery slope in that it is difficult to define exactly what should be exempted. Overall, most states trust the practicing physicians and pharmacists on the DUR Board to make the appropriate decision.

Since HB 1470 passed the House, the Department has already experienced several issues concerning the exemption of drug classes from the PA process. First, a pharmaceutical representative for a new pain medication stated to me that Medicaid could not prior authorize the new drug (if HB 1470 passes) since it is used for cancer patients. This is the type of argument that will become more common if exclusions are allowed. Second, an analysis of the effect of Medicare Part D on ND Medicaid shows that psychiatric medications will account for an even higher percentage of drug expenditures than they do now. The type of medications will shift somewhat as children are the largest users (e.g. attention deficit disorder drugs). Third, as the President's proposed budget includes

significant planned savings obtained by changes in Medicaid, the landscape that exists today may not exist in the future. What may appear to be a good idea today may not be as appropriate in the future. Fourth, final rules for Medicare Part D were recently issued, and despite calls for exemptions, the above classes were not exempted from prior authorization. In fact, the Centers for Medicare and Medicaid states that prior authorization may be useful in the case of anti-nausea drugs for cancer patients to ensure that the appropriate plan is billed for the drug (Part B vs. Part D).

The Department would prefer to let the DUR Board determine through scientific evidence whether a particular drug or drug class should be exempted from the PA process.

We would also suggest the following changes for page two, starting on line 30 "~~an~~ AB-rated generic equivalent drug<u>s</u> for which the cost to the state postrebate is less than the brand name drug<u>s, in the aggregate</u>." As drug rebates are not known in advance, and can and do change from quarter to quarter retrospectively, there will be cases where the generic is cheaper one quarter and more expensive in the next quarter. The Department does not want to cause an undue burden on providers or us to have to continuously monitor and change policies and procedures in this area. This language is similar to federal guidelines on another part of the pharmacy services (Federal Upper Limits).

The fiscal note remains $0 because ND Medicaid has not planned on prior authorizing any of the medications in these drug classes in the foreseeable future.

I would be happy to answer any questions you may have.

"Lee, Judy E."
<jlee@state.nd.us>

03/28/2005 05:34 PM

To: <shms@state.nd.us>
cc:
Subject: 1470

Cathy - There is some confusion about the votes on 1470. The amendment passed 5-0. The bill passed 4-1. Please make the correction in the minutes.

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