Approved 4-10-92
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by SENATOR ROY M. EHRLICH at
Chairperson

2:00 ~~a.m./~~p.m. on April 7, 1992 in room 527-S of the Capitol.

All members were present except:

Committee staff present:
Emalene Correll, Legislative Research
Bill Wolff, Legislative Research
Norman Furse, Revisor's Office
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Dick Pratt, Super D Drugs, Owner
William W. Sneed, Health Insurance Association of America
Brenda Eddy, Kansas Commission for the Deaf and Hearing Impaired
Mary Ann Gabel, Behavioral Sciences Regulatory Board
Bill Henry, Pharmaceutical Manufacturers Association
Bob Williams, Kansas Pharmacists Association

Chairman Ehrlich called the meeting to order at 2:00 p.m.

The Chairman asked for consideration of the minutes of March 30, 31, and April 1, 1992. Senator Hayden made a motion to approve the minutes as presented, seconded by Senator Strick. No discussion followed. The motion carried.

Continued Hearing HB 3064 - Out-of-state pharmacy registration.

Dick Pratt, owner of Super D Drugs - Topeka, appeared in support of **HB 3064** and expressed concern why Kansas should make it easier for firms outside of the state to do business with Kansas residents than firms within the state. Mr. Pratt believes the same restrictions and requirements should be made on out-of-state pharmacies as is placed on pharmacies in the state.

Bill Sneed, Health Insurance Association of America, submitted written testimony on **HB 3064** and stated there should be reasonable registration of mail-service pharmacies to assure a safe, effective means of dispensing prescriptions drugs, however, his organization is concerned with the bill in its present form. Subsections (c) and (e) of the bill were addressed and amendments were recommended that would rectify those concerns. (Attachment 1)

Hearing on HB 2925 - Establishing the deaf and hearing impaired fee fund.

Brenda Eddy, Kansas Commission for the Deaf and Hearing Impaired, submitted written testimony on **HB 2925** and stated the bill is needed to allow the Commission to collect fees for interpreter certification and create a fee fund in which fees collected by the Commission would be deposited. The fee fund would also allow flexibility to creatively utilize monies received from any source, including general funds, gifts, grants and bequests. (Attachment 2) Discussion related to whether the Commission had an opinion regarding the amendment that changed the name to Kansas Commission on the deaf and "hard of hearing", and Ms. Eddy stated the change was to follow the national trend. The other amendment relating to training service and guide dogs was not anticipated by the Commission.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 527-S, Statehouse, at 2:00 ~~a~~m./p.m. on April 7, 1992.

Hearing on SB 781 - Fee for examination of psychologists.

Mary Ann Gabel, Behavioral Sciences Regulatory Board, submitted written testimony in support of **SB 781** and stated the bill was introduced at the Board's request as a result of an upcoming increase in the Board's cost to purchase the national psychology examination and urged passage of the bill. (Attachment 3)

Hearing on SCR 1645 - Constitutional amendment making public health a constitutional responsibility of the legislature.

Senator Hayden, sponsor of **SCR 1645**, gave a history of his background relating to the health care field and the need now to have more comprehensive health care. He stated that healthier people are more prone to better education and open to different ideas and views, and there should also be more equality of health care in the various parts of the state. Written testimony in support of the Resolution was received from Terri Roberts, Kansas State Nurses Association. (Attachment 4)

Hearing on SB 775 - Creating the medicaid drug utilization review board.

Bill Henry, Pharmaceutical Manufacturers Association, submitted written testimony in support **SB 775** and stated drug utilization review is a process that has been mandated for all states by the federal government in 1990. The mandate requires all pharmaceutical manufacturers providing drugs to Medicaid Programs to offer rebates to states and the federal government. Drug utilization review is already in effect in Kansas since 1976, however, the federal act requires certain things that are not contained in Kansas law. Mr. Henry addressed the federal changes that would carry out the intent of federal requirements in this area and urged passage of the bill. (Attachment 5) Public hearings by the Board as referenced on page 7, line 17 of the bill were discussed, as well as what would constitute a quorum. Mr. Henry defined "summary of interventions" as types of information that could be presented to medical practitioners in the case of questionable practices of prescribing. Generic drugs that would meet certain federal requirements and possible language change on page 2, line 8 relating to the board being responsible for the implementation of retrospective and prospective drug utilization programs obtained from another state's statute were discussed.

Bob Williams, Kansas Pharmacists Association, submitted written testimony on **SB 775** and stated drug utilization review has been done in Kansas for 15 years, and such review is in compliance with federal guidelines. Several amendments were recommended to address his organization's concerns with the bill. (Attachment 6) During Committee discussion, Mr. Williams stated that the current DUR Committee does prevention counselling, mails out letters to physicians and alerts the educational aspect. The make-up of the DUR Committee and the possibility of public hearings were also discussed.

Due to the time element, the Chairman announced continuation on **SB 775** will be held at the next meeting.

The meeting was adjourned at 3:00 p.m. The next meeting is scheduled for April 8, 1992, 2:00 p.m., Room 527-S.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 4-7-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Karlon L. Cause	Ks. Comm f/t Deaf.
Irene L. Warner	
Mindell Strome	AARP - CCTF
George Goebel	AARP - SLC - CCTF
Tom Hitchcock	Bd. of Pharmacy
Bob Williams	Ks. Pharmacists Assoc.
Anita Kolusich	Ks. Phaimacists Assoc.
[illegible]	KMA
Margaret Lenzi	Boehringer Ingelheim
BILL HENRY, TOPEKA	PMA
Myrle Myers	Lederle
Chip Wheelen	KMS
Marilyn Bradt	KINH
Patricia Maben	KDHE
Bill Sneed Topeka	KIDD
Joyce Sugrue	SRS
[illegible]	[illegible]
MaryAnn Gabel	BSRB
Robert Epps	SRS

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE
DATE 4-7-92

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
E Eugene Stephens RPh.	SRS/DMS
Amy Blalock	Glaxo Inc
Robbie Bridges	BSW Student - W.S.U.
Glen Yancey	SRS - Rehab Services
Bill Howell	VirJohn Co.

MEMORANDUM

TO: Senator Roy Ehrlich
Chairman, Senate Public Health & Welfare Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: April 1, 1992

RE: House Bill 3064

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am legislative counsel for the Health Insurance Association of America ("HIAA"). HIAA is a health insurance trade association consisting of over 325 insurance companies that write over 85% of the health insurance in the United States today. Please accept this memorandum as our testimony regarding H.B. 3064.

Initially, my client keenly aware of the concerns that can be generated relative to the regulation of out-of-state pharmacies. My client agrees that there should be reasonable registration on mail-service pharmacies to assure a safe, effective means of dispensing prescription drugs for chronic and long-term conditions consistent with the legitimate objectives for the citizens of Kansas. However, we believe that this legitimate concern must be balanced with the benefits that are derived from mail-service pharmacies. Needless to say, the major benefit is a reduction in overall pharmaceutical costs to the consumers. We are concerned that H.B. 3064, in its present form, may inappropriately cause an increase in costs for these services in relation to the requirements that will be implemented under H.B. 3064.

Senate P. H & W
Attachment #1
4-7-92

My client wishes to thank the Kansas Pharmacists Association for agreeing to statutorily defining the guidelines for out-of-state pharmacies. However, in reviewing the proposed bill, we are concerned with two sections that may in fact be overreaching, and in balance, create unneeded regulation in this area. Further, we contend that without an amendment, the two sections in question make the bill constitutionally flawed. Therefore, we would suggest the following amendments.

1. On page four, line 24, between the words "comply and "with," we would add the following phrase: "to the extent such compliance does not violate the laws of the domiciliary state of the non-resident pharmacy." As you can see, there is an attempt to require the non-resident pharmacy to comply with Kansas law. There is the potential that a non-resident pharmacy could be requested to comply with Kansas law that might in fact violate the laws of the state of domicile. Thus, by inserting this phrase, so long as the Kansas law does not conflict with the domiciliary state, Kansas law would apply.

2. On page five, line 19, after the comma, we would suggest striking the word "or" and continuing on to strike line 20, and at the beginning of line 21, striking the word "board" and the accompanying comma. Again, this is an attempt to allow the state of Kansas Board of Pharmacy to take action if the domiciliary state fails to take action. The phrase I have suggested deleting states that the Board could take action even if the domiciliary state has taken action, but such action is unsatisfactory to the Kansas Board. Clearly, this begs for a potential conflict of law question and threatens the integrity of the bill.

In this time of legitimate concern pertaining to health care costs, we urge this Committee to carefully construct any registration requirements for out-of-state pharmacies. We believe out-of-state pharmacies provide a genuine and legitimate service to the citizens of not only the United States, but in particular, the State of Kansas. We believe that reasonable registration requirements should be reviewed by the legislature, and by utilizing the above-mentioned amendments, a more practical and beneficial result can be derived that will benefit not only the interests that appear in front of this Committee, but also the ultimate interests of Kansas citizens.

Again, we appreciate the opportunity to appear before this Committee, and if there are any questions or comments we will be happy to discuss them with you.

Respectfully submitted,

William W. Sneed
Legislative Counsel
Health Insurance Association of America

Kansas Commission for the Deaf and Hearing Impaired
Brenda J. Eddy, Executive Director

Presenter's name:	Brenda Eddy Executive Director Kansas Commission for the Deaf and Hearing Impaired (913) 296-2874 (V/TDD)
Topic:	Testimony in favor of HB 2925 to establish a fee fund for Kansas Commission for the Deaf and Hearing Impaired
Date:	April 7, 1992
Committee:	Senate Public Health and Welfare Committee

Senator Ehrlich and members of the Committee:

Thank you for the opportunity to address you today.

My name is Brenda Eddy and I am Executive Director of the Kansas Commission for the Deaf and Hearing Impaired. I have been hearing impaired since birth. My mother, older brother and three year old son have a hearing impairment. We do not view our hearing impairment as a tragedy. Nor does our hearing impairment make us special. We are normal people with unique communication needs.

I am here today to talk about the importance of understanding the unique communication needs of deaf and hard of hearing impaired people because this is really what HB 2925 is all about. Deafness is a communication handicap. Deaf people are only handicapped when there is a communication barrier. Sign language interpreters provide the bridge to allow communication to occur between deaf and non-deaf persons. Without interpreters, we are handicapped.

Sign language interpreting is a relatively new profession. Only in the past twenty years has interpreting grown from a volunteer service to a bonafide profession. For this reason, the profession is still in the infancy stages and regulatory standards that monitor the profession are weak. There is a national organization called the Registry of Interpreters for the Deaf which offers an evaluation tool to certify interpreters. However, the $800.00 fee for being evaluated by this organization is cost prohibitive for most interpreters in Kansas. As a result, there was no quality assurance measure of sign language interpreters and the deaf consumers were paying the price.

In 1986, a group of professionals from a six state region in the midwest, gathered to develop an evaluation tool to certify sign language interpreters that would be cost effective and would encourage potential interpreters to become certified. Hence, the Mid-America Quality Assurance Screening Test was born. The Kansas Commission For the Deaf and Hearing Impaired was designated as the appropriate agency to administer this test. Since it's inception, KCDHI has certified approximately 151 interpreters from Kansas, Missouri, Nebraska,

(OVER)

Senate P. H&W
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Oklahoma, and Arkansas. Kansas is considered somewhat of a trendsetter with our state-administered Quality Assurance system. We have assisted several states in establishing their own QA system and have been invited to present our model on the national level. I personally, am very proud of our system and in our ability to work cooperatively with other organizations who need this service. We are currently working with the Department of Education to establish a QA system modeled after our Mid-America QAST which would enable us to evaluate the skills of interpreters working in the educational setting.

This year, we have established monthly QAST evaluations in Topeka and have a waiting list of about eight months duration. We are also offering special QAST evaluations for specific organizations in various locations around the state. With the passage of the Americans with Disabilities Act, we are anticipating a 30 percent increase in requests for interpreting services. Our proactive response to this is to encourage more interpreters to become certified by offering a workshop on how to prepare for the QAST certification.

As you can see, we take the task of monitoring the standards of interpreters very seriously. We have established a sub-committee of the Commission which deals specifically with interpreting issues and are in the process of implementing a recommended fee scale for interpreters based on certification, education, experience and professional affiliation. Now that the Commission has earned the credibility and established a reputation of doing the certification job well, we feel that it is time to amend K.S.A. 75-5393 allowing the Kansas Commission for the Deaf and Hearing Impaired to "provide for a program of regulation and certification of interpreters."

The second part of HB 2925 regarding establishment of a fee fund goes hand-in-hand with our certification program. Our current statute requires that any fees collected from interpreting services be deposited in state general fund. We request an amendment to K.S.A. 75-5397a allowing the Kansas Commission for the Deaf and Hearing Impaired to collect fees for interpreter certification and deposit fees collected for providing interpreter services, interpreter certification and sign language instruction in a "deaf and hearing impaired fee fund." Use of a fee fund would allow the certification program to become self-supporting by recycling the revenue earned from certification fees to pay the evaluators' costs. Aside from the staff required to administer the certification program, a fee fund will eliminate the need for increased State General Funds to support this increasing service need.

In addition, K.S.A. 75-5396 gives us authority to receive monies from any source, including federal funds, gifts, grants and bequests. An opportunity was lost earlier this year to receive a bequest from an individual due to the lack of a mechanism to deposit said request. A fee fund would allow us the flexibility to creatively utilize these monies to address unmet service needs of deaf and hard of hearing people.

The Kansas Commission for the Deaf and Hearing Impaired is unique from most state agencies in that we are governed by a 17 member, Governor appointed board which is responsible for the policies and management of the commission. Yet for administrative and budgetary purposes we are located with Rehabilitation

Brenda Eddy Testimony
HB 2925
April 7, 1992

Services within Social and Rehabilitation Services. A KCDHI fee fund would be monitored by the Rehabilitation Services budgetary process. Any expenditures from the fee fund would be first approved by the financial committee of the commission.

For the above reasons, I urge you to support HB 2925. Please contact me if you have further questions.

STATE OF KANSAS

MARY ANN GABEL, *Executive Director*

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TESTIMONY BEFORE THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

S.B. 781

Tuesday, April 7, 1992

CHAIRPERSON EHRLICH, VICE-CHAIRPERSON LANGWORTHY, AND COMMITTEE MEMBERS:

I am Mary Ann Gabel, Executive Director of the Behavioral Sciences Regulatory Board, appearing on behalf of the board and in support of SB 781.

This legislation was introduced at the board's request as a result of an upcoming increase in the board's cost to purchase the national psychology examination.

K.S.A. 1991 Supp. 74-5310(a) sets out an examination requirement of all applicants for psychology licensure in the State of Kansas. The examination that is used in Kansas, as well as in each of the states, is owned by the American Association of State Psychology Boards and is administered through Professional Examination Service (PES) each year in April and October. The current cost to the board to purchase the examination is $135. Licensees are assessed $175, 20% of which ($35) is deposited directly to the state general fund. The remaining $5 is used by the board for administrative costs.

Effective with the October 1993 examination, the board's cost to purchase the examination will be $250. The current statutory limitation of $250 will not allow the board the mandatory 20% deposit to the state general fund or permit reimbursement of the board's administrative costs. The current limitation, in fact, will require the board fee fund to supplement psychology applicants. The amendments in SB 781 to increase the statutory limitation for the examination to $350 will enable the board to amend its fees' rule and regulation to reflect the cost increase.

The board respectfully requests your favorable action on this legislation. Thank you for providing me an opportunity to appear before you today. I will be happy to answer any questions you may have.

Senate P.H.&W.
Attachment #3
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KSNA

the voice of Nursing in Kansas

NURSING
SHAPING THE FUTURE OF HEALTH CARE
NATIONAL NURSES WEEK, MAY 4-10, 1992

FOR MORE INFORMATION CONTACT:

Terri Roberts, J.D., R.N.
Executive Director
Kansas State Nurses' Association
700 S.W. Jackson Suite 601
Topeka, Kansas 66603-3731
(913) 233-8638
April 7, 1992

SCR 1645 CONSTITUTIONAL AMENDMENT MAKING PUBLIC HEALTH A CONSTITUTIONAL RESPONSIBILITY OF THE LEGISLATURE

Chairperson Ehrlich and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts and I am the Executive Director of the Kansas State Nurses' Association.

The Kansas State Nurses' Association supports the concepts embodied in SCR 1645 which supports a constitutional amendment regarding the provision of healthcare services to Kansas citizens and making this responsibility one that the legislature is accountable for financing. We believe strongly that basic health care services should be available to Kansas citizens and at our 79th annual convention and business meeting adopted a resolution to that effect entitled "Health Care for All".

The exercise of Kansas citizens voting on this provision would also be a very valuable learning experience.

Attached is a copy of that resolution and we encourage your support of SCR 1645 in the Senate and this committee.

testimony 92:scr165

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Attachment
#4
4-7-92

KSNA

the voice of Nursing in Kansas

RESOLUTION 91-13
Health Care for All
Submitted by: District 17

WHEREAS, It is estimated that 27 million Americans are uninsured including 300,00 to 500,000 Kansas and millions more are underinsured; (1) and

WHEREAS, nearly 2/3 of uninsured people are members of families above the poverty level and more than 2/3 uninsured adults belong to the labor force; (1) and

WHEREAS, the fastest growing group among the poor is the working poor; (1a) and

WHEREAS, the poor are less likely to obtain preventive care and are more likely to delay seeking care until an illness is quite serious; (2) and

WHEREAS, poor children are far less likely to receive health services; (3) and

WHEREAS, survey and vital statistic data reveal continuing racial disparities in access to health care; (4) and

WHEREAS, policy makers will be unable to act effectively without understanding the nature of barriers to health care, their severity and what will eliminate them; (5) and

WHEREAS, nurses, on the "Front Lines" of health service delivery, have a wealth of knowledge and experience to share; (5) therefore be it

RESOLVED, that the Kansas State Nurses' Association become actively involved in reshaping the Health Care System of Kansas, with the formation of a task force to develop a position paper on Kansas Health care access for basic health services; and be it further

RESOLVED, that KSNA collaboratively work with other individuals and organizations in this process, including official bodies sanctioned to develop health policies; and be it further

RESOLVED, that KSNA take an active role in promoting ANA's "Proposal for a National Comprehensive Health Policy Plan" at the State and District level; and be it further

RESOLVED, that KSNA work to assure basic health care to all people.

References:

1. Governor's Commission on Health Care. (November 28, 1990) Report and Recommendations on the Kansas Health Care System. Governor, State of Kansas; State Capitol Bldg. Topeka, KS 66612.

1a. Harrington, M. (1987). WHO ARE THE POOR? A profile of the changing faces of poverty in the United States in 1987. Justice for All National Office, 1334 G. St. NW, Washington, DC 22005

2. Newachectk, P.W. (1988, Aug.) Access to ambulatory care for poor persons. Health Serv. Res., 23, 401-419.

3. Newachectk, P.W. (1986. Aug.) Access to ambulatory care services for economically disadvantaged children. Pediatrics, 78, 813-819.

4. Blendon, R.J. and others. (1989, Jan. 13). Access to medical care for black and white americans: a matter of continuing concerns. JAMA, 26, 278-281.

5. Brecht, M. (1990) Nursings' role in assuring access to care. Nursing Outlook, 38 (1), 6-7.

Kansas State Nurses' Association Constituent of The American Nurses Association

700 S.W. Jackson, Suite 601 • Topeka, Kansas 66603-3731 • (913) 233-8638 • FAX (913) 233-5222
Michele Hinds, M.N., R.N.—*President* • Terri Roberts, J.D., R.N.—*Executive Director*

4-2

Testimony for the Senate Public Health and Welfare Committee
April 1, 1992

Mr. Chairman, Members of the Committee, I am Bill Henry, appearing before you today on behalf of the Pharmaceutical Manufacturers Association in support of S.B. 775.

For many years Kansas has promoted drug utilization review in its Medicaid Program. The review of drug prescribing practices has been viewed as a cost containment measure as well as a method for promoting proper use of medicines by the Medicaid population. The program has been run by the Kansas Pharmacy Foundation under contract with SRS. In 1990, the Legislature statutorily recognized the DUR Program and granted advisory powers to a "committee of health care professionals to assure the appropriate utilization of drugs by patients receiving medical assistance under the medicaid program." (SB 180)

In the Fall of 1990, Congress mandated drug utilization review for all states and specified requirements for such DUR programs. (OBRA '90) See 42 U.S.C.A. 1396r-8. The Omnibus Budget Reconciliation Act, 1990 was the measure which required all pharmaceutical manufacturers providing drugs to Medicaid Programs to offer 12.5%, and in the future 15%, rebates to states and the federal government. Millions of dollars in rebates are being returned now to Kansas and the federal government. Among other things, the federal law requires that state law "establish standards for (pharmacies) counseling" of medicaid patients. Other matters specified by federal law are membership on the DUR Board, recording and reporting of patient information and the development of educational programs. While some of these functions may be carried out by contract as is currently done, some cannot. In any event, it is preferable for the legislature to make many of these decisions rather than leave them to contract negotiations.

Numerous states are now considering legislation to implement the federal law. Indiana & Utah have passed legislation establishing DUR and with some simplification and modification these bills have been used as the model for S.B. 775.

It is the belief of the Pharmaceutical Manufacturers Association that S.B. 775 will carry out the intent of federal requirements in this area and can be performed without any additional cost to the state.

Sec. 1 amends K.S.A. 39-7 118 (S.B. 180), regarding the scope of duties and authority of the Drug Utilization Review Program.

New Sec. 2 of S.B. 775 establishes a medicaid drug utilization review board which would be responsible for the implementation of retrospective and prospective Drug Utilization Programs under the Kansas Medicaid Program.

The board would consist of seven members, including two licensed physicians engaged in the practice of medicine and one licensed physician actively engaged in the practice of

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osteopathic medicine; two licensed pharmacist actively engaged in the practice of pharmacy and one person licensed as a pharmacist who is actively engaged in academic pharmacy; and one person representing medicaid consumers appointed by the governor. The qualifications for the members of the board in the new section two are consistent with federal law on this subject.

If the committee determines the number of board members should be enlarged we hope that the makeup of the committee would be consistent with the qualifications and proportionate representations that have been established.

New Sec. 3 of the bill allows the Secretary of Social and Rehabilitation Services to provide support to the Medicaid Drug Utilization Review Board either by SRS staff or by contract. This section would allow the secretary to continue the contract with the Kansas Pharmacy Foundation which is currently providing drug utilization and review services.

New Sec. 4 sets DUR program standards and authorizes the Board to set guidelines for implementing prospective and retrospective DUR. This section closely complies with federal law and also establishes procedures for the recording by pharmacists of certain pertinent information for Medicaid recipients.

New Sec. 5 of the bill is the general definitions section and also complies with federal law in the duties of the committee.

New Sec. 5 also amends K.S.A. 65-4915 and provides that the activities of the Drug Utilization Review Board would be subject to peer review statutory protections (on liability and confidentiality) that are recognized for peer review committees by current Kansas law.

New Sec. 6 of S.B. 775 addresses the issue of prior approval by permitting such procedures under limitations permitted by federal law and by adding hearing and voting requirements. This Section also allows the Drug Utilization Review Board to establish advisory committees to assist the board in carrying its duties out in this area.

Representatives of the Pharmaceutical Manufacturers Association met with Secretary Donna Whiteman, Medical Services Commissioner Robert Epps and other SRS staff on February 21 to discuss this bill and the requirements and federal law that mandate the imposition of a Drug Utilization Review Board in every state by January 1, 1993. Two weeks after that meeting Commissioner Epps said SRS did not wish to co-sponsor the introduction of S.B. 775. Subsequent to that meeting this draft legislation was also discussed with the Kansas Pharmacists Association, the Kansas Medical Society and the Kansas Osteopathic Society. In addition we have also made contact with the Board of Pharmacy to discuss other statutory changes necessary to allow Kansas Pharmacists to provide counseling as required by the federal act.

In conclusion, Mr. Chairman, Members of the Committee, the Pharmaceutical Manufacturers Association believes S.B. 775 meets federal requirements without added

state costs. The bill also clears up some statutory language in regard to S.B. 180 which was passed by the legislature in 1990.

Respectfully Submitted,

William M. Henry
Attorney at Law
on Behalf of the Pharmaceutical Manufacturers Association

THE KANSAS PHARMACISTS ASSOCIATION
1308 SW 10TH STREET
TOPEKA, KANSAS 66604
PHONE (913) 232-0439
FAX (913) 232-3764

ROBERT R. (BOB) WILLIAMS, M.S., C.A.E.
EXECUTIVE DIRECTOR

TESTIMONY
SENATE PUBLIC HEALTH & WELFARE COMMITTEE
SENATE BILL 775
Wednesday, April 1, 1992

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address Senate Bill 775. The Kansas Pharmacists Association is a long-standing supporter of drug utilization and review. Many of you have previously heard me discuss the virtues of drug utilization and review. The Kansas Medicaid DUR program was the first in the nation and was begun 15 years ago. The current contract with the Kansas Pharmacy Foundation is for $75,000. Among other provisions contained in the so-called "OBRA 90" legislation passed by Congress, states are required to have a DUR program in place by January 1, 1993. The current Kansas Medicaid DUR program is in compliance with the Federal guidelines. That is not to say that there is no room for improvement. Indeed the DUR Committee continually strives to make improvements in their monitoring of drug utilization by Medicaid recipients. Because the current DUR program is in compliance, KPhA questions the necessity of SB 775. The involvement of Kansas pharmacists with the Medicaid DUR program will change little with the passage or defeat of SB 775.

However with that thought in mind we do have some suggestions regarding SB 775. On page 1, line 26, "prescription only drugs" should be changed to read "medication." An effective DUR program involves the monitoring of not only prescription medication but over-the-counter medication as well.

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On page 2 we recommend lines 11 through 29 be struck and replaced with the language contained in the Federal law which states: "The membership of the DUR board shall include health care professionals who have recognized knowledge and expertise in one or more of the following: a) the clinically appropriate prescribing of covered outpatient drugs, b) the clinically appropriate dispensing and monitoring of covered outpatient drugs, c) drug use review, evaluation and intervention, d) medical quality assurance. The membership of the DUR board shall be made up of at least one third but no more than 51% licensed and actively practicing physicians and at least one third licensed and actively participating pharmacists."

The current DUR Committee consists of two physicians, one osteopath, one pharmaceutical chemist, one pharmacologist, three practicing pharmacists and one R.N. Candidates are nominated by their respective professional associations and appointed by the Secretary of Social & Rehabilitation Services. The Federal language allows for more flexibility in committee makeup. Additionally, the committee may want to consider some conflict of interest language which would prohibit individuals from serving on the DUR Committee who have a vested economic interest in what drugs are covered.

On page 3, new Section 3 and new Section 4 are all but identical to the Federal law.

On page 4, new Section 5, would include the DUR Committee in the state's peer review laws. While we have no objection, we understand that the DUR Committee is currently protected under the 1986 Federal Health Care Quality Improvement Act.

On page 7, we recommend new Section 6 be struck in its entirety. The Federal law more than adequately restricts the state's ability to use the prior approval process

and I have attached a copy of the Federal legislation for your review. Of the thousands of drugs covered by the Kansas Medicaid Drug program, only 25 currently need prior authorization. As a result of the OBRA 90 legislation the state of Kansas now has an open formulary which is costing the state $1 million a month in additional expenditures. This additional $12 million a year expenditure is hardly offset by the projected $3 million to $4 million the state will be receiving in rebates from drug manufacturers. In order to balance a shrinking budget, it is conceivable that in the future the state of Kansas may want to consider a prior approval program similar to a program offered in Georgia. Today, the Georgia Department of Medical Assistance is realizing a cost-savings estimated between $20 million and $30 million annually without corresponding cost increases within other segments of health care and without adverse affect upon the patient's overall "quality of care." I have attached a draft copy of the "Georgia experience" for your review. New Section 6 would severely inhibit the state of Kansas from implementing any type of prior approval program.

In conclusion, I have attached a copy of the Kansas DUR Committee's Annual Report for your review. Please note the number of prior authorizations which were removed as a result of the committee's actions. Additionally, the Pharmacy Manufacturers Association and the National Council of State Pharmacy Association Executives have been developing a document entitled "Tenets For a Model Public Medication and Pharmaceutical Care Benefit Program." Attached is a copy of our seventh draft for your review. Thank you.

"(aa) the average manufacturer price for each such covered drug; and

"(bb) the number of units of the covered drug sold to any State program under this title during such period, to

"(II) the total number of units of all such covered drugs sold under a State program under this title in such period, except that the Secretary may exclude certain new drugs from the calculation of the weighted average if the inclusion of any such drug in such calculation has the effect of—

"(aa) reducing the rebate otherwise calculated pursuant to subparagraph (A)(ii); or

"(bb) increasing the rebate otherwise calculated pursuant to subparagraph (A)(ii) (in cases where such calculation under the conditions outlined in clause (ii).

"(ii)(I) The Secretary may exclude drugs approved by the Food and Drug Administration on or after October 1, 1990, from the calculation of weighted average manufacturer price if inclus manufacturer demonstrates through a petition, in a form and manner prescribed by the Secretary, undue hardship on such manufacturer as a result of the inclusion of such drug in such calculation).

"(II) The Secretary may promulgate guidelines to restrict the conditions under which the Secretary may consider such petitions.

"(C) For each of 8 calendar quarters beginning after December 31, 1991, the Secretary shall compare the aggregate amount of the rebates under subparagraph (A)(i) to the aggregate amount of rebates under subparagraph (A)(ii). Based on any such comparison, the Secretary may propose and utilize an alternative formula for the purpose of calculating an aggregate rebate.

"(3) REBATE FOR OTHER DRUGS.—The amount of the rebate to a State for a calendar quarter (or other period specified by the Secretary) with respect to covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

"(A) the applicable percentage (as described in paragraph (4) of the average manufacturer price for each dosage form and strength of such drugs (after deducting customary prompt payment discounts) for the quarter (or other period), and

"(B) the number of units of such form and dosage dispensed under the plan under this title in the quarter (or other period) reported by the State under subsection (b)(2).

"(4) For the purposes of paragraph (3), the applicable percentage is—

"(A) with respect to calendar quarters beginning after December 31, 1990, and ending before January 1, 1994, 10 percent; and

"(B) with respect to calendar quarters beginning on or after December 31, 1993, 11 percent.

"(d) LIMITATIONS ON COVERAGE OF DRUGS.—

"(1) PERMISSIBLE RESTRICTIONS.—(A) Except as provided in paragraph (6), a State may subject to prior authorization any

covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

"(B) A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

"(i) the prescribed use is not for a medically accepted indication (as defined in (k)(6));

"(ii) the drug is contained in the list referred to in paragraph (2); or

"(iii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4).

"(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

"(A) Agents when used for anorexia or weight gain.

"(B) Agents when used to promote fertility.

"(C) Agents when used for cosmetic purposes or hair growth.

"(D) Agents when used for the symptomatic relief of cough and colds.

"(E) Agents when used to promote smoking cessation.

"(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

"(G) Nonprescription drugs.

"(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

"(I) Drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations ('DESI' drugs)).

"(J) Barbiturates.

"(K) Benzodiazepines.

"(3) UPDATE OF DRUG LISTINGS.—The Secretary shall (except with respect to new drugs approved by the FDA for the first 6 months following the date of approval of such drugs shall not be subject to being listed in paragraph (2) under the provisions of this paragraph), by regulation, periodically update the list of drugs described in paragraph (2) or classes of drugs, or their medical uses, which the Secretary has determined, based on data collected by surveillance and utilization review programs of State medical assistance programs, to be subject to clinical abuse or inappropriate use.

"(4) INNOVATOR MULTIPLE-SOURCE DRUGS.—Innovator multiple-source drugs shall be treated under applicable State and Federal law and regulation.

"(5) PRIOR AUTHORIZATION PROGRAMS.—A State plan under this title may not require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of the drug before its dispensing for any medically ac-

cepted indication (as defined in subsection (k)(6)) unless the system providing for such approval—

"(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

"(6) TREATMENT OF NEW DRUGS.—A State may not exclude for coverage, subject to prior authorization, or otherwise restrict any new biological or drug approved by the Food and Drug Administration after the date of enactment of this section, for a period of 6 months after such approval.

"(7) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, provided such limitations are necessary to discourage waste.

Nothing in this section shall restrict the ability of a State to address individual instances of fraud or abuse in any manner authorized under the Social Security Act.

"(8) DELAYED EFFECTIVE DATE.—The provisions of paragraph (5) shall become effective with respect to drugs dispensed under this title on or after July 1, 1991.

"(e) DENIAL OF FEDERAL FINANCIAL PARTICIPATION IN CERTAIN CASES.—The Secretary shall provide that no payment shall be made to a State under section 1903(a) for an innovator multiple-source drug dispensed on or after July 1, 1991, if, under applicable State law, a less expensive noninnovator multiple source drug (other than the innovator multiple-source drug) could have been dispensed.

"(f) PHARMACY REIMBURSEMENT.—

"(1) NO REDUCTIONS IN REIMBURSEMENT LIMITS.—(A) During the period of time beginning on January 1, 1991, and ending on December 31, 1994, the Secretary may not modify by regulation the formula used to determine reimbursement limits described in the regulations under 42 CFR 447.331 through 42 CFR 447.334 (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1990) to reduce such limits for covered outpatient drugs.

(B) During the period of time described in subparagraph (A), any State that was in compliance with the regulations described in subparagraph (A) may not reduce the limits for covered outpatient drugs described in subparagraph (A) or dispensing fees for such drugs.

"(2) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—HCFA shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

"(g) DRUG USE REVIEW.—

"(1) IN GENERAL.—

"(A) In order to meet the requirement of section 1903(i)(10)(B), a State shall provide, by not later than January 1, 1993, for a drug use review program described in paragraph (2) for covered outpatient drugs in order to assure that prescriptions (i) are appropriate, (ii) are medically necessary, and (iii) are not likely to result in adverse medical results. The program shall be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs including education on therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.

"(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

"(i) compendia which shall consist of the following:

"(I) American Hospital Formulary Service Drug Information;

"(II) United States Pharmacopeia-Drug Information; and

"(III) American Medical Association Drug Evaluations; and

"(ii) the peer-reviewed medical literature.

"(C) The Secretary, under the procedures established in section 1903, shall pay to each State an amount equal to 75 per centum of so much of the sums expended by the State plan during calendar years 1991 through 1993 as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of this subsection.

"(D) States shall not be required to perform additional drug use reviews with respect to drugs dispensed to residents of nursing facilities which are in compliance with the drug regimen review procedures prescribed by the Secretary for such facilities in regulations implementing section 1919, currently at section 483.60 of title 42, Code of Federal Regulations.

"(2) DESCRIPTION OF PROGRAM.—Each drug use review program shall meet the following requirements for covered outpatient drugs:

"(A) PROSPECTIVE DRUG REVIEW.—(i) The State plan shall provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits under this title, typically at the point-of-sale or point of distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of

Draft

An Advanced State Association

Managed Program

for

Pharmacy "Prior Authorization" Review

Developed By:

Georgia Pharmacy Foundation

Atlanta, Georgia

6-6

THE "GEORGIA EXPERIENCE"

Georgia's Medicaid agency, the Department of Medical Assistance(DMA), has utilized prior authorization (PA) as a cost-containment mechanism for over a decade. Through this period, its program has grown tremendously. With the assistance of two professional advisory committees, drug prior authorization has evolved responsibly while keeping the patient's care primarily in mind. Today the Department is realizing tremendous cost savings within its drug program. Estimates of these savings, between $20-30 million dollars annually, have been accomplished without corresponding cost increases within other segments of health care and without adverse affect upon the patient's overall "quality of care."

With the enactment of OBRA '90 came regulations requiring coverage of additional drug products and the establishment of Federal regulations governing drug "prior approval" processing. In order to balance its shrinking budget while meeting the burden of strict Federal standards, it appeared that continuing to operate an in-house prior approval program would be difficult, if not impossible. Hence, the Department decided to release a proposal and accept private bids for the administration of its program.

At the successful conclusion of the state's bidding process, the Georgia Pharmacy Foundation was awarded and entered into a contract to administer the "prior authorization" program for Georgia's Department of Medical Assistance.

OPERATION/FUNCTION

Over 60,000 drug approval requests have been reviewed and processed in the first eight-plus months of the contract. Compliance to OBRA '90's main provision of "24 hour" response has been maintained throughout this entire period. Key operations and functions are described in the following list:

- All requests are reviewed by a registered pharmacist.
- All required file segments are entered via electronic network into fiscal agent's data bank. This allows for immediate adjudication after approval is granted.
- Board certified physician(s) reviews all clinical/therapeutic denials.
- All inquiries from providers and recipients are handled by unit staff.
- An advanced software package tracts each request from receipt through completion of the review process.

- Instantaneous access to approval status is available by either recipient's name or Medicaid number.
- Extensive summation reports are available upon demand.
- Notification of approval/denial to provider is by phone/FAX and mail.
- Toll free phone accessible to all providers for submission of requests.
- Facsimile (FAX) equipment available for receipt of requests.

AFFECTED DRUGS AND CATEGORIES (GEORGIA)

Anti-Ulcer Drugs:
H2 Antagonists/Carafate/Prilosec

Anti-Arthritic Drugs:
Brand Name NSAIDS/Dolobid/Anaprox/Lodine

Five Prescription Limit Per Month

Benzodiazepines:
Xanax/Lorazepam Inj./Multi-Source Products

Other Categories:
Persantine/AZT/Growth Hormones/Clozaril/Retin-A

REVIEW PROCESS

Prior Approval requests for the above are reviewed for both clinical appropriateness and coverage limitations. Most of the criteria used in the review process were developed by the Department's Formulary and Pharmacy Advisory Committees. Requests are subsequently reviewed based on criteria supplied by Medicaid and include review for DESI status, non-covered status, and length of therapy, to name a few.

Additionally, clinical review of the patient's medications includes the following:

- Drugs compared to listed diagnosis or conditions
- Therapeutic duplication review

- Possible drug interactions
- Acceptable medical justification
- Appropriateness of dosage parameters/frequency

Since the above listed criteria are those utilized in many prospective review programs, there exists a substantial "unspoken" DUR component that deserves mentioning. Numerous inappropriate medications and potentially harmful interactions have been avoided by the intervention of our pharmacists during the review process.

All proposed therapeutic or clinical based denials issued by our pharmacists receive secondary physician review before a final decision is issued to the providers.

COST JUSTIFICATION

The following discussion and attachments are to illustrate the cost saving potential of a prior approval program. It should be understood that these are projected cost savings that are derived from various sources and may not match those from Georgia's Department of Medical Assistance or its administration. For a truly revealing state-by-state comparison of Medicaid programs refer to the 1991 edition of "Pharmaceutical Benefits Under State Medical Assistance Programs" compiled by the National Pharmaceutical Council, Inc.. This publication contains drug dollar utilization data and recipient population data from recent years. Upon review it will become obvious that a ranked comparison of drug Medicaid programs places Georgia at or near the top in containment of drug costs over recent years. Although Georgia's DMA developed and utilized other cost-containment mechanisms over recent history, the majority of their realized savings are directly attributable to the "Prior Approval Drug Program."

The following pages contain information that projects annual savings from various "prior approval restrictions:"

- DMA's Public Notice - See Attachment "B"
- Dr. Kotzan Draft (NSAID's) - See Attachment "C"
- Dr. Kotzan Draft (H2 Antagonists) See Attachment "D"
- Estimated Total Impact (Various Sources) See Attachment "E"

DUR/"REAL TIME" DISCUSSION

We are currently exploring potential relationships with companies that supply advanced POS technology in anticipation of HCFA's further defining of the "Prospective Drug Utilization Review" regulations. In addition, we are examining hardware requirements that will allow instantaneous processing of approval requests as "real time" claim adjudication is initiated by Medicaid.

SUMMARY

The Georgia Pharmacy Foundation's Prior Approval Program has been engineered to meet the needs of it's current and future clients. Extensive management experience with formulary development and prior authorization programs allows our staff to easily modify our data base and adjust staffing support to fit the needs of major third party drug prior approval programs.

Our staff is constantly working to design applications that enhance efficiency and decrease the administrative costs of the program.

Our information about the program or the availability of consultant services please contact Charles P. Callihan, R.Ph., at (404) 231-5403 or Larry L. Braden, R.Ph., at (404) 231-5074.

GEORGIA'S PRIOR APPROVAL PROGRAM

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Charles P. Callihan, R.Ph.
Chief Operating Officer

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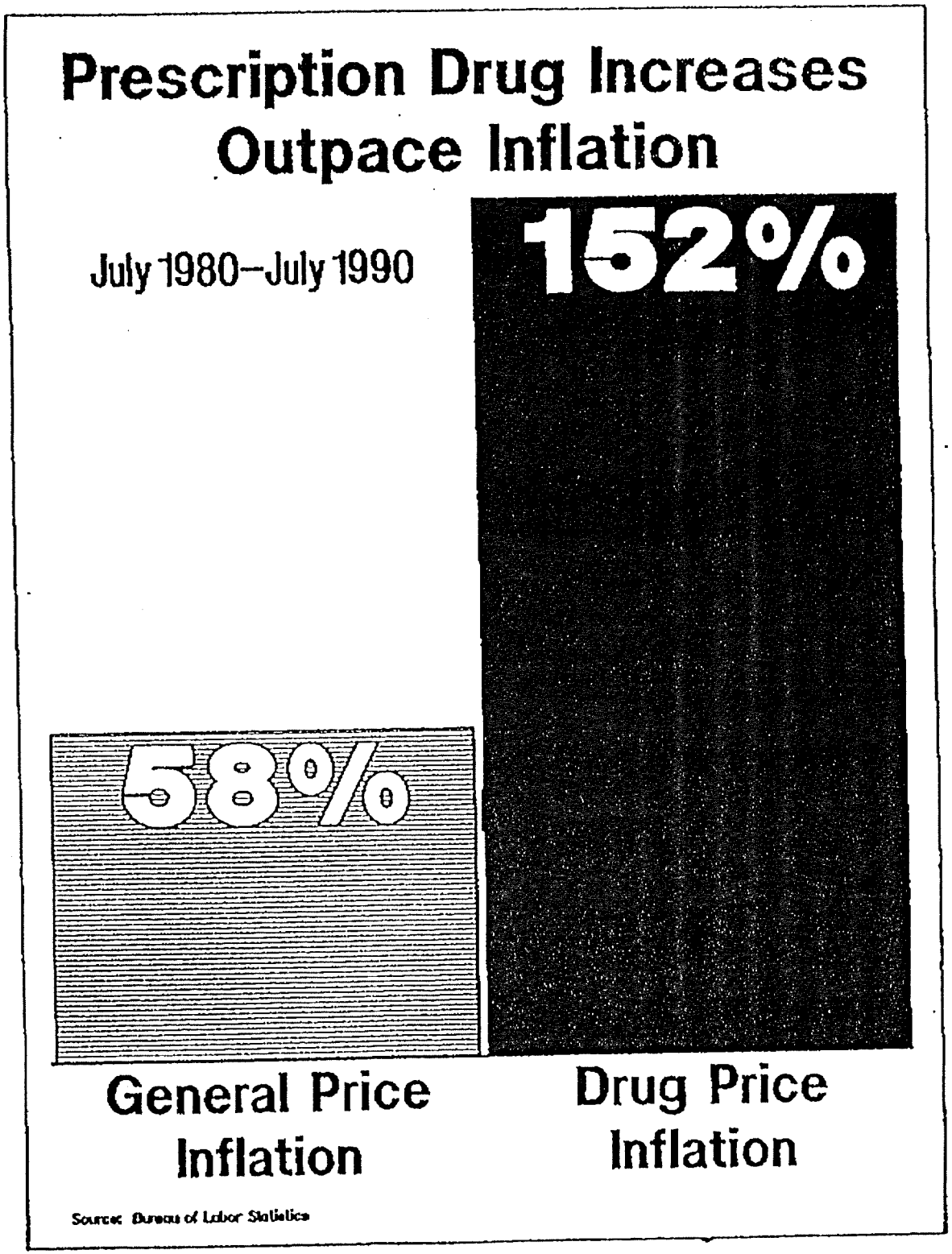
ATTACHMENT "A"

Prescription Drug Increases Outpace Inflation



6-1-92

ATTACHMENT "B"

DMA's Projected Annual Savings with Program Changes - Nov. 1, 1991

Projected Annual Savings in Pharmacy Program:

$ 9,213,176

- Note: Includes discontinued coverage of cough/ cold for recipients over 21 and Monistat and Gyne-Lotrimin Vaginal Products

DMA Public Notice, September 1991

ATTACHMENT "C"

NSAIDS Prior Approval

Dr. Jeffrey Kelzan, UGA, Draft Report

Situation

- State of Georgia imposed a prior approval process for single source NSAID prescriptions beginning on January 1, 1990.
- The process required the physician or pharmacist to obtain a prior approval number before submitting the claim.
- Physicians and pharmacists were informed of the procedure by a letter from the Commissioner of the Department of Medical Assistance.

Discussion

- The prior approval process appeared to reduce total costs when other studies have shown the opposite effect
  - Prior approval is not an absolute process which totally makes a product unavailable for a recipient base
  - The program targeted a specific therapeutic category
  - The category consists of both patented and generic products
    - The patented products may have only marginal therapeutic advantage above generics within the class
  - No more expensive substitute products are available

Objectives

- To determine the utilization and total costs for NSAID prescriptions before and after implementation of the policy
- To determine shifts in utilization following implementation
  - Other drug categories
    - Analgesics
    - Narcotic Analgesics
    - Other antiarthritic drug products
  - Medical Services
    - Total Claims
    - Physician Claims

Projected Results

Assumptions

- Discontinuous recipients respond to the prior authorization program in the same manner as the continuous recipients
- August to December continues with the same patterns among drug products
- No change in utilization of physician and other medical services

Net savings for the study period

Observed Savings = $3,013,303

Additional Analgesics = ($193,540)

Additional Narcotics = ($13,096)

Net Reduction = $2,811,672

For ALL Recipients = $4,097,338

For ALL Months and Recipients = $7,024,009

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ATTACHMENT "D"

H2 Antagonists Prior Approval

Dr. Jeffrey Kotzan, UGA, Draft Report

Situation

- The Georgia Department of Medical Assistance imposed a maintenance dose program for Tagamet®, Axid®, Pepcid® and Zantac® on January 1, 1990
- Acute dosage was permitted for 90 days, thereafter a maintenance dosage was required
- Prior approval required to return to acute dosages

H2 Antagonists Prior Approval

Dr. Jeffrey Kotzan, UGA, Draft Report

Objectives

- To determine the utilization and total costs for the four H2 antagonist products
- To determine the shifts in utilization prior and following the 90 day acute dosage limit
- To characterize the demographic characteristics for the H2 antagonist patients

H2 Antagonists Prior Approval

Dr. Jeffrey Kotzan, UGA, Draft Report

Projected Results

- $1,377,928 apparent savings from maintenance dose policy
- Four months (April to July)
- 68.21% of antispasmodic prescriptions dispensed to continuous recipients
- If same patterns exist for remaining 5 months and discontinuous recipients consume H2 antagonist prescriptions in patterns similar to continuous recipients, then....
- *$3,100,000 total savings for the year accrued from the program*

H2 Antagonists Prior Approval

Dr. Jeffrey Kotzan, UGA, Draft Report

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ATTACHMENT "E"

ESTIMATED ANNUAL IMPACT OF PRIOR APPROVAL DRUG PROGRAM

Limitations	Project Savings
"Over Six" Limitations (GPhF projection)	$ 5,700,000
H2 Antagonist (Dr. Kotzan projection, UGA)	$ 3,100,000
NSAIDS (Dr. Kotzan projection, UGA)	$ 7,024,000
Persantine/Prilosec/Carafate (GPhF projection)	$ 1,991,000
Others: AZT, Retin-A, Clozaril (GPhF projection)	$ 500,000
Nov. 1991 & Jan. 1992 Changes (DMA Public Notice) - Benzodiazepines, "5 Rx Limit," Cough & Cold Non Coverage, etc.	$ 9,213,000
TOTAL PROJECTED ANNUAL SAVINGS	**$27,528,000**

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J: ANN-RPT.11 DRAFT

Drug Utilization Review (DUR) Committee
1991 ANNUAL REPORT

1991 was a year of adjustment for the DUR committee. Because of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) the Federal Government was mandating virtually an open formulary. Because of this mandate, the DUR committee would no longer serve as a formulary committee. The committee would only consider drugs in the allowable exclusion class and drugs to be added to the physician injectable list.

In 1991, the committee reviewed and considered 17 drugs for addition to the Medicaid or MediKan formulary. See Appendix A for recommendations and action taken by SRS. All recommendations made by the committee were accepted by SRS.

All current prior authorization criteria was reviewed by the committee. The following recommendations were made: (action taken by SRS is also noted.)

* Alprazolam (Xanax) -- Criteria #2a: Change "three panic attacks within a three-week period" to "four panic attacks within a four-week period" (criteria changed)

* Anticonvulsants -- remove from PA; not based on medical necessity, based on cost

* Antihyperlipidemic agents -- remove dextrothyronine (Choloxin) from formulary and remove PA from all products (no longer require PA 10/91)

* Cephulac (Lactulose) -- not based on medical necessity, concern that if taken off PA would be used as laxative

* Etretinate (Tegison) -- Criteria #2: change to read "the following therapies should have been tried and failed"

* Fluconazole (Diflucan) -- remove PA and monitor use, should be available for first drug of choice (no longer require PA 10/91)

* Ibuprofen Suspension -- take PA off, monitor and write physicians and notify them of cost compared to tablets

* Imipenem-cilastatin (Primaxin) -- take off PA, would not be used by outpatients (no longer require PA 10/91)

* Interferon Alpha-2A (Roferon-A) and Interferon Alpha-2B Intron-A) -- add Criteria #5 hepatitis C (no longer require PA 10/91)

* Novolin penfill insulin (Novo Nordisk) -- PA be removed, no medical reason for it to be on PA (no longer require PA 10/91)

* Ketoconazole (Nizoral) -- PA be removed, not based on medical necessity (no longer require PA 10/91)

* Misoprostol (Cytotec) -- take off PA, no medically necessary reason; have audit in place in case NSAIDS are discontinued the Cytotec will be discontinued too (no longer require PA 10/91)

* Nitroglycerin transdermals -- remove PA, sent out educational letters on intolerance

* Potassium citrate (Urocit-K) -- take off PA, will not be used as potassium supplement (no longer require PA 10/91)

* Sympathomimetic amine -- Criteria #3: add "or trauma induced brain dysfunction"

* Tetracyclines -- take PA off, not based on medical necessity (no longer require PA 10/91)

* Tuberculosis drugs -- take PA off, not based on medical necessity

In April a study was conducted identifying prescribing physicians and their recipients receiving Trental. 275 letters were sent to physicians in regards to 463 recipients currently on Trental. A follow-up study was conducted on the same recipients in December 1991. The follow-up study showed that 205 physicians were still prescribing Trental to 308 of the original recipients. This showed a 33.5% decrease in recipients and a 25.5% decrease in prescribing physicians. NOTE: Deceased recipients and recipients no longer eligible for Medicaid were not traced.

In May the narcotic agonist/combination review was completed and audits were placed into the computer. In October the first referrals were received from the Drug Review Unit in regard to recipients who failed the audit. By December, 16 referrals had been received from the Drug Review Unit and 11 letters were mailed to prescribing physicians.

Referrals were also received from the Surveillance & Utilization Review Unit. By December, 1 recipient and 1 physician referral had been received; 7 letters were mailed to prescribing physicians.

In August a study on Lincomycin was conducted to identify physicians prescribing Lincomycin. 76 letters were sent to prescribing physicians, identifying recipients receiving Lincomycin. Five letters were received and Chairman Marples responded thanking them for their letter. A follow-up study has been requested and should be conducted in 1992.

A study on Dextrothyroxine was also conduced in August to identify physicians prescribing this antihyperlipidemic agent. One recipient was identified and a letter was sent to the

prescribing physician. A follow-up study has been requested and should be conducted in 1992.

In October a study was conducted on H_2 antagonists and miscellaneous anti-ulcer agents. The computer identified recipients receiving two H_2 antagonists or an H_2 antagonist and Carafate or Prilosec. 235 letters were sent out to physicians, including recipients where there were two prescribing physicians. 23 responses were received with some physicians indicating that, while no clinical studies document an increased effect of using Carafate with an H_2 antagonist, they have found in their practice that this drug combination leads to improved ulcer healing rates. No follow-up study has yet been requested by the DUR committee.

In December study was conducted on non-steroidal anti-inflammatory drugs (NSAIDs). This study looked at the percentage of generics that were prescribed by each physician. The top 220 prescribers of NSAIDS to Medicaid recipients were reviewed and prescribing habits were identified. 53 letters were mailed to physicians with a low percentage of generic usage, and 56 letters were sent to physicians with a high generic usage. The average percent of generics prescribed from this group of physicians was found to be 65%. A follow-up study has not yet been requested by the DUR committee.

In junction with the Drug Review Unit, six studies were conducted in 1991 and 714 letters were mailed to prescribing physicians. The DUR committee will continue to work with the Drug Review Unit and conduct specialized studies.

TENETS FOR A MODEL PUBLIC MEDICATION AND PHARMACEUTICAL CARE BENEFIT PROGRAM

PMA/NCSPAE

(Seventh Draft)

JANUARY 18, 1992

6-25

SEVENTH DRAFT
TENETS FOR A MODEL PUBLIC MEDICATION AND PHARMACEUTICAL CARE BENEFIT PROGRAM

January 18, 1992

Modern pharmaceuticals and pharmaceutical care spell the difference between life and death, between hospitalization and prompt return to productive, high quality life. To prescribers, the impressive array of prescription medications forms an indispensable part of their capability to prevent and treat illness. Pharmacists add the ingredients of patient counselling services and knowledge of pharmaceutical science to the prescriber's diagnosis and selection of appropriate therapy. Pharmaceutical manufacturers investment in research and development guarantees continued improvement in prescriber and pharmacist's ability to serve patients' needs.

Appropriate design of a public medication and pharmaceutical care benefit program will take these strengths and the following eight tenets into account while seeking to assure the best possible healthcare outcomes for beneficiaries.

TENET I:

Patients shall have the freedom to choose their health care providers.

TENET 2:

Patients shall have access, under the supervision of prescribers and pharmacists, to all medications prescribed for medically accepted treatments, as described in FDA approved labelling, the major medical compendia or the peer-reviewed literature.

CHARACTERISTICS:

Sources to determine medically acceptable treatments should include the following:

1) the peer-reviewed clinical and scientific literature and compendia;

2) Relevant guidelines developed by professional groups based on a consensus process;

3) FDA-approved labeling.

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TENET 3:

Primary emphasis in evaluating the cost effectiveness of a program should be first its effect on the quality and outcome of health care for individual patients, and second its effect on total health care costs.

CHARACTERISTICS:

1) Benefit programs should not interfere with therapeutic outcomes solely in the interest of saving medication and pharmaceutical care costs.

   a) Procedures should be developed to evaluate public programs.
   b) The expenses of administering public programs shall be included in a program's cost effectiveness study.
   c) Standards for evaluating the quality of public program outcomes and cost effectiveness studies should be developed.

2) The cost effectiveness of a program should only be considered after the program has been evaluated for its effect on quality of care and the potential to influence therapeutic outcomes.

3) Document the impact public programs have on other health care costs.

TENET 4:

The program should incorporate a system of drug use review designed to ensure the delivery of pharmaceutical care consistent with principles adopted by national and state medical and pharmacy organizations.

CHARACTERISTICS:

1) The primary purpose of a drug utilization review system is to ensure quality of care for public program beneficiaries.

2) A drug utilization review system should include adequate safeguards against progressional liability exposure for professionals who participate in good faith.

3) Drug utilization review seeks to alter behavior by educating prescribers, pharmacists, and patients on the proper use of drugs.

TENET 5:

The program shall foster the use of the rational professional judgment of prescribers and pharmacists in the design and delivery of a medication and pharmaceutical care system.

CHARACTERISTICS:

1) The focus of prescribers and pharmacists regarding appropriate drug therapy should be paatient care; not to control costs.

2) Educational programs for prescribers and pharmacists should focus on enhancing drug therapy and improving therapeutic outcomes.

TENET 6:

Compensation for medication and pharmacists' services should be established at levels appropriate for both components of a model public program.

CHARACTERISTICS:

1) Pharmaceutical care should be compensable, even when the delivery service results in no medication being dispensed.

2) The coverage of new services provided by pharmacists and prescribers should be evaluated based on their ability to assure cost effective, quality care, and improved therapeutic outcomes.

TENET 7:

Claims processing systems should use cost effective technology to pay and adjudicate claims promptly, maintain patient confidentiality, and support systems of drug utilization review.

TENET 8:

Public medication and pharmaceutical care benefit programs should develop safeguards to prevent fraud and abuse. These safeguards should be cost effective, quality of care oriented, and developed in close consultation with program administrators, prescribers, pharmacists, pharmaceutical manufacturers, and other parties.

CHARACTERISTICS:

1) The primary goal of such safeguards should be to prevent fraud and abuse. They should not be used to control costs by limiting access to medications.

2) Health care professionals should be educated on their role and responsibilities in the prevention of fraud and abuse.

3) Fraud and abuse systems for public programs should be administered separately from drug utilization review systems.