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**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

PUBLIC HEARING

MONDAY, MAY 1, 2017
Elihu Harris State Office Building Auditorium
1515 Clay Street
Oakland, California

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Moderator
Acting Administrative Director

Raymond Meister, MD
Medical Director

Jacqueline Schauer, JD
Industrial Relations Counsel

Maureen Gray
Regulations Coordinator

DIR Official Reporters: Emily Hatton and Rex Holt

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1 (Time Noted: 10:04 AM)

2 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Good morning
3 and Happy May Day. My name is George Parisotto, and I'm the
4 Acting Administrative Director of the Division of Workers'
5 Compensation. This is our noticed public hearing for the
6 proposed Medical Treatment Utilization Schedule Formulary
7 Regulations.

8 There are copies of proposed regulations on our front
9 desk, which you will see over here on my stage right. I think
10 I said that right. I don't know how it is from your
11 perspective over there. Please make sure you sign the sign-in
12 sheet and indicate if you want to testify today.

13 I'd like to introduce the other members of the Division
14 who are joining me. On my left is Jackie Schauer, Industrial
15 Relations Counsel, and on my right is Dr. Raymond Meister, the
16 DWC Executive Medical Director. We're also joined by Maureen
17 Gray, our Regulations Coordinator, and our Hearing Reporters
18 today, which are Rex Holt and Emily Hatton, if I've got that
19 right.

20 When you come up, I'd like you to please give your card,
21 if you have a card, to Maureen. All testimony today will be
22 taken down by our hearing reporters. If you have any written
23 testimony that you would like to give to us right now, please
24 give it to Maureen. If you wish to be notified of the final
25 adoption of our formulary or subsequent changes, please provide

1 your complete name and mailing address on our hearing
2 registration attendance sheet, which is located at the sign-in
3 table. The final notice and notice of changes to the
4 regulations will be sent to everybody who requests that
5 information.

6 I will call the names for those who have checked that they
7 wanted to testify. At the end of the list -- when I get to the
8 end of everybody's name, I'll check to see if anybody new has
9 come in who wants to testify or if anybody else has additional
10 comments. This hearing will continue as long as there are
11 people who want to testify on our regulations, but we'll close
12 at 5 o'clock this afternoon. If the hearing continues into the
13 lunch hour, we will take at least an hour break. So please
14 maybe you will plan on that. Written comments, if you do have
15 them, can be given to Maureen, as I said, right now or will be
16 accepted by fax, email, or hand delivery up to 5 o'clock this
17 afternoon at the Division's office, and that's located on the
18 18th floor of this building. You have to cross the security,
19 go up the elevator to the 18th floor. Please give them to our
20 receptionist.

21 The purpose of this hearing is to receive comments on our
22 proposed formulary, and we welcome any comments you have about
23 them. We will not question, respond, or discuss anyone's
24 comments, although we may ask for clarification or ask you to
25 elaborate on any points you are presenting. All comments, both

1 given today orally or provided in writing, will be considered
2 in determining whether we will make any revisions to our
3 regulations. When you come up, please restrict the comments --
4 the subject of your comments to the regulations and any
5 suggestions you have for changing them. Also we ask that you
6 please limit your comments to three minutes.

7 Since this is May 1st and we are in Oakland, the
8 possibility that May Day celebrations, demonstrations, and/or
9 rallies may occur in the area, whether it be at Frank Ogawa
10 Plaza or here at the Federal Building, which is a block down.
11 I sincerely doubt they will involve people with flowers in
12 their hair, dancing around a pole. These incidences could
13 impact traffic, the availability of public transportation, or
14 caffeine options. I don't expect any issues at this hearing.
15 Please check your mobile devices -- I know you all have them --
16 for any news and updates.

17 Now again, a reminder, please make sure you've signed in
18 and, if you wish to speak, that you have checked the boxes
19 indicating so. When you come up, please give your card to
20 Maureen -- your business card to Maureen if you have them so we
21 can get the correct spelling of your name in the transcript.
22 Please speak into our microphone, which is, again, here to my
23 right which is at the podium. Before beginning your comments,
24 please state your name and identify yourself for the record.

25 So let me go to our list, and our first person is Denise

1 Algire.

2 DENISE ALGIRE: Algire.

3 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Algire. Sorry.

4 I do apologize in advance for mispronunciations of names,
5 which I am very well known for.

6 -o0o-

7 **DENISE ALGIRE**

8 -o0o-

9 Good morning. I'm Denise Algire with Albertson's
10 companies and we are also members of CCWC and we will be
11 providing written comments. I just wanted to include a few
12 more details or provide a little bit more commentary.

13 First of all, I'd like to commend the DWC on putting
14 together the formulary based on evidence-based medicine and
15 tied to evidence. We feel like that's critically important.
16 So we really want to commend the DWC for doing that.

17 Specifically though I'd like to call your attention to the
18 area called Perioperative Fill in the formulary. We feel like
19 this needs to be further defined to avoid unintended
20 consequences. We feel like it needs to be further defined to
21 eliminate zero day -- postoperative days. I'm not sure if
22 you're aware the CMA defines global days in three different
23 areas: Zero-to-eight postoperative period, a ten-day
24 postoperative period, and then a 90-day postoperative period.
25 We feel that including zero-day postoperative periods could

1 have unintended consequences and include simple procedures
2 where you wouldn't normally have a postoperative period, and
3 those are my comments.

4 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

5 DENISE ALGIRE: Thank you.

6 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: I hope I can
7 get this one right. Brian Allen.

8 -o0o-

9 **BRIAN ALLEN**

10 -o0o-

11 Thank you. Good morning. I'll be brief. We did submit
12 written comments and so a lot of this will be in our written
13 comments. I just wanted to kind of reiterate a couple points.

14 First of all, we would like to thank the Division for the
15 process. We think it was a very open process. We think it was
16 a very inclusive process, and I think the outcome was very
17 good. We're very appreciative about it. We do have a couple
18 suggestions.

19 The first one that I want to kind of emphasize is the
20 definition section. We think the definition of compound should
21 be strengthened a little bit to avoid any potential loopholes.
22 We suggested some language in our written comments. I know
23 that it would be hard for you to believe that someone could
24 actually exploit a loophole in the system, but we think it's
25 better to tighten this up before they get exposed by

1 exploitation.

2 The other thing we have some concern about is the
3 transition of existing claimants who are using non-preferred
4 drugs. The rule talks about a transition time, but there is no
5 definitive time frame.

6 And the other part of it that was concerning to us is that
7 it talks about the claims adjuster not being able to
8 unilaterally make decisions or change treatment, but there is
9 nothing in there that puts any kind of onus or burden on the
10 treating providers to actually implement a transition plan. So
11 we suggest, in our written comments, just to move that line.
12 It would be difficult and challenging if you put the claims
13 adjusters in the untenable position of having to try to
14 transition somebody and have someone on the other end of the
15 treating side and not even have a conversation about that. The
16 way the rules are written, you're sort of at a stalemate at
17 that point and nothing has changed. I think it would be
18 important to put some kind of language in there just to sort of
19 encourage those conversations to occur.

20 The other area that we have some concern about was the --
21 just the overall effective date. We talked with some of our
22 customers and trading partners. There is some concern that
23 they may not be ready programmatically just because of the
24 tight window. So we recommended in our written comments that
25 you change your approach to the legislature about pushing that

1 effective date out a little bit and give everybody more time.

2 I think the other important thing about that is that one
3 of the hallmarks of success in other states adopting a
4 formulary is there was an educational process that happened by
5 the state to providers and that occurred over a period of
6 several months. With this tight time frame when this rule is
7 finalized and the effective date, there would not be a whole
8 lot of time to do that education process, and we think that's
9 an important component. It's not mentioned anywhere in the
10 rule. It's certainly something that could be done, just to
11 help medical providers and those who are treating injured
12 workers and working for injured workers to understand what does
13 this formulary do and how should we implement this for maximum
14 effectiveness. I think that's a really important component and
15 something that we've seen drive success for formularies in
16 other states.

17 So we recommend that, if you can get that delay, do that
18 education process, I think your results long-term -- while they
19 will be delayed a little bit, you'll have better results and
20 fewer disputes that occur because of the formulary. I think
21 other than that, those are kind of the main points.

22 Like I said, I think it's a very good proposed draft with
23 a couple minor tweaks that we would recommend, and we're
24 happy to help answer any questions you might have, and if you
25 need additional inside work, we're open to that as well. Thank

1 you very much.

2 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

3 Don Lipsy.

4 -o0o-

5 **DON LIPSY**

6 -o0o-

7 Don Lipsy, First Script Network Services. I feel like I
8 have the easiest job, following Brian. We have very similar
9 comments as both being parts of PBM. I will say my outlook is
10 a little bit more out of the negative side than Brian's, not
11 from lack of effort from anyone who took part in any part of
12 the process.

13 We have significant concerns, as a PBM and also as someone
14 who works closely with the networks in the State of California
15 from the prescribers' side, about the two pieces that were
16 echoed just a few minutes ago. First of all, the close
17 adoptive date of July 1st really, at this point in time, seems
18 untenable from both a programmatic, as well as an educational,
19 perspective. I think, if you look at the language -- and we
20 will suggest these as well in written form -- there is wiggle
21 room to take an approach that says this is the format, these
22 are the standards that are being adopted, but delay the
23 effective date to actually match up with what is out there,
24 from a utilization review perspective, new rules that come
25 through the pipe on 1-1-2018. That six-month time frame seems

1 to be in line with what other states have done and substantial
2 enough to allow for, not only, the transitional process for the
3 injured worker, which is the person we should be valuing most,
4 but also to reach out to prescribers.

5 It's a little bit funny when I look at the opioid
6 guidelines from last year and everything. There was this great
7 educational process that we had where we had this info, and
8 prescribers were trained for that. There is a bit of a fallacy
9 that we've seen play out in other states that have been
10 exploring formularies that people really delay actually getting
11 on board with the program, so to speak, until about the last
12 quarter of development.

13 So, again, delay time allows PBMs, networks, everyone else
14 to catch up from a programing perspective and also allows folks
15 a really more important part of the transitioning of injured
16 workers to a safer plan and working with those problematic
17 prescribers. That is really kind of one of the reasons we have
18 a formulary in the first place, from a legislative perspective.

19 The other part that I would push for -- and I have spoken
20 with folks from ACOEM. Having the level of specificity of the
21 formulary today, as what's been posted, is okay. It's kind of
22 like looking at drugs from a high school gymnasium perspective.
23 It's not quite the draw as looking at it from a major league
24 baseball stadium. But what we see in other states that is very
25 effective is a more NDC-driven formulary. Of course, as a PBM,

1 we can program to that, but when we're talking about making
2 life easier for everyone, including the injured worker and the
3 prescriber and anyone in the administrative process, including
4 the State at the end of the day, it's a much better system if
5 we actually use a more specific NDC-driven formulary. ACOEM
6 has commented and hopefully -- I know Carlos is here today --
7 that someone from that group will support this as well. They
8 can program, as other states have done, to a more specific
9 level, making things accessible to everyone within the work
10 comp system at very little to no cost. That seems to then
11 level the playing field so we don't have that uncertainty,
12 something that will drive better communication, better
13 conversation, better treatment or outcome, which I think is
14 really what everyone is looking for. So that --

15 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.
16 Ben Roberts.

17 -o0o-

18 **BEN ROBERTS**

19 -o0o-

20 Thanks for the opportunity to speak this morning on the
21 formulary and the proposed rules. I represent PRIUM. My name
22 is Ben Roberts.

23 PRIUM is a utilization review organization in the State of
24 California. We've been operating since 2009 and have acute
25 focus nationally on the overuse and misuse of prescription

1 drugs. As a result, we've been involved in formulary
2 implementations across the country, and we are pleased with the
3 steps that California has taken with proposed rules. I think
4 they represent an excellent draft at addressing all the majors
5 of concern that -- the major areas of concern that we feel are
6 important and should be looked at when considering adopting the
7 formulary.

8 We submitted some very specific written comments on the
9 language of the rules, tweaks to specific wording, as well as
10 definitions, and I just want to comment broadly on two specific
11 areas publicly while I have an opportunity, the first just
12 being around the transition period.

13 As others have stated, the transition period is an
14 important component of the formulary, transitioning injured
15 workers who are already on non-preferred medications, injured
16 workers who are maybe on long-term opioids, things that require
17 a significant clinical and administrative process. We need a
18 discontinuing transition to an appropriate medication regimen.
19 It concerns PRIUM that there is no definition around "phase
20 in." The use of the term "phase in" is used in the rules, but
21 there is no guidance there: Phased in over what period of
22 time; who's responsible for enforcing, kind of, the process;
23 who's responsible for educating the physicians and the other
24 stakeholders. So we have some concerns about that language.

25 The other issue that I want to just mention briefly is

1 around the perspective of the new requirement. The Rand
2 Report -- quoting from the Rand Report that DWC relied on in
3 order to, I suppose, come up with maybe these rules --
4 specifically says, "[a]n initial transition may be less
5 important for California [Workers' Compensation] program
6 because the MTUS has been in effect since 2004, and
7 [utilization review] typically occurs for all prescriptions on
8 a prospective basis."

9 As a utilization review organization, we do not see that
10 as the case. We don't feel that prescription drugs are
11 routinely requested through prospective review process through
12 the submission of the RFA process. So we have some concerns
13 about the assumption that physicians will follow the
14 requirement to prospectively request utilization review on
15 non-preferred drugs and other scenarios outlined in the rules.
16 If the burden is on the physicians to request prospective
17 review and they weren't adequately educated and they haven't
18 been given the guidance that that's what they are going to need
19 to do going forward, we don't see on July 1st any significant
20 change in behavior of physicians; and we're going to see
21 essentially what the payers are doing today, which is filling
22 medications, even if they are non-preferred, and then having to
23 use the retrospective review process to effectively deny those
24 medications going forward. PRIUM doesn't feel that meets the
25 ultimate goal of the formulary, which is to reduce the

1 administrative burden and the associated administrative cost of
2 the formulary. So we would like those things addressed
3 specifically in a future draft as indicated in our written
4 comments as well. Thank you.

5 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

6 Don Schinske.

7 -o0o-

8 **DON SCHINSKE**

9 -o0o-

10 Good morning. I'm Don Schinske. I'm here today on behalf
11 of Western Occupational and Environmental Medical Association.
12 We've submitted full comments, but I just want to highlight a
13 couple of things.

14 For starters, we agree with the DWC's choice to derive a
15 formulary based on the ACOEM guidelines published by the Reed
16 Group. We, of course, are the regional component of ACOEM so
17 we're on the same family tree but fundamentally we agree that
18 evidence-based is a good place to build a formulary from and
19 it's a good place to turn first as drugs and treatments evolve.

20 Three points really -- one, we do have some concerns about
21 the fulfillment of prescriptions at the pharmacy level for
22 drugs that are either preferred or non-preferred. Depending on
23 the diagnosis, denials that are based on retroactive
24 review/retrospective review could create confusion at the
25 pharmacy and lead to uncertainty about what exactly gets

1 reimbursed and what doesn't, and could undermine the whole
2 enterprise. We don't have a solution but we do see a problem.

3 Secondly, we do think there are some specific medications,
4 which we've listed in our comments, that could be added to the
5 preferred list. These include antivirals for exposures to
6 blood-borne pathogens. They include antibiotics for
7 soft-tissue infections. There are some others. We think they
8 all are safe and unlikely to be abused and are appropriate.

9 Finally is the issue of legacy prescriptions for what we
10 now believe are non-preferred drugs. We believe that any
11 weaning or changes to the drug regimen should be instituted by
12 the payer rather than the physician. I think that will help
13 make things very clear where the focus of the first action
14 lies. There needs to be some sort of robust consultation
15 process between the physician and the adjuster or the UR doc or
16 the PBM as things apply. It needs to start with some sort of
17 shared understanding that it may take a year or two to
18 transition patients that have complex pain management regimes.
19 Thank you.

20 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

21 Diane Worley.

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2 **DIANE WORLEY**

3 -o0o-

4 Good morning. I'm Diane Worley with the California
5 Applicants' Attorneys Association. Thank you for the
6 opportunity to have us here today to provide testimony, as well
7 as submit written comments.

8 I want to echo the comments that came before from everyone
9 about the amount of work that I understand went into preparing
10 this draft, all the meetings you've held. I have great respect
11 and appreciate the work you've done. Our written comments will
12 be submitted later on today. I provided a copy to Maureen, but
13 I want to highlight two areas of concern that we have with the
14 proposed formulary as drafted.

15 First is with regard to the transition provisions which
16 other stakeholders have mentioned. AB 1124 requires a phased
17 implementation of the formulary for those workers who are in
18 the system before July 1st of this year, and in the current
19 draft, I don't see any phase implementation. There is a lot of
20 discussion about other formularies in other states, such as
21 Texas where they had a two-year implementation transition for
22 so-called legacy workers.

23 There are a couple of important things about that. One,
24 it gives doctors a time frame to do something, to do -- a
25 protocol to transition workers onto formulary medications or to

1 justify why they need to stay on medications that they've been
2 on for years.

3 The second, and even more important, aspect of having a
4 time frame is to protect the workers. You have a fine line
5 you're walking here with this formulary, which has a lot of
6 policy benefits, saving costs to the system, and decreasing
7 opioid dependency. For those workers, through no fault of
8 their own, who are already caught up in that problem, it really
9 is completely necessary to protect them during the
10 implementation period.

11 The second part of that is that, in the draft, it talks
12 about the claims administrators can't, I think, abruptly
13 terminate medication. Well, claims administrators cannot deny
14 or delay treatment as it is already in the system. They are
15 not supposed to. That's supposed to go to UR so they can't do
16 that.

17 What I can perceive happening, based on some of the
18 problems occurring going on with UR and IMR, is that when a new
19 prescription comes in for that existing medication and it's a
20 non-formulary drug or a non-preferred drug, that's going to go
21 to UR and get denied based on MTUS's formulary, and that's
22 going to create a lot of problems for the workers. So to be in
23 compliance with AB 1124, I think you need to put back into the
24 draft a phase implementation for workers before July 1st.

25 The last thing is with regard to the preferred drug list.

1 The term evidence-based medicine is kind of thrown around
2 loosely and we all understand it to mean medical
3 recommendations that are tied into treatment guidelines or
4 scientific studies or literature. I think the preferred drug
5 list is something where drugs were selected based on their low
6 cost, and obviously there are no opioids on that list. I
7 understand the policy consideration there obviously, but I
8 don't think we should talk about the preferred drug list as
9 being evidence-based. It's above my pay grade to talk about
10 what medications to be added to the preferred drug list so I
11 leave that to the physicians and pharmacists to say that. I do
12 think there must be a number of other drugs that can be on that
13 list and not increase the current problems we're having with
14 opioids.

15 And the last part of that is with regard to UR and IMR.
16 I'm a little skeptical that we're going to see a lot of change
17 in cost benefits in the system from a reduction in UR and IMR
18 for pharmaceuticals if you just look at the preferred drug
19 list, because most of those drugs shouldn't be going through UR
20 anyway. We're talking about aspirin, Tylenol, Pepcid. If
21 those things are going through UR on an isolated basis, we're
22 really in trouble. I'm hoping that they aren't, but the
23 counterpoint to that means you're not going to see a lot of
24 cost savings if that's the intention with the preferred drug
25 list. Thank you.

1 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.
2 Matthew O'Shea.

3 -o0o-

4 **MATTHEW O'SHEA**

5 -o0o-

6 Good morning. Thank you. I'm Matt O'Shea with Safeway,
7 Albertsons, and I appreciate all the work and effort that you
8 guys did in drafting the regulation.

9 I did have one comment, and that is in terms of the
10 physician dispensing section, which is 9792.27.8. Within that
11 section, you left an exclusion for the MPNs, which we
12 appreciate, where there's an MPN contract that restricts
13 physician dispensing, but you did not include anything for the
14 Pharmacy Benefit Networks. And the concern is that 9792.27.1,
15 physician dispense definition, is so far distance from this
16 section that someone's going to look at this section and say,
17 "I can prescribe medication."

18 There's no exclusion for the Pharmacy Benefit Network, and
19 we're going to create a lot of liens and other issues that
20 we're going to have to litigate. So I think it's a very simple
21 solution to add a section excluding the Pharmacy Benefit
22 Networks under 4600.2(a).

23 That's my comment. Thank you.

24 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.
25 Saul Allweiss.

1 -o0o-

2 **SAUL ALLWEISS**

3 -o0o-

4 Hi, my name is Saul Allweiss. I'm an attorney. I'm here
5 actually testifying on behalf of Schools Insurance Authority.
6 SIA is part of CCWC and will be submitting written comments,
7 but there is one particular section I would like to highlight a
8 major concern over, and I'm referring to 9792.23.3(b).

9 This is the paragraph that addresses transition, and
10 there's one sentence that we believe must be stricken from the
11 regulations. It's towards the middle. It states, "The claims
12 administrator shall not unilaterally terminate or deny
13 previously approved treatment," and this is in regard to
14 injuries prior to 7-1-17.

15 The problem here is that there's nothing in the formulary
16 that ever allows for the claims administrator to unilaterally
17 deny a medication. All the formulary does is if it's a
18 preferred medication, it gets filled. If it's non-preferred,
19 it goes to pre-authorization. So with there being absolutely
20 no provision anywhere in the formulary for a claims
21 administrator to unilaterally deny anything, by putting this
22 sentence in there, it's going to cause a firestorm of
23 litigation.

24 I believe advocates for the other side of my profession
25 will be immediately jumping on that to say that even if a

1 claims administrator did a utilization review for an injury
2 prior to 7-1-17, that the claims administrator can't cut off
3 that medication because there is -- because of this sentence
4 taken out of context. So I foresee a tremendous amount of
5 litigation and suing. And while I'm confident that we'll
6 prevail in the courts eventually, probably millions of dollars
7 of resources will be expended fighting that battle, and I
8 really believe that this one sentence should be taken out.

9 There are other technical comments that CCWC has offered
10 that I will defer to the written comments. And like others
11 have mentioned, I want to recognize the herculean effort that
12 the administration's done, Dr. Meister and Administrative
13 Director Parisotto in getting these regs out. We appreciate
14 it, and thank you for letting me testify.

15 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

16 Mark Pew.

17 -o0o-

18 **MARK PEW**

19 -o0o-

20 Good morning. My name is Mark Pew with PRIUM. My
21 colleague Ben Roberts already represented the comments that
22 we've publicly posted in regards that I have really only one
23 comment, and it's been reiterated already before that July 1st
24 is a premature implementation date.

25 From the way I've read AB 1124, there's two phrases that

1 the legislature guessed two years ago that might be appropriate
2 from a timing standpoint. They said to establish a drug
3 formulary on or before July 1st, it shall include a drug
4 formulary. I believe that language allows you to establish the
5 drug formulary, the rules, and finalize the rules that allows
6 you flexibility to decide when it should be implemented.

7 I've lived through formularies in a variety of other
8 states. There's a lot of moving parts. There's a lot of
9 stakeholders engaged in this. I've often made the comment that
10 a bad formulary is worse than no formulary at all. I would
11 adjust that a little bit and say a premature formulary is worse
12 than no formulary at all.

13 So I would recommend that you delay the implementation
14 date to potentially January 1st which should allow everyone
15 enough time. From my understanding in talking with folks, a
16 lot of folks have not begun the implementation or the design
17 phase or the programming phase until the rules have been
18 finalized. And at this juncture, we're just shy of two months
19 to the implementation date. So my recommendation would be to
20 move the implementation date when it is actually effective to
21 be January 1st instead of July 1st.

22 Thank you very much.

23 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

24 Roman Kownacki.

25 / / / / /

1 -o0o-

2 **ROMAN KOWNACKI**

3 -o0o-

4 Good morning. My name is Roman Kownacki. I'm the Medical
5 Director for Kaiser Permanente's Occupational Health Program.
6 I'm going to start with my conclusion and recommendation first.

7 My feeling is that it will increase some of the frictional
8 costs in the system that I know this was trying to eliminate.
9 There is room for inconsistency in the application, and there's
10 a fundamental flaw in just the current design. And while I
11 appreciate linking evidence-based medicine into it, there is a
12 fundamental problem that I think needs to be addressed.

13 The spirit of this is really to control bad behavior and
14 ideally not impact good behavior or even reward good behavior,
15 and this really extends -- we've talked a lot about physician
16 prescribing, but it also extends to UR companies. And the plan
17 to have some medications that are non-preferred, but then they
18 could be recommended or non-recommended by ACOEM guidelines is
19 a fundamental flaw in this, and I'll take -- I'll use the
20 example of Cyclobenzaprine.

21 Cyclobenzaprine, according to ACOEM, can be used for
22 severe neck pain, or it will be inappropriate for mild neck
23 pain. That really is going to be on the basis of the subject
24 of experience of pain by that patient to determine whether it's
25 recommended or non-recommended. Okay. But it's a

1 non-preferred drug to begin with; so you'll have to go through
2 the preapproval process. Fundamentally, that's a very, very
3 difficult process to manage.

4 Number two, our back of the envelope calculation for our
5 organization is that conservatively, about 50 percent of our
6 prescriptions would now have to require an RFA, and when we see
7 64,000 new injuries per year, that equated to about 30,000
8 prescriptions that would now have to go through the RFA
9 process. That really is going to be challenging not only for
10 us, but also -- I'll go back to you're trying to not -- you're
11 trying to get rid of bad behavior, and that bad behavior that
12 occurs in a small fraction of physicians is the same bad
13 behavior that occurs on the UR side on that small group of UR
14 companies too.

15 So my recommendation would be as to push the date out, get
16 it right, get it right the first time, and that way we won't be
17 here a year later trying to solve the problems that are created
18 by some of the fundamental problems with the way it's currently
19 written.

20 Thank you.

21 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

22 Kim Ehrlich.

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KIM EHRLICH

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Thank you, and good morning. My name is Kim Ehrlich. I'm with Express Scripts, and really, the comments that I have to make are not anything that you haven't already heard, but I just feel that we need to go on record and state these verbally for everyone.

I think we all would agree that we really need and want this formulary to work, and so with that said, we just have a couple of recommendations or considerations we'd like you to give some thorough thought to.

The first is the effective date and, you know, while the effective date -- adoption date can remain the same, we feel strongly that with less than 60 days at this point that it would be appropriate to move the implementation date to 1-1-18. As we all know, there's a lot of time and effort that goes into it, and without the rules being finalized -- the regulations being finalized at this point, I think it would be helpful for all system participants to have that opportunity to not only do systematic changes if necessary, but also process changes within the system. And this all for, you know, the betterment of the stakeholders and success of the formulary.

Second would be the transition time, and I think we would all agree that whether it's personal work, we all work against

1 deadlines. And without a deadline in there, I think that we're
2 not going to see the discussions that need to take place
3 between all the system participants to transition or agree to a
4 treatment plan that's appropriate for the betterment of the
5 injured worker.

6 And so that's really all I had to say today. Appreciate
7 it. Thank you.

8 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

9 Mitch Seaman.

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11 **MITCH SEAMAN**

12 -o0o-

13 Mitch Seaman with the California Labor Federation. I
14 thank you for the opportunity to come in and testify today.
15 We'll be submitting written comments this afternoon; so we just
16 wanted to kind of generally expand on a few points that we're
17 going to make in that letter and also add to some of the
18 comments that have already been said.

19 The one that -- the one issue that we wanted to raise
20 respective to the specific language was that we think it would
21 be helpful to clarify that for preferred drugs, not only is
22 prospective review not required, but that it's really not
23 allowed. That the intent here is to take a lot of the
24 unnecessary costs out of the system with prospective or with
25 unnecessary URs. And that while it's pretty clear to a lot of

1 people that read this that, "Oh, that means you shouldn't do
2 prospective UR for drugs that are on the preferred list," it
3 could be less clear to others.

4 When you say something is, you know, not allowed, that's a
5 lot more -- something is prohibited. It's a lot more clear
6 than it is not required prior to dispensing. And so, you know,
7 it seems like it could be read either way. We don't see any
8 harm in just including language in there that would clarify for
9 those preferred drugs, prospective review is not allowed.

10 We would also echo comments that have been made about
11 potential confusion over the word "unilaterally" and that
12 sentence. You know, we very much appreciate the intent of that
13 sentence and overall appreciate a lot of the changes made in
14 the second draft that responded to a lot of the concerns raised
15 by us and other stakeholders in the system and do think that
16 that's a step in the right direction to say that we need to be
17 careful in kicking workers off of their old treatment plan as
18 this new formulary takes place, but the specific wording of
19 that sentence could create a lot of confusion and potentially
20 litigation. And so, hopefully, there's a future draft that
21 clarifies the intent without raising that risk of additional
22 litigation.

23 And then just generally wanted to make the comment that
24 this is a pretty restrictive formulary. From the worker's
25 perspective, it's a little concerning just overall. I mean,

1 obviously, we didn't hear a lot of concerns from our members,
2 like, "Hey, make it harder for me to get drugs. That's how you
3 fix this system." We hear the exact opposite all the time.
4 And so, just putting this into place, especially one that is as
5 restrictive as this, is kind of a giant leap of faith on the
6 part of injured workers that we can get this right and that we
7 can make this work without a real negative impact on injured
8 workers that are in a really tough place trying to get these
9 drugs that they need to feel better.

10 And so with that in mind, we hope that a future draft of
11 the language can expand the study that's outlined in the
12 current version to really get into what the effectiveness is on
13 workers and make sure that once this is in effect and being
14 implemented, that there isn't some new struggle workers are
15 facing. That there isn't just this, you know, sort of ripple
16 effect across the system where workers can't get the drugs they
17 need because physicians are afraid it's going to be denied, or
18 they don't want to deal with UR, or the, you know, the UR
19 process for non-preferred drugs is for some reason not working,
20 that those does exist in other states. It is kind of new here,
21 and I assume the other state's language doesn't look exactly
22 like ours.

23 So there is a real concern here that workers could suffer
24 no matter how hard we try to get this right. So we do think
25 it's really, really important to expand that study and make

1 sure that there aren't those negative impacts -- or if there
2 are, then we can identify them and deal with them as quickly as
3 possible.

4 We also think that it would be good to expand that study
5 and make sure that as it was just raised by one of the
6 speakers, requiring UR for non-preferred drugs isn't doing a
7 lot to increase costs that, you know, we finally got costs
8 moving in the right direction at kind of a predictable rate,
9 and requiring UR on a lot of the drugs that are prescribed in
10 the system does carry with it some risk of unnecessary
11 increased costs, unnecessary increased delays. And if this
12 formulary does do that, we think it's really important to
13 identify that so that we can make sure to fix that if that is a
14 problem that's created.

15 And we would just close with another comment about the
16 education point that was raised by someone else. May or may
17 not need to be in the actual regs themselves, but we do see a
18 real problem out there in the system with people struggling to
19 cite to the MTUS correctly enough to get treatment approved.
20 And there are a variety of reasons for that, but with something
21 like this, that we've got a system right now that a lot of
22 people are struggling with and trying to figure out how to cite
23 correctly to get a treatment approved, and we're now going to
24 make it more complicated, and we're going to make it more
25 restrictive. And that's concerning, but we do think a lot of

1 that concern could be addressed by just a massive education
2 process.

3 And I know that there's a plan in place to do that, but we
4 would just stress the importance of that and really putting
5 some thought into making sure that we're going to physicians
6 and getting to them ahead of time and giving them enough time
7 to learn about all of this that is coming so that they're not
8 just kind of caught flat-footed when all of a sudden things
9 start getting denied, and they're not totally sure why.

10 And would just echo the comment that we certainly wouldn't
11 object to a 6-month delay. We do think that the statutory
12 language probably would allow that, and there are a lot of
13 moving parts here and a lot of questions raised that an
14 additional 6 months probably wouldn't really hurt, but it does
15 carry the potential to really help injured workers.

16 So thank you.

17 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you very
18 much.

19 Surprisingly, I have reached the end of the list of
20 everybody who wanted to testify. So at this point, I would
21 like to invite anyone here who has some comments on the
22 formulary, whether you're in the front row or sitting in the
23 back row, to come up and offer some comments.

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2 **DEVIN MOTLEY**

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4 Good morning. My name's Devin Motley. I work for
5 myMatrixx Workers' Compensation Pharmacy Benefits Manager, and
6 just to echo everything everybody else has said, the work
7 that's gone into it, you know, thank you all.

8 The one thing that I want to point out working for a
9 Pharmacy Benefits Manager, I'm relatively new to both work comp
10 and pharmacy benefits. And a unique perspective to it is that
11 I see what the Division did with the regulation is they're
12 trying to guide behavior of doctors, you know, by the MTUS
13 whether it's compound, whether it's physician dispensing,
14 whether it's brand, generic. You know, we're trying to promote
15 best practices evidence-based medicine, and everything is
16 addressing doctors, and the stick that the Division gave in the
17 regs is retrospective review. That whenever a doctor doesn't
18 do anything according to MTUS, they're not going to get paid.
19 And that makes complete sense, and I agree with that.

20 The problem is is that the way we do business today, the
21 way point-of-sale pharmacy, mail order, and that sort of thing
22 works is these doctors have already been paid. That Pharmacy
23 Benefits Management companies, we're stepping up, and we're
24 paying these bills, you know, because we have to to pay them in
25 accordance with, you know, time lines for whatever it might be.

1 So what happens is that Pharmacy Benefits Management
2 companies get stuck holding the bag for these regs and, you
3 know, it's not the way that the Department intended it to
4 happen. It's just a fact of life of the way that business is
5 done today.

6 So by giving that retrospective review hammer, you know,
7 in the regs, it's going to really, really hurt PBMs. And with
8 the way the fee schedule is already structured in California,
9 you know, we could leave the system. And I'm not saying that
10 me -- my company is going to, but, you know, it has to be, you
11 know, PBMs provide a lot of really useful services to the
12 system. We do clinical review, drug review, formulary, all
13 sorts of useful things. We process things to the pharmacy, and
14 I think the Division acknowledges having the regulations. And
15 enforcement says that, you know, we can't put a more
16 restrictive formulary on top of the MTUS formulary, and that's
17 fine, but it's the retrospective review hammer. And I really
18 don't think it's going to cut down on doctor behaviors the way
19 the Division wants it to because these doctors are going to get
20 paid anyways.

21 So thank you.

22 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

23 Would anyone else like to offer comments?

24 All right. Well, at this time, it's 10:50. I think what
25 I'll do is take a 10-minute break, and if anyone else shows up

1 and would like to offer any type of comments, we'll take them
2 at that time. So we'll be back in 10 minutes.

3 (Recess taken.)

4 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: We'll go back
5 on the record, and at this time, again, I'd like to offer
6 anyone the opportunity to offer comments -- oral comments on
7 our formulary.

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9 **MARY ELLEN SZABO**

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11 Hi, my name is Mary Ellen Szabo, and I'm with Enstar
12 Group, Paladin Managed Care, and I think our organization
13 agrees with most of what everyone has indicated here about the
14 time frame that is going to be needed to fully implement this
15 and the education of providers, which I think is a huge gap in
16 California.

17 Wondered if there might be some consideration for some
18 kind of a trial or a follow-up date in which you can allow the
19 organizations and the claims administrations to provide for you
20 the gaps that are present in the system that you do implement,
21 whether there's an increase of drugs on a level that they can't
22 control, whether the injured workers are finding that there's
23 additional delays, whether the information that comes between
24 who's deciding whether it's adhering to the MTUS guidelines or
25 not.

1 I see a little bit of a gap in there whereby the rule says
2 that the preferred drugs still need to adhere to the MTUS
3 guidelines, and I think there's going to be instances in which
4 that might fall on a pharmacy. If you have a PBM involved, a
5 PBM may be able to control that to some degree, but it might
6 just fall into a lot of -- an increase of retrospective reviews
7 because things are being dispensed that aren't part of the
8 industrial injury.

9 So we would like some consideration if we can come back in
10 a quarter or six months from the day we go live and see what
11 some of the gaps are. Thank you.

12 ACTING ADMINISTRATIVE DIRECTOR PARISOTTO: Thank you.

13 Anyone else?

14 Very well. If no one else is going to testify, this
15 hearing will be closed. The opportunity to file written
16 comments will stay open until 5 o'clock this afternoon. Again,
17 if you do have written comments, please be sure that they are
18 received at the Division. We're on the 18th floor. You can
19 send them to us by e-mail or hand-deliver them -- your
20 preference. As I said, 18th floor.

21 So I'd like to thank you for your attendance and your
22 input here today, and I'd especially like to thank our DWC
23 staff for their work.

24 This hearing is now closed.

25 (The proceedings adjourned at 11:06 AM.)

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REPORTERS' CERTIFICATE

We, the undersigned Official Hearing Reporters for the State of California, Department of Industrial Relations, Division of Workers' Compensation, hereby certify that the foregoing matter is a full, true and correct transcript of the proceedings taken by us in shorthand, and with the aid of audio backup recording, on the date and in the matter described on the first page thereof.

Dated: May 8, 2017
Oakland, California

/s/ Rex Holt
Rex Holt
Official Hearing Reporter

Dated: May 8, 2017
San Francisco, California

/s/ Emily Hatton
Emily Hatton
Official Hearing Reporter