



National
Caucus of
Native
American
State
Legislators

c/o National Conference
of State Legislatures

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NATIONAL CAUCUS OF NATIVE AMERICAN STATE LEGISLATORS

RESOLUTION ELIMINATING BARRIERS TO HEALTH CARE ACCESS AND MAINTAINING INDEPENDENT OVERSIGHT

The National Caucus of Native American State Legislators (NCNASL) is made up of American Indian, Alaska Native and Native Hawaiian State Legislators from 18 states and is organized to provide a forum for discussion, education and increased communication. Additionally, the NCNASL identifies and proposes legislation and administrative actions to eliminate barriers to achievement of a better quality of life for Native people.

WHEREAS the National Caucus of Native American State Legislators was formed in 1992 and formally established in its current form in 2005, with the goals of increasing awareness of the diverse Native American cultures in the United States, encouraging open dialogues, understanding, and cooperation between state and Indian nation governments; and

WHEREAS the National Caucus of Native American State Legislators has long sought to promote effective, equal and culturally appropriate access to healthcare for all, including American Indian/Alaska Native, Native Hawaiian peoples and all other minority cultures; and

WHEREAS limitations to treatment, barriers to the access and disruption of continuity of health care can result in detrimental life threatening consequences to the individuals who are the most vulnerable and can result in more medical complications and higher health care costs; and

WHEREAS scientific research shows there are gender, racial and ethnic differences in responses to treatments and limiting access further widens already existing health disparities; and

WHEREAS access to health care includes meaningful access to all medications in order to maintain consistent disease management and continuity of care, regardless of provider; and

WHEREAS many states, in an effort to cut short-term health care costs, have considered or instigated programs allowing the development and management of a Medicaid formulary or preferred drug list without independent oversight; and

WHEREAS the Medicaid system, which disproportionately serves people of color, should not establish additional obstacles which might limit access to vital life-saving medications, resulting in disruption of continuity of care and increasing the long-term costs of Medicaid by increasing the number of unnecessary hospitalizations and emergency room visits; and

WHEREAS basing decisions for inclusion on a formulary or preferred drug list based on cost rather than clinical considerations, ignores important variations that can exist among patients in terms of safety, efficacy and tolerability in drug classes; and

WHEREAS establishing administrative barriers, such as prior authorization requirements, can discourage health professionals from prescribing the most appropriate medication for their patients, thus delaying access to care, exacerbating existing health disparities and increasing costs.

NOW THEREFORE BE IT RESOLVED THAT the National Caucus of Native American State Legislators asks that states choosing to rely upon a formulary or preferred drug list establish an independent, accountable, committee made up of independent individuals with appropriate clinical experience to develop and manage the program in a manner that institutionalizes basic patient protections and ensures that prescribers maintain necessary discretion with regard to which medications are best for their patients.

BE IT FURTHER RESOLVED that to accomplish this goal effectively, the National Caucus of Native American State Legislators recommends the following provisions be added at the appropriate place in each state's Medicaid statute:

1. Rebates Negotiated by Managed Care Organizations. A managed care organization may not negotiate or obtain a rebate with respect to a product for which the state (or applicable state agency) has negotiated or obtained a supplemental rebate.

2. Formulary Requirements. Formularies shall comply with the following requirements:

- A plan's drug formulary shall provide coverage for all products where a Medicaid rebate is provided.
- A plan's drug formulary shall include coverage that is no more restrictive than the state's Medicaid preferred drug list in terms of access to covered drugs.
- A plan's drug formulary shall provide coverage in categories and classes for all medical conditions and shall provide a broad range of therapeutic options for all therapeutic categories.

3. Pharmacy and Therapeutics Committee. Standards shall be developed to assure that a Medicaid managed care plan's formulary is developed and reviewed by an independent pharmacy and therapeutics committee (P&T) that meets the following requirements:

- Formulary development shall be conducted pursuant to a transparent process, such as state open meeting rules.
- Not less than 30 days prior to a meeting, the P&T Committee shall post to the appropriate state website: (i) the meeting agenda, (ii) a list of the drug classes to be considered at the meeting; and (iii) background materials

and supporting documentation provided to committee members with respect to drugs and drug classes that are before the committee for review.

- The P&T Committee shall provide appropriate opportunity for public testimony at each regularly scheduled committee meeting. Prior to deliberating on any recommendations regarding a drug or a class of drugs, the committee shall accept testimony, in writing or in person, that is offered by a manufacturer of those drugs or another interested party.
- The P&T Committee shall post its recommendations to an appropriate state website not later than 30 days after the Committee approves the recommendations
- A majority of P&T Committee members shall be state licensed practicing physicians, practicing pharmacists, or both.
- The P&T Committee members shall represent various clinical specialties and specialists with expertise in a specific therapeutic area shall participate in formulary decisions regarding each therapeutic area.
- The P&T Committee shall meet no less frequently than on a quarterly basis.
- The P&T Committee shall base its clinical decisions on the strength of scientific evidence, standards of practice, and nationally accepted treatment guidelines.
- The P&T committee shall review formulary management tools, such as prior authorization, step therapy, quantity limitations, generic substitutions, and other drug utilization and management tools for clinical appropriateness (and consistency with industry standards as well as appropriate guidelines from expert patient and provider organizations)

4. Criteria related to Prior Authorization/Step-Therapy/Fail-First.

- A managed care plan shall provide a response within 24 hours of receipt of all necessary information for a request for prior authorization.
- If a medicine requires prior authorization, the pharmacist or physician shall be reimbursed for dispensing a 72-hour supply to a Medicaid beneficiary.
- A uniform form shall be established, electronic as soon as practicable, for plans to provide physicians seeking authorization for a covered drug, including a uniform, streamlined, convenient process to expeditiously request an override from the insurer of any restriction.
- An override of a restriction shall be expeditiously granted by the insurer if: (i) the prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first has been ineffective in the treatment of the insured's disease or medical condition; or (ii) based on sound clinical evidence or medical and scientific evidence the prescribing physician can demonstrate that the preferred treatment required under the step therapy or fail first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or (iii) the prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

- The prescriber's recommendation shall ultimately prevail if the prescriber certifies the drug is medically necessary.

5. Coverage Determination Decisions. Coverage for any newly approved FDA product shall be made within 180 days of the product's market entry.

6. Product selection. Where the prescriber has indicated on the face of the prescription "dispense as written" [or other notation set forth by state law], or other appropriate form for electronic prescriptions—

- The pharmacy shall not substitute another drug without explicit written permission of the prescriber, and
- Notwithstanding any other provision of law, the pharmacy shall receive payment for a drug dispensed pursuant to a "dispense as written" order without seeking prior authorization of the state or any benefit administrator, and without telephone or other confirmation that the physician does not wish to substitute another medication; and

BE IT FURTHER RESOLVED that states must consider and account for the impact on patient access to health care by evaluating barriers to services, the impact on utilization of services, and the use of prior authorization and other management tools, to ensure that existing health disparities are not exacerbated by any efforts to control short term costs by the use of a prescription drug formulary.

Sponsored by: Rep. John McCoy (WA)

Approved date is: August 3, 2011

Certified by Caucus Chair: Rep. John McCoy (WA)

Ratified certified by: The NCNASL, August 3, 2011

Distribution List: President
Members of Congress
National Congress of American Indians
Other federal and state government officials as appropriate