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DESCRIPTION

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2005 HOUSE HUMAN SERVICES

HB 1459

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

House Human Services Committee

☐ Conference Committee

Hearing Date January 25, 2005

Tape Number	Side A	Side B	Meter #
#1	x		1356-4149
Committee Clerk Signature			

Minutes:

Chairman Price opened hearing. 12 members present.

Arnold Thomas, President of the ND Health care Assoc.

Testimony attached:

Note: Typo in Paragraph 3, line 6 - change realistic to unrealistic.

Rep Potter: How did the one million figure was settled on.

A. Thomas: Years ago, before managed care took on any type of sharp focus, one of the members, Al True Health, started a health maintenance organization. In the process, they found they needed to build certain kinds of infrastructure information systems, training of their people to go from episodic kinds of delivery and services, to much more of a continuum arrangement of making sure a person goes to the area they need, that there is not just a restorative emphasis on the services. That discussion was, it took approx. $350,000 to develop that infrastructure. What we did to get that figure, we talked to the 6 largest facilities in 4 major cities, and we asked them

where they were relative to move into a managed care option similar to Al True and the dept. will be able to answer those questions. All areas of the programs should be covered by this action. We have a strong indication that those in the Fargo area that they are interested in looking at this program. It could possibly be, there would be other areas and different systems.

Rep. Potter: Is there discussion with groups to have a co-op arrangement?

A. Thomas: This summer we took a strong look at Medicaid, and the reason was what was done in regards to the payment reduction system in Medicaid to the provider community. We do not disagree that this is a very difficult population to manage. Their medical health needs are quite varied. We looked at the eligibility, the programs, what we came up with is that we are not as a provider community really applying our skills in helping to manage the services availability that is being delivered to these people, we could do it differently, we could do it better if we had more synchronization in the provider community. We feel there is something unique going on in Grand Forks, so we want to pursue this idea. No laws that say we can't do this, the current capitol capacity is stressed. Secondly the payment mechanism currently in place for Medicaid doesn't really hold out much attraction to really do much more than sit back and say this is just bad and its going to get worse, so somebody needs to do something. We had good interaction with the Dept. We will have strong reaction to this proposal, but we feel that overall this agenda is a workable plan We believe we can manage this activity in a different way to improve results.

Chairman Price: You see the benefit coming from the results.

A. Thomas: Yes. We want to come back to report that there is a difference in performance and financing is improved.

David Zentner, Director of Medical Services, DHS. See Attached Testimony

Rep. Kreidt: Do you feel at this point, is it more feasible now vs several years ago.

D. Zentner: I would like to think so. Each situation will be somewhat varied.

Chairman Price: We really have nothing to compare the results from managed care at Al True as far as putting more toward client disease care management, are we doing a better job on the diabetics, or asthmatics. Maybe we are only saving 2%, however we have prevented amputation or whatever that would have been in the record.

Tom Soldberg: Some of the QS programs have done, regarding disease management, the ALTrue program has done, Health Systems doing their own management systems, seem to have a good record.

Close hearing on HB 1459

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

House Human Services Committee

☐ Conference Committee

Hearing Date Feb. 2, 2005

Tape Number	Side A	Side B	Meter #
#1		x	600-1330
Committee Clerk Signature			

Minutes:

Chairman Price reopened hearing.

Rep. Porter: #2 CMS is implementing reason codes, will be implemented in 2005/2006, I am concerned about the diagnostic codes because there may be situations where they could be considered fraudulent regarding Ambulances. CMS gave 30 diagnostic codes, which we only use some. The same thing that is happening to the Dept. will be happening to the rural ambulance systems, it would be nice to make them to use those same codes.

Rep. Potter: No. 10 ?

Chairman Price: This language would like to put "risk managed care" in to use all over the state.

Rep. Sandvig: Did you contact any of the health care providers?

Chairman Price: No, there are 51 million dollars worth of claims out there without a diagnostic code, they should be doing something.

Rep. Porter: All third party payers that they are using are required to use the codes. Medicare requires.

Rep. Potter: I would move the amendment.

Voice Vote: 11-0-1

Rep. Potter: Move Do Pass as amended and re referred to Approp

Rep. Damschen: 2

Vote: 11-0-1 Carrier: Rep. Price

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. Joint Meeting - HB 1459

House Human Services Committee

☐ Conference Committee

Hearing Date 03/01/05

Tape Number	Side A	Side B	Meter #
2	x		0-end
		x	0-27.2
Committee Clerk Signature	Gene Stetson		

Minutes:

Chairman Price: This is a learning time for us. The Senate has already heard a bill and there is some information that may benefit the state of North Dakota. We are gathered together because of time restraints. Senator Lee is going to give us a little background.

Chairman Lee: (.6) In the Senate we heard a bill that would have called for Electronic Monitoring of Prescription Drugs. We had a lot of enthusiasm about that idea, it is not a new idea. People have been looking into this for 4 years or more. The FN told us that it was not going to fly, and we ended up moving that out of committee with a Do Not Pass, and that is what happened not the floor as well. Primarily we thought timing was going to be an issue. If we gave it more time and gave the private sector to do their work together, the board of pharmacy and pharmacists association, and the medical association, and the health care association, some of these working on this and we were just kind of crunched for time. In the meantime, I got a call a couple of weeks ago from John Horton, White House Drug Policy Office, saying there is

some grant money available and they are very interested in seeing North Dakota consider the possibility of establishing this program and there is federal money available to help us with the implementation. We want to hear more about it. My idea for today is for both of our committees to hear from Mr. Horton while he is here and also anyone who has a concern with this aspect of it that has not been heard in the House will know that we are having a hearing on it, and the best way for us to be able to consider this was to consider it as an amendment to an existing bill. HB 1459 looked like the best bill to attach this amendment to.

John Horton, Associate Deputy Director for State and Local Affairs in the Drug Policy Office of the White House: (2.2) (See attached Testimony). Not normal for a federal official to testify on state legislation such as this. I would like to describe the role of my office and also the national drug control picture right now. What we have learned of the drug problem in America has raised the importance of dealing with prescription drug abuse through a program such as Prescription Drug Monitoring. The office of Nation Drug Control Policy is the arm of the White House that is charged with reducing drug use in America and the overall drug problem (drug use and drug trafficking). Last week the President released his second term drug control strategy, and in fact in my written testimony there is one error. The release date was actually a week ago not yesterday. The strategy on drug control has typically been on cocaine, heroine, and meth amphetamines, etc. One of the things we have seen in the past few years is that prescription drug abuse, unlike the other categories of illegal drug abuse, seems to be on the rise. It is now the number 2 drug problem in America. (continues into testimony).

Representative Porter: (9.7) I get 10 or 15 e-mails a day that sat to buy vicaden or oxicotton there - I haven't done it yet, but I was just wondering will you actually receive the product by doing that inside the United States?

John Horton: Often no, sometimes you do. The answer to that is first of all, the DA and the Federal Government and Customs, is trying very hard to fight against those illegal internet pharmacies. There are about 12 or 13 nationwide that are legal. Many of them are at least in part overseas. What we have found that if you fill out one of those forms a couple of things happen. Sometimes you go back to that web site later and it doesn't exist anymore, or you get something in the mail that is not what you thought you bought. That probably is about two thirds of the situations. There are occasions where you can order specially scheduled things online and you will get what you paid for. Of course if you do that it is illegal. The government has been trying very hard to cut down on that route, and we have had some significant success in that.

Representative Porter: (10.8) We had a bill in front of us early on in the session on internet cigarette sales and I know that it is a little bit outside of your area of expertise, but I was wondering what the federal government is doing in regards to the three problems it creates is a taxation problem because they are being shipped direct from places like Russia, and second is that the biggest offender of the system is the United States Postal Service, and third is that it is an easy way for someone under 18 to get cigarettes without having to tell anyone. What I was wondering is if the same postal carrier system if drugs are shipped first class through the postal system - are those loop holes being looked at to close both on the schedules 3's and 4's along with non-taxed cigarettes.

John Horton: You've hit one of the most complex problems in the federal government; which is trying to figure out how to make sure that the prescription drug that are being sent in illegally through the US mail are better detected. The frank and the honest answer is that we need to do a lot better on that. Customs and DEA and some other agencies have now created some task forces, and what we are trying to do is try and raise the percentage of detecting and finding those illegal shipments. Our overall strategy on this is that as we look at the different methods of diversion, at the federal level I hope that we can be doing a better job with what we described - it is very very tough. At the same time we are looking at states to push down on doctor shopping - we hope that is going to have a positive impact in what we are trying to do.

Rep. Weisz: (12.9) I have a couple of questions having to do with your grant itself, and what the money could be used for. One, would the money be available to use for reimbursing pharmacies for their increased cost for reporting the information? Two, could the grant be used for helping some pharmacies convert to electronic filing of the information?

John Horton: I am going to look to Jim Carter for answers on those. I believe the answer on the first one is no, but I believe the answer to the second one is yes. Generally, the implementation of new computer systems or software, or something that would be typically born as part of this grant, the understanding that I have is that there has not been as much of an increase in costs to pharmacies. Probably what does increase is the time required to put in the data that is then required to be part of the system. Again, the process of making sure that pharmacies have the software, data, and programs is something that would valuably be part of the grant.

Rep. Potter: (14.3) With the doctor shopping, what is the federal government doing about that specifically?

John Horton: Certainly, doctor shopping, where it happens, tends to be something that is often a criminal activity. It often involves the act of forgery, it certainly in the end contains the act of possession of a controlled substance without a prescription. Having said that, at that level, possession of drugs or prescription drugs is very rarely prosecuted at the federal level. That is why as a federal government tries to deal with the internet issue, and the occasional bulk shipments, at the same time we cannot deploy FBI and DEA agents to arrest a person with frankly has an addiction problem, and really needs treatment not jail time. We know at the federal level we cannot do this on our own, and that is why our support of reducing doctor shopping by educating the medical and pharmaceutical community. Working with them in several different forms and financially supporting them. States have a more effective role here.

Attorney General Wayne Stenejhem: (16.1) A large part of what I do has to do with efforts to keep our citizens, and particularly our young people, free from use of illegal and illicit drugs. When I came into office I met with some of my counterparts at one point to talk about our respective drug problem, and I was alerting them of the big problem we have here in North Dakota with Meth amphetamines. Out on the east coast the problem has been a prescription drug oxicotton, which I have rarely heard of. I am now seeing the influx of abuse of prescription drugs. I have worked with Howard Anderson about this kind of a concept for at least three or four years to see if ND can develop the kind of program we need to address the problem. I want to talk for just a minute because I talked to some of our agents to have them report the kind of problems we are seeing in ND with prescription drug abuse, and sure enough they report that

agents out on the street are seeing increasing burglaries of pharmacies because a typical cost of a 80mg tablet of oxycotton is $17, out on the street it sells for $80. We are seeing increased incidents of doctor shopping. The prevalence of the problem is increasing. We have charged more people with prescription fraud in the last two years than we had in the prior five years. It is an increasing problem. I am aware of the concept of this bill is, and I want to urge you to consider passing it. I think we would have introduced something long ago, except for the funding mechanism, which is always a problem even when you are trying to do the right thing. Now I understand there is some funding for this. I view this as not only a law enforcement tool, but also a health care tool so that doctors can make sure that patients are taking prescriptions prescribed for them and nothing more and not shopping from one place to another. Anything that my office can do we are here to assist.

Chairman Price: (19.1) With so many people in the valley and on the border - Do you have to talk to your counterpart in Minnesota if there is something we should add to make sure we don't have the across the border problem with the clinics in East Grand Forks or Moorehead or something so that people can still do shopping?

Attorney General Wayne Stenehjem: It does need to be addressed, and I don't know what kind of mechanism there needs to be for interplay across the border. That is a very good question, especially in ND where a large portion of our population lives on the border and circumvent what is intended by this legislation. I will leave that to Mike Mullens.

Senator Warner: (19.7) I have a question about confidentiality of information and the number of people that have access to it. I understand from the legislation that this likely be reported to

law enforcement, but if we are going to treat this as a health issue then it would be more important that the doctors have information and can you give me some outline of how that information would move back and forth?

Rep. Kreidt: Referring to one of the lines of Attorney General Stenejhem, our pharmacy in New Salem which is located close to Interstate 94 in the last year and a half has been robbed six different times, and one of the consequences of that is that they now are limited to the number of these types of drugs that they can keep on hand because of the consistent robbery of that business. It is a real problem.

Senator Brown: (21.3) This internet thing is kind of frightening. Is there any way to try and control that? If nothing else that someone would give their credit card number over the internet and not get a product.

Attorney General Wayne Stenejhem: When you are ordering, you do not know where you are getting it from. You might think you are getting it from a pharmacy here or Canada, but you are getting it from Indonesia. Some of these folks don't care about quality control. The internet is a wonderful tool, but there are all kinds of possibilities of mischief. The possibility of us here in North Dakota really being able to get a handle of someone here today and gone tomorrow and operating out of somewhere soon to be vacated it makes it difficult to get a handle on it. This is really an area where the federal government is the agency is going to have to be the one responsible for it. Sometimes states work together and other law enforcement agencies as well.

Senator Lee: (22.7) A couple of years ago I was at a national conference of state legislators in Washington DC, and one of the gentlemen from the federal office was there talking about exactly these kind of things. Someone may think they are safe, but these drugs travel from country to

country and you really never know where they are really coming from. There is a seal of approval developed by the authorities to indicate which internet sites that drugs may be appropriate and quality control. But people don't give a weight to the quality, they don't give a weight about forging the field and that has come to mean nothing very quickly.

James Carter, Executive Director of the Wyoming Board of Pharmacy:(24.0) To address what to do with the adjoining states, and the issue of the people jumping state lines. Wyoming has clearly recognized the need for prescription monitoring programs, and we encourage and testify in adjoining states to consider or establish a prescription monitoring program. **(See Attached Testimony).**

Rep. Porter: (36.7) A lot of the information is entered and passed through from the pharmacist; what happens in the case where the physician is giving samples of medication that may cover the illness completely where the person never has to go to a pharmacist?

James Carter: In Wyoming we only require pharmacies who have computerized data base to submit the information to forward. We are currently not collecting data from the individual practitioner. That is an issue we have talked about in WY, what we may do in WY is that we may start tracking the sale of controlled substances to the practitioners from the wholesalers. If one is doing quite a bit of dispensing, we have the authority to go in and inspect and look at the record. The problem we have with practitioners reporting the data is that they do not have computerized systems for the most part. In WY our biggest prescriber would be veterinarians. You may ask why, but people will try anything.

Rep. Porter: (39.0) On the program itself, the hours of operation and the fax on demand type system - when you looked at the overall program, did you look at more a virtual program and the cost associated with being fully internet accessed or a secure site type centralized data base?

James Carter: Yes we did, we were trying to get a program established at a minimal cost to the state of Wyoming that would also service its ????????. The state of Utah now has a 24/7 internet based program. The state of Kentucky is trying to get theirs implemented sometime this year. Wyoming is just kind of wait and see - we want to see how they work, we want to see the problems they have with hackers, and we want see the problems they have with cost. I know the Utah program has gone up in cost considerably. The feedback I have gotten back from practitioners trying to access the program have had some issues with it. I think that is where we need to go. I mentioned earlier about our survey results from the users the biggest feedback we have gotten is that they would like to have 24/7 data. The ER doctor would like to be able access the data at all hours. We would like to have a little picture of time to see how well the state of Utah and the state of Kentucky do in the program.

Representative Porter: (40.8) Mr. Carter, do you have ball park figures on what they were spending to be a virtual online system?

James Carter: In Utah, what I have seen so far, my best guess is that they were looking at $50,000 and now they are looking at $150,000.

Rep. Porter:(41.2) Do you know what the initial implementation costs were?

James Carter: The did it strictly did it in house. They collected all the data in house, and had all of the IT people where they could do it. Wyoming, the board of pharmacy is located in Casper and most of the state offices are in Cheyenne about 200 miles away. We really didn't have the IT

or computer back up support, so we started our program with a contractor out in New Hampshire. That approximates about half of the cost. We used a grant to buy hardware, desks, hire a person to set up the contract, and I am sure our costs will average about $80,000 a year with using Atlantic Associates to collect the data. To bring that in house I will have to decide if I need bring in a half or full time person. If I have to bring in a full time person, I probably can't do it any cheaper than I am currently doing it, but I may have the capability of getting the data more often with the data being more up to date.

Rep. Weisz: (42.7) I have a couple of questions. One, earlier pharmacies in Wyoming, are they currently computerized, as far as the database?

James Carter: We had only one in the state that wasn't computerized, and he ended up retiring and closing the store. All of the stores in Wyoming are computerized. We have only have 140 pharmacies. About 66 of them are mom and pops and the rest are all chains.

Rep. Weisz: (43.5) Since you have been going, I realize it has only been 7 months, have you followed up with your Department of Human Services, and have they found this information useful for Medicaid and some of the issues there? I know in our state we have got some Medicaid issues recipients that are currently taking over 20 drugs at the same time. As far as monitoring and that, has your Human Services Agency been able to access this information and found it useful?

James Carter: Actually the Medicaid program in Wyoming does not access the program. They are considered a law enforcement agency and would be able to. Wyoming law is set up really unique in that if you are a law enforcement agency or a professional licensing board, you may receive data from the board but the board has to make the determination if we feel it is suspicious

or fraudulent activity. The statute doesn't allow the local police department or Medicaid to contact the board and get a profile on a person. We look at the profile and feel there some kind of fraudulent or illegal activity. We do that for patient protection. We take that confidentiality very seriously, have done it that way. We work very closely with the DEA, because they have inspection authority.

Senator Warner: (45.4) I would like to follow up on your comments on the timeliness of the information. My understanding is because you use an outside contractor you only receive the information once a month. Can you give me some idea of what you think would be ideal timeliness?

James Carter: I think right now once a month works out well. I will tell you some of the issues we have, and that is education. The chains have to respond to these programs in other states already. They are probably reporting data about once a week. The mom and pop stores don't. They do it once a month. If I have had problems, the problems have been with getting those pharmacies to turn in their data complete without errors by the 10th of the following month. What we will find is that they turn it in with errors and it gets rejected by the contractor because they left out vital information. It goes back and needs to be cleaned up and sent back in. Often times it then late and has to be held over to the next month. I think that if we went to a shorter time period, we would have to get the pharmacies to be on a routine pattern of turning their data in.

Senator Dever: (48.9) There has been some discussion of interstate issues. Here in North Dakota we have international issues. I guess I am curious, I know the federal stance is that

importation of drugs from Canada is illegal. Do we see a growing problem if we tighten up issues within the state?

Mr. Horton: I don't know that we have seen that resulting directly from the Prescription Drug Monitoring Program. It is clearly an issue as announced by the federal congress. I don't know what the answer is going to be. I don't think that there has been a link however to proliferation of monitoring programs and people running for drugs to Canada. Frankly, I think that one, we don't believe that everyone trying to purchase drugs from Canada is doing it because they have an addiction. There are price issues as well. I think that is going to be a factor, but perhaps somewhat of a fraction of the existence of prescription drug monitoring programs. We see these programs as a method of preventing abuse. I can promise you that on the federal level we are going to continue to deal with that issue, but at the same time, I am not sure that there is going to be a cause and effect. Comment on prior statement about time limits of information. Various states have dealt with the problems of time limits in different ways. We think it is very important that states try and get the information back as quickly as possible. Bringing the data review process in house as Idaho has done, has tended to not only make sure pharmacists and doctors have information more quickly, but as I understand it, it lowered their operating cost after an initial investment that is required to do that. When asked the question - should we try to have the program implemented only if it is as perfect as it can be in terms of time limits, or should we try and get programs implemented and work with states to make sure that that concern that you raised is addressed. We believe that having these programs in place and then working with them to discuss best practices is the way to go.

Senator Lee: (53.0) I think it is also important to note that we see this as not only as a law enforcement issue but at least as important as a good health issue. One of the Senators this morning was mentioning why he things this is a good idea, not someone on our committee, but because he lives in a small community that is some distance from an urban area and the local pharmacy can't stock all of the prescription drugs that some people take, and they have to go to their doctors and the doctors need to have a resource to know what other doctors are prescribing. This is a really good tool to consider.

Howard Anderson, Executive Director of the ND Board of Pharmacy: (Side B of Tape) (See Attached Copy of Testimony and Model Prescription Monitoring Act).

Rep. Porter: (11.4) The one thing that was brought up that was not mentioned in the amendments was the veterinarians and the potential for abuse out there with Phidol(?), and I know that I have heard about numerous cases of that happening and I was wondering how that could be dealt with to bring them in under this same program to assist them in some of the problems that they have?

Howard Anderson: To tell you the truth I did not think that veterinarians were that big of a problem I guess. So we specifically left them out, but we can change that if you want to. I have not seen that in North Dakota, but we can adopt that now or later on.

Senator Lee: (12.5) We are not going to micro manage Mr. Anderson. What if we were going to throw veterinarians into the pot here, where would we put them?

Howard Anderson: It would just be that we had taken them out and we can find where we did that and put them back in.

Senator Lee: You can get back to me on that.

Howard Anderson: We do have to remember that they don't have all of the equipment they would need and we have to be sensitive to that, and we don't want to cause undo costs to their practices. Mike will address the interstate issue of that bill.

Rep. Porter: (13.3) On the funding mechanism on page 4, do you have just an idea of what the providers are going to be expected to pay to make this system ongoing after the grant would run out?

Howard Anderson: I am guessing that if we can do this for $100,000, that we are looking at $30 to $50 per year, for anyone who handles prescriptive authority.

Senator Warner:(14.0) I'd like to discuss the definition on page 1, the exclusions in the term dispenser, and I understand that on page 3 when you are talking about health care providers, that includes people who dispense medicines or allowed access to the information. But in the definition on page 1 that would exclude a licensed hospital pharmacy, a practitioner, and a wholesale distributor from having access to the information. Is that true?

Howard Anderson: The exclusions in here - lets go through them specifically. A dispenser, when we consider dispensing, that is the person who gives you a prescription to take home with you. If the physician gives you a injection or gives you a tablet to take, that is considered administration. That is not included. There is no intention here to keep track of that, and I don't think that it is necessary. In patient hospital, that is when the patient is in the hospital, we don't feel that it is necessary for them to report that because they are under the hospitals care and there is not much chance of that being diverted to someone else. The wholesaler is the person who handles a lot of controlled substances - ships them to our pharmacies, but we are not expecting them to report that. We have other methods to capture wholesaler data through the drug

enforcement administration. I think those exclusions there are for people we don't need the information from.

Senator Warner: (15.8) Can I ask for a definition of practitioner?

Howard Anderson: A practitioner in North Dakota, which we use this definition throughout the medical regulations, is someone who has the authority to prescribe drugs.

Senator Warner: (16.4) I still don't understand how you can exclude, they are excluded from the term dispenser then. They are actually giving the drug to someone?

Howard Anderson: Administration is when you actually give them a shot or a single dose of something - that is administration. Dispensing means that I gave you a bottle of pills or a bag of samples and I sent you home.

Senator Warner: (16.8) So this excludes practitioners only when they are administering not when they are prescribing.

Howard Anderson: That is correct.

Mr. Mullen: With respect to the extra territorial application, if you turn to page 4 of the draft bill that Mr. Anderson distributed, you will see right in the middle of the page a paragraph titled "Extra Territorial Application" and that language explicitly permits the disclosure of information across state lines. In looking at that this morning, and I realize you are not acting on the bill, but I do have a slight change in the language that I would recommend. Instead of saying "nothing in this chapter shall be construed to prohibit the disclosure" substitute the language, "the board of pharmacy may disclose information about a patient in the monitoring program database to a practitioner in another state". That would cover disclosures across state lines.

Arnold Thomas, President of the North Dakota Health Care Association: (18.9) I would like to respond to this proposal. I think the pursuit of enabling language should be pursued. I think the specificity of the proposal as it was shared with you today was too technical and too complex, and I for one nor any of my members have not seen it. I have been very involved in moving this measure forward, particularly with respect to it's medical applications. To be putting a bill together at this particular juncture that has major consequences; particularly when we bring law enforcement and medical together. Where there may be mutually overlapping purposes, exclusive purpose without the necessary bringing together of all participants such as was done in Wyoming to work through the details with respect of what we are trying to accomplish, it is seemingly premature at this juncture. I would pledge to you to work on enabling language to allow us to take full advantage of all resources available federally as well as state to put a plan into effect to assure that we are monitoring the appropriate dispensing and prescribing of prescription drugs in North Dakota. It is just that what you have before you right now is just hard for me to grasp. Secondly, where is this going to be housed? The White House's proposal is triggered by drug diversion and their concern with respect to that. Its a law enforcement concern. Wyoming has elected to go a medical route. We need to sit down and decide whether we want to have multiple objectives or a singular objective. A lot of that determination will have impact relative to its structure, its policy setting, who participates, who come to set the rules and standards of regulation. I am not sure if this permits a public/private partnership, or is it exclusively a state partner with the federal government with respect to what may or may not happen and be required on the private sector. I am equally concerned of the exclusion of hospitals. By virtue of the fact in North Dakota 80% of the physicians are integrated with

hospitals. It is our computer systems that are being developed to help manage patient services, and to exclude the institutions it would seem to me at the outset to be very short sighted. How would we participate and be involved with respect to the computerization of this endeavor is something that would need to have further discussion both with the state and any vendors with whom we would agree. I am equally concerned about the invitation to participate with the Medicaid programs computer program. I just came from HB1012 down the hall and they are indicating they need 35 million to operate that mechanism. We experienced significant payment shortage in the last session due to the MIF short inadequacies. And we are going to use that system for this program? Unless someone is thinking of something different, I am very reluctant to use any application of the current Medicaid computer system to an endeavor such as this without further opportunity to discuss this more fully. And finally, the participants, you heard another question this morning with respect to who should be at the table. I certainly think the doctors need to be involved in this discussion; law enforcement, and pharmacy. I don't know about what the physicians will say when they hopefully come here to testify with you. I just find it very interesting that in the last three and a half years in which this issue has been discussed no hospitals have been involved. Frankly, an undertaking such as this which has major policy implications and good benefits, to be dropped on a committee halfway through the session I find uncontionable.

Senator Lee: (23.3) Just a comment, I think that it would be inappropriate to say that it was brought to us without warning on anybody. We had no idea that there was going to be any kind of support financially or any other source offered by the White House. As you well know, we had gone over this in the Senate, and did not move forward on this because of many reasons. It is

because of a grant possible available and we would be remiss if we did not consider this possibility. We may choose to deny application if we so decide.

Arnold Thomas: My issue was not with the committee. This was a proposed bill to implement this measure.

Senator Lee: (24.3) Mr. Thomas, the model legislation was on the web site. I think it is appropriate for us as committee members to accept any information that was provided for us and decide what to do with it.

David Peske, North Dakota Medical Association: (24.7) I thought the committee would like to hear that the medical community is behind moving this concept forward. As you heard from various witnesses earlier, we have been involved in discussing this issue to some extent, and again for members of the House Committee to reiterate what the Senate Committee may have heard from us. Looking at SB 2312, we are in favor of this concept as a patient care vehicle, however the complexity of the bill we are looking at now the same amendments can be looked at on HB1459. I think I echo Mr. Thomas' concerns that we have an opportunity to look at what is going to be put together. I told the Senate Committee that if you did not pass SB2312 we would commit to sitting down as a group of stake holders and looking at the issues involved so it comes out a correct way and doesn't place on anyone. As a matter of fact, the day that I heard Mr. Horton was going to be here, Mr. Anderson and I were starting to look at our calendar to set a date in May to sit down and do that. I was pleased to hear Mr. Carter's comments that they spent a great deal of time that is ongoing involving the stakeholders in their process in Wyoming. I also wanted you to know that in visiting with Mr. Horton yesterday, he offered two other states that he helped and holds out as models that we might want to look at how they are operating etc.

The bottom line is to enact the amendments that Mr. Anderson may have proposed, I haven't seen the latest version; it may not be exactly the right program we want to put in place. Coming with some type of enabling legislation that is not as specific as who is going to do it, where it is going to be housed, etc., might be to our advantage.

Senator Lee: (26.8) Mr. Peske, what were the other two states that Mr. Horton mentioned?

Mr. Peske: I believe they were Idaho and Nevada.

Chairman Lee: Any more questions? O.K. - Joint committee adjourned.

FISCAL NOTE

Requested by Legislative Council
04/19/2005

Amendment to: Reengrossed HB 1459

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

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	($610,470)	$0	($247,359)
Expenditures	$0	$0	($154,530)	($610,470)	($247,359)	($803,445)
Appropriations	$0	$0	$0	$0	$0	$0

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

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

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

This bill would provide for creation of a prescription drug monitoring program and medical assistance program management.

The expenditures would include the operating costs to contract for the managed health care system which would be offset by the savings that should result in the medicaid grants line item.

The appropriation affected would be the agency's appropriation.

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

Revenue includes Title XIX funds at a 50% match rate for the contracted costs offset by the Title XIX that would not be drawn as a result in savings on the grants after implementing such a program.

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

Expenditures are comprised of the contracted costs of operating an integrated system for the management of health care needs of medical assistance patients in the 2005 - 2007 biennium of $765,000 total funds - $382,500 from the general fund. These expenditures are offset by the projected savings that should result in the medicaid grant expenditures estimated to be $1,530,000 total funds - $537,030 from the general fund. It is believed that it will be six months before the program is fully implemented. Prior to adding the $1 million appropriation in section 4, the net savings amounts to $765,000 total funds of which $154,530 is from the general fund.

2005 - 2007 biennium estimates the program to be fully implemented for the full 24 month period while considering the cost of inflation and future FMAP.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on*

the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

The effects of this bill are included in the 2005-2007 appropriations bill.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	04/20/2005

FISCAL NOTE

Requested by Legislative Council
03/18/2005

Amendment to: Reengrossed HB 1459

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

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	($610,470)	$0	($247,359)
Expenditures	$0	$0	($154,530)	($610,470)	($247,359)	($803,445)
Appropriations	$0	$0	$0	$0	$0	$0

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

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

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

This bill would provide for the development of a system for managing the health care needs of medical assistance patients; it would also provide for the implementation of a prescription drug monitoring program.

The expenditures would include the operating costs to contract for the managed health care system which would be offset by the savings that should result in the medicaid grants line item.

The appropriation affected would be the agency's appropriation.

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

Revenue includes Title XIX funds at a 50% match rate for the contracted costs offset by the Title XIX that would not be drawn as a result in savings on the grants after implementing such a program.

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

Expenditures are comprised of the contracted costs of operating an integrated system for the management of health care needs of medical assistance patients in the 2005 - 2007 biennium of $765,000 total funds - $382,500 from the general fund. These expenditures are offset by the projected savings that should result in the medicaid grant expenditures estimated to be $1,530,000 total funds - $537,030 from the general fund. It is believed that it will be six months before the program is fully implemented. Prior to adding the $1 million appropriation in section 4, the net savings amounts to $765,000 total funds of which $154,530 is from the general fund.

2005 - 2007 biennium estimates the program to be fully implemented for the full 24 month period while considering the cost of inflation and future FMAP.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on*

the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

The effects of this bill are included in the 2005-2007 appropriations bill.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	03/22/2005

FISCAL NOTE

Requested by Legislative Council
02/17/2005

Amendment to: Engrossed HB 1459

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

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	($610,470)	$0	($247,359)
Expenditures	$0	$0	($154,530)	($610,470)	($247,359)	($803,445)
Appropriations	$0	$0	$0	$0	$0	$0

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

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

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

This bill would provide for the development of a system for managing the health care needs of medical assistance patients.

The expenditures would include the operating costs to contract for the managed health care system which would be offset by the savings that should result in the medicaid grants line item.

The appropriation affected would be the agency's appropriation.

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

Revenue includes Title XIX funds at a 50% match rate for the contracted costs offset by the Title XIX that would not be drawn as a result in savings on the grants after implementing such a program.

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

Expenditures are comprised of the contracted costs of operating an integrated system for the management of health care needs of medical assistance patients in the 2005 - 2007 biennium of $765,000 total funds - $382,500 from the general fund. These expenditures are offset by the projected savings that should result in the medicaid grant expenditures estimated to be $1,530,000 total funds - $537,030 from the general fund. It is believed that it will be six months before the program is fully implemented. Prior to adding the $1 million appropriation in section 4, the net savings amounts to $765,000 total funds of which $154,530 is from the general fund.

2005 - 2007 biennium estimates the program to be fully implemented for the full 24 month period while considering the cost of inflation and future FMAP.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on*

the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.

The effects of this bill are included in the 2005-2007 appropriations bill.

Name:	Brenda Weisz	**Agency:**	Human Services
Phone Number:	328-2397	**Date Prepared:**	02/17/2005

FISCAL NOTE

Requested by Legislative Council
02/07/2005

Amendment to: HB 1459

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

	2003-2005 Biennium		2005-2007 Biennium		2007-2009 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				($610,470)		($247,359)
Expenditures			$845,470	($610,470)	($803,445)	($247,359)
Appropriations			$745,470	($710,470)		

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

2003-2005 Biennium			2005-2007 Biennium			2007-2009 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

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

This bill would provide for the managed care development fund and the development of a system for managing the health care needs of medical assistance patients.

The expenditures would include the operating costs to contract for the managed health care system which would be offset by the savings that should result in the medicaid grants line item.

Additionally section 4 of the bill provides for an appropriation of $1,000,000 general funds for establishing a managed care development fund for managing the health care needs of medical assistance patients as negotiated with service providers, health care cooperatives, or health care consortia.

The appropriation affected would be the agency's appropriation.

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

Revenue includes Title XIX funds at a 50% match rate for the contracted costs offset by the Title XIX that would not be drawn as a result in savings on the grants after implementing such a program.

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

Expenditures are comprised of the contracted costs of operating an integrated system for the management of health care needs of medical assistance patients in the 2005 - 2007 biennium of $765,000 total funds - $382,500 from the general fund. These expenditures are offset by the projected savings that should result in the medicaid grant expenditures estimated to be $1,530,000 total funds - $537,030 from the general fund. It is believed that it will be six months before the program is fully implemented. Prior to adding the $1 million appropriation in section 4, the net savings amounts to $765,000 total funds of which $154,530 is from the general fund.

2005 - 2007 biennium estimates the program to be fully implemented for the full 24 month period while considering

the cost of inflation and future FMAP.

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

For the 2005 - 2007 biennim, the above costs are offset by $200,000 total funds included in the agency's appropriation for disease management of which $100,0000 is from the general fund.

Name:	Brenda M. Weisz	**Agency:**	DHS
Phone Number:	328-2397	**Date Prepared:**	02/09/2005

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1459

Page 1, line 2, remove "and"

Page 1, line 3, after "appropriation" insert "; and to declare an emergency"

Page 1, after line 16, insert:

"SECTION 2. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance program management. The department of human services, with respect to the state medical assistance program shall:

1. Provide statewide targeted case management services for neonates and the 2,000 medical assistance recipients with the highest cost for treatment of chronic diseases. Case management services must focus on those recipients in these groups that will result in the most cost savings taking into consideration available resources and may include a primary pharmacy component for the management of medical assistance recipient medication.

2. Require medical assistance providers to use the appropriate diagnostic and procedure codes when submitting claims for medical assistance reimbursement. The department may exempt qualified service providers and providers of institutional care services from this requirement.

3. Review and develop recommendations for the improvement of mental health treatment and services including the use of prescription drugs for medical assistance recipients.

4. Review and develop recommendations regarding whether the number of medical assistance recipients who are placed in out-of-state nursing homes should be reduced.

5. Review and develop recommendations regarding whether the use of post-office addresses or street addresses are the appropriate mailing addresses for medical assistance recipients.

6. Review and develop recommendations regarding whether to require medical assistance providers to secure prior authorization for certain high-cost medical procedures.

7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification medical assistance cards for all medical assistance recipients should be implemented.

8. Review and develop recommendations regarding whether medical assistance providers should be required to use tamper-resistant prescription pads.

9. Develop a plan to provide information to blind and disabled medical assistance recipients who may also be eligible for Part D benefits under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173: 117 Stat. 2066; 42 U.S.C. 1396kk-1) so that they may enroll for such benefits.

10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and medical assistance providers.

Reporting to legislative council. During the 2005-2007 interim, the department of human services shall report to the legislative council regarding the review and recommendations required in this Act."

Page 1, line 17, replace "2" with "3"

Page 1, after line 23, insert:

"**SECTION 4. EMERGENCY.** This Act is declared to be an emergency measure."

Renumber accordingly.

Adopted by the Human Services Committee
February 2, 2005

VR
2/3/05
1 of 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1459

Page 1, line 2, replace "and" with "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance program management; to provide for a report;"

Page 1, line 3, after "appropriation" insert "; and to declare an emergency"

Page 1, after line 16, insert:

"**SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance program management. The department of human services, with respect to the state medical assistance program, shall:

1. Provide statewide targeted case management services for neonates and the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases. Case management services must focus on those recipients in these groups which will result in the most cost-savings, taking into consideration available resources, and may include a primary pharmacy component for the management of medical assistance recipient medication.

2. Require medical assistance providers to use the appropriate diagnostic or reason and procedure codes when submitting claims for medical assistance reimbursement. The department may exempt qualified service providers and providers of institutional care services from this requirement.

3. Review and develop recommendations for the improvement of mental health treatment and services including the use of prescription drugs for medical assistance recipients.

4. Review and develop recommendations regarding whether the number of medical assistance recipients who are placed in out-of-state nursing homes should be reduced.

5. Review and develop recommendations regarding whether the use of post-office addresses or street addresses are the appropriate mailing addresses for medical assistance recipients.

6. Review and develop recommendations regarding whether to require medical assistance providers to secure prior authorization for certain high-cost medical procedures.

7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification medical assistance cards for all medical assistance recipients should be implemented.

8. Review and develop recommendations regarding whether medical assistance providers should be required to use tamper-resistant prescription pads.

9. Develop a plan to provide information to blind and disabled medical assistance recipients who may be eligible for part D benefits under the

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The information must inform recipients of part D benefits for which the recipient may be eligible.

10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and medical assistance providers.

SECTION 3. REPORT TO LEGISLATIVE COUNCIL. During the 2005-06 interim, the department of human services shall report to the legislative council regarding the development of recommendations required in section 2 of this Act."

Page 1, after line 23, insert:

"**SECTION 5. EMERGENCY.** This Act is declared to be an emergency measure."

Renumber accordingly

Date: 2/2/05 Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

House **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as amend- Re Ref Approp.

Motion Made By Potter Seconded By Damschen

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

Total ( ) 11 yes **No** 0

Absent 1

Floor Assignment Chrm Price

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

REPORT OF STANDING COMMITTEE

HB 1459: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (11 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1459 was placed on the Sixth order on the calendar.

Page 1, line 2, replace "and" with "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance program management; to provide for a report;"

Page 1, line 3, after "appropriation" insert "; and to declare an emergency"

Page 1, after line 16, insert:

"**SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance program management. The department of human services, with respect to the state medical assistance program, shall:

1. Provide statewide targeted case management services for neonates and the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases. Case management services must focus on those recipients in these groups which will result in the most cost-savings, taking into consideration available resources, and may include a primary pharmacy component for the management of medical assistance recipient medication.

2. Require medical assistance providers to use the appropriate diagnostic or reason and procedure codes when submitting claims for medical assistance reimbursement. The department may exempt qualified service providers and providers of institutional care services from this requirement.

3. Review and develop recommendations for the improvement of mental health treatment and services including the use of prescription drugs for medical assistance recipients.

4. Review and develop recommendations regarding whether the number of medical assistance recipients who are placed in out-of-state nursing homes should be reduced.

5. Review and develop recommendations regarding whether the use of post-office addresses or street addresses are the appropriate mailing addresses for medical assistance recipients.

6. Review and develop recommendations regarding whether to require medical assistance providers to secure prior authorization for certain high-cost medical procedures.

7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification medical assistance cards for all medical assistance recipients should be implemented.

8. Review and develop recommendations regarding whether medical assistance providers should be required to use tamper-resistant prescription pads.

9. Develop a plan to provide information to blind and disabled medical assistance recipients who may be eligible for part D benefits under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The information must inform recipients of part D benefits for which the recipient may be eligible.

10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and medical assistance providers.

SECTION 3. REPORT TO LEGISLATIVE COUNCIL. During the 2005-06 interim, the department of human services shall report to the legislative council regarding the development of recommendations required in section 2 of this Act."

Page 1, after line 23, insert:

"**SECTION 5. EMERGENCY.** This Act is declared to be an emergency measure."

Renumber accordingly

2005 HOUSE APPROPRIATIONS

HB 1459

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. 1459
Health Care for Medical Assistance Patients

House Appropriations Committee
Human Resources Division

Hearing Date: 2-10-05 Thursday a.m.

Tape Number	Side A	Side B	Meter #
I	X	X	25.8 - 1-4
Committee Clerk Signature	Diana M. Overby		

Minutes: **Chairman Delzer** opened the meeting on HB 1459.

Rep. Clara Sue Price, District 40: This bill is based on Don Muse' recommendations. We picked ten of them and tried to prioritize given the MMA and MMIS. Section two: 1) Provides statewide targeted case management services for 2,000 cases and look at 200 of the highest cost recipients; 2) Requires medical assistance providers to use the right diagnostic and codes when submitting claims for reimbursements. You saw how many claims are being paid despite incorrect codes. Other points deal with the several Medicaid claims going to post office boxes; whether our reciprocity is working; if prior authorization is needed; if photo IDs are needed since North Dakota does not seem to have a lot of fraud; if tamper-resistant prescription pads are needed since a lot is being done electronically; 9) Deals with a real concern of developing a plan to provide information to blind and disabled medical assistance recipients who may be eligible for part D benefits; 10) Reviews permitting risk-sharing arrangements between the department and medical assistance providers. There is a $1 million appropriation in the original bill and left

it. I have asked the Dave Zentner, with the department, to look at 2,000 cases and what it will cost us to serve them. Mr. Muse said he will teach the department how to run the tapes.

Chairman Delzer: Why the emergency clause?

Rep. Price: If Mr. Muse is already in the state, why not utilize his services now?

Chairman Delzer: The way section two is written, many of them only say Review and Recommendation.

Rep. Price: Correct. I do not think we can bite off all of them given what is on tap.

Chairman Delzer: I do not see anyone but the Department of Human Services involved. Is there anyone else?

Rep. Price: I think we need to have an interim committee. We need the bill to say that. Mr. Chairman, I prefer that you line it up here.

Chairman Delzer asked Celeste (OMB) to explain her note relating to a different bill.

Rep. Price: It will help us face the Medicaid population in the future.

Chairman Delzer: Would you prefer to carry it yourself or Appropriations?

Rep. Price: It does not matter.

Dave Zentner, Director of Medical Services for the Department of Human Services: The original bill carved a $1 million appropriation to assist in determining whether they want to be involved in managed care. The bill asks us to look at the 2,000 most expensive and it is part of the fiscal note. We anticipate it starting January 2006. We looked at a two-for-one figure, saving us $1.5 million.

Chairman Delzer: In essence, it should be a positive fiscal effect on Medicaid if the $1 million is not part of the appropriation. If we leave the $200,000, how do we appropriate for that?

Zentner: What is needed is $675,000 as we already have $200,000 (of which $100,000 is General fund).

Chairman Delzer: How do we budget for it? The appropriation should come out of the Human Services budget. Take $200,000 out of the budget?

Zentner: If you do not want to deal with the $1 million.

Chairman Delzer: In essence, we need to take increase administration from $200,000 to $565,000 (there will be a 50/50 match), and then reduce grants by $800,000.

Rep. Price: I would like to recommend you remove section one from the bill. It was an oversight on my part.

Chairman Delzer: Also take out section four and change section three to see that the interim committee is involved in the development of the recommendation.

Rep. Price: Anything that pertains to Hbs 1459 and 1465 and anything pertaining to this Medicaid issue, should remain in one committee.

Chairman Delzer: Carol or Dave, have we ever involved an interim committee to develop recommendations? We want to be efficient in getting this done in the interim.

Zentner: We can look at things that would cost us administratively and look at what the potential savings might be. The interim committee can give input on these.

(*Tape I Side B starts*)

Chairman Delzer: We will close this hearing now. We will stand in recess until later at the call of the Chair at 4:00 or tomorrow morning.

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. 1459

House Appropriations Committee
Human Resources Division

Hearing Date: 2-11-05 Friday a.m.

Tape Number	Side A	Side B	Meter #
II	X		22.4 - 27.7
Committee Clerk Signature			

Minutes: **Chairman Delzer** called the meeting to order on HB 1459 and handed out proposed amendments 50695.0201.

Chairman Delzer: The amendments remove sections one and four. Line five of page three of engrossed bill changes the reporting.

Vice Chair Pollert: I move the amendment 50695.0201.

Rep. Larry Bellew: I second it.

Chairman Delzer: With the removal of section four appropriation, we do not need any HB 1012 changes. Motion carries by voice vote.

Rep. Bellew: I move Do Pass As Amended on HB 1459.

Rep. Alon C. Wieland: I second it.

Chairman Delzer: I would like to say for the record that this is the outcome of the non-use study, which has provided good information that will help the department and the legislature.

Motion carries 6-0. **Rep. Bellew** will carry the bill. Rep. Pollert, there will not be an updated fiscal note. This will hit full committee before HB 1012.

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1459
Medical Assistance Program Management

House Appropriations Full Committee

❑ Conference Committee

Hearing Date February 14, 2005

Tape Number	Side A	Side B	Meter #
2	X		#4.0 - #11.0
Committee Clerk Signature	Chris Alexander		

Minutes:

Rep. Ken Svedjan, Chairman opened the discussion on HB1459.

Rep. Larry Bellew explained that the big part of this bill is in section 2 where it says that this bill targeted case management program in the state within the Medicaid program.

Rep. Ken Svedjan, Chairman commented that the President is considering reductions in case management in Medicare. Did your committee get to this discussion at all.

Rep. Larry Bellew answered that they did not.

Rep. Jeff Delzer commented that the amendments were built in conjunction with the standing committee. Human Services wanted section #2 that require certain things to be done with case management and with diagnostics. Sections 3-10 is basically to review and develop things that might be done within the department. This develops reports from the Department and Interim Committees. The standing committee suggested that we remove section 1 of bill since we don't

need the fund and section 4 because we put the appropriation in budget bill 1012. This should net us $150,000 in general funds with better care overall.

Rep. Ken Svedjan, Chairman summarizes that you are making an investment in the program through the $200,00 in the budget and the remaining $545 was a 50/50 split. And given the effectiveness of this program it will net $15,000 in general funds. (meter Tape #2, side A, #7.0)

Rep. Jeff Delzer further explains that we added the $745 to the administrative side and we took 1.53 away from the grant side.

Rep. Larry Bellew moved to adopt amendment #0201 to HB1459.

Rep. Alon C. Wieland seconded.

Rep. Ken Svedjan, Chairman called for a voice vote on the motion to adopt amendment #0201 to HB1459. Motion carried.

Rep. Larry Bellew moved a Do Pass As Amended motion to HB1459.

Rep. Alon C. Wieland seconded.

Rep. Ken Svedjan, Chairman commented that this was a wise thing to do with the Medicaid program. This gives significant focus to how we might care for these people in a more cost effective way by incorporating these things like disease management. Please read the Muse and Associates report. We need to be more effective in how we deliver the services to people.

Rep. Ken Svedjan, Chairman called for a roll call vote for to Do Pass As Amended motion to HB1459. Motion carried with a vote of 21 yeas, 0 neas, and 2 absences. Rep Price will carry the bill to the house floor.

Rep. Ken Svedjan, Chairman closed the discussion on HB1459.

Date: 2/11/05
Roll Call Vote #: 1

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1459

House **Appropriations - Human Resources** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 50695.0201

Action Taken DO PASS AS AMENDED

Motion Made By Rep. Bellew Seconded By Rep. Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Jeff Delzer	✓		Rep. James Kerzman	✓	
Vice Chairman Chet Pollert	✓		Rep. Ralph Metcalf	✓	
Rep. Larry Bellew	✓				
Rep. Alon C. Wieland	✓				

Total (Yes) 6 No 0

Absent

Floor Assignment Rep. Bellew

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

Deals with the removal of Sections one & four, and changes the reporting regarding the medical assistance programs.

Date: **February 14, 2005**
Roll Call Vote #: **1**

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB1459

House Appropriations - Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number **50695.0201**

Action Taken **DO PASS AS AMENDED**

Motion Made By **Rep Bellew** Seconded By **Rep Wieland**

Representatives	Yes	No	Representatives	Yes	No
Rep. Ken Svedjan, Chairman	X		Rep. Bob Skarphol	X	
Rep. Mike Timm, Vice Chairman	X		Rep. David Monson	X	
Rep. Bob Martinson	X		Rep. Eliot Glassheim	X	
Rep. Tom Brusegaard	X		Rep. Jeff Delzer	X	
Rep. Earl Rennerfeldt	AB		Rep. Chet Pollert	X	
Rep. Francis J. Wald	X		Rep. Larry Bellew	X	
Rep. Ole Aarsvold	X		Rep. Alon C. Wieland	X	
Rep. Pam Gulleson	AB		Rep. James Kerzman	X	
Rep. Ron Carlisle	X		Rep. Ralph Metcalf	X	
Rep. Keith Kempenich	X				
Rep. Blair Thoreson	X				
Rep. Joe Kroeber	X				
Rep. Clark Williams	X				
Rep. Al Carlson	X				

Total Yes **21** No **0**

Absent **2**

Floor Assignment **Rep Price (Human Services)**

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

REPORT OF STANDING COMMITTEE

HB 1459, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (21 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1459 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "to provide for the managed care development fund and the development of a"

Page 1, line 2, remove "system for managing the health care needs of medical assistance patients;"

Page 1, line 4, remove "to provide an appropriation;"

Page 1, remove line 7 through 18

Page 3, line 5, after "shall" insert "receive input from and"

Page 3, line 6, replace "2" with "1"

Page 3, remove lines 7 through 13

Renumber accordingly

2005 SENATE HUMAN SERVICES

HB 1459

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 1, 2005

Tape Number	Side A	Side B	Meter #
1		x	5650-end
2	x		00-5790
Committee Clerk Signature			

Minutes:

Chairman Lee reopened the hearing on HB 1459. The hearing began this morning with a joint meeting (see House minutes). A presentation was given by John C. Horton, Associate Deputy Director for State and Local Affairs, White House Office of National Drug Control Policy. (Attachment 1)

Rep. Price: This comes from the joint meeting with Don Muse on January 31. We decided to split out the two pieces from the Don Muse, we didn't want to put the MMA, the drug program and this together so we used another bill, as you see in front of you, as a vehicle for this piece of it. Our goal is to try to get a handle on some of the costs and what's involved in the Medicaid population and budget. In talking to the department and Mr. Muse, we realized that not everything that we would like to address is going to be possible in the next three years. We're looking at several changes. We want to stress the first two pieces in this bill. First is the targeted case management. We talked about the highest 200 cost recipients and about 3500 people for

case management. We cut the number down to 2000 so its just the people with dual diagnosis. The 200 that might be in the really high cost group, there are a lot of burn victims in that group. The biggest line item didn't have a code on them so we couldn't tell why they were getting that dollar amount. Some of it may be because of institutionalized and not requiring it. We did exempt the QSPs and those currently in an institution and QSPs really don't need to know. They're there for housekeeping or transportation or basic needs and they don't need to know what the person's diagnosed as. We're looking to get more information in the interim. The department can do some of these things themselves without prior authorization or legislation. We put the emergency clause on this because, after talking to Mr. Muse, it was estimated that his costs would range between $70,000-$100,000. The quicker we can get started the better. We need to make things more efficient.

Testimony in favor of the bill

Arnold 'Chip' Thomas, President of the North Dakota Healthcare Association. See written testimony (Attachment 2)

Sen. Warner: Number 8, could you elaborate, will prescription pads have colored features that would prevent photocopying or something electronic?

Thomas: I defer to Mr. Peske.

Chairman Lee: My goal is to do away with prescription pads and go all electronic to prevent forgery.

Thomas: The real rush to move down the electronic highway is a patient-safety driven initiative. It's to reduce interpretation error.

Chairman Lee: Why has ALTRUs program not been replicated anyplace else, it was successful.

Thomas: They were part of our study effort this summer. That was one of the questions; they were not only successful, but were able to demonstrate to the department's satisfaction, cost savings under the current Medicaid arrangement. What their comment is, is that there are two things going on: they are more aggressive in managing the population that is enrolled in their program, but they also believe that they have a positive population.. The people who are enrolled in their managed care effort seek that type of an arrangement. If you replicate it in other parts of the state, you'll hear 'adverse selection' and 1460 is one of the reasons we came to you and asked that we put some actuarial information in the hands of the department just to be able to make sure that if there is adversity, that you knowledgeably are offering a service which you can afford to offer. ALTRU always cautions anyone who's looking at what they're doing, to make sure your population is not adverse.

There was further discussion on ALTRUs experience and their population. Senator Brown mentioned that managed care has not been successful because people like their independence. He said it could be workable with the Medicaid population because they are more used to being told what to do, so they'd be more receptive.

Thomas: One valuable thing we did was determine who are the people in the program who would find a more managed environment appropriate--which are mom's with children. Most of those individuals are single mom's. They are working mom's--not the stereotypical non-working person. They are hardworking people who need assistance.

There was some discussion on the method of writing prescriptions.

Dave Peske, North Dakota Medical Association. We were involved in the study of the Medicaid system and how it can be improved. We are in support of this bill. We think some of

these items in the bill will tie in with the notion of creating an electronic prescription monitoring system.

Sen. Warner: I know pharmacies maintain list of what drugs you're on; do doctors have access to that same information?

Peske: There might be some access if the doctor is associated with an in-house clinic or hospital system. But that really is the gist of the electronic monitoring system. A doctor has a patient's chart, which has in it the drugs that he/she prescribed. But they don't know if the script was filled. But by and large a physician would not know what else they're taking.

There was some discussion concerning topics not directly related to the bill.

Chairman Lee: Are there any concerns with this bill as it came to us? It pretty much covers the items that were review when Mr. Muse came to us, and since we had that other bill that would result in his assisting the department in developing a plan, that would be part of this as well. We can assume for now that this is, and we can wait for Mr. Zentner's comments, that that part doesn't have any special questions from you. As far as the information we heard this morning from Mr. Horton, I heard him say that when we become eligible for the grant at the time that enabling legislation is introduced, we don't have to have a fixed plan in place in order to qualify for a federal grant.

Sen. Warner: Is that the planning grant or an implementation grant?

Chairman Lee: I thought the $350,000 grant, we could be on the list as applying for it when the enabling legislation for the plan was put into place. So we don't have to have something concrete in order for us to apply for the big grant.

Sen. Warner: He said we could skip the planning grant process, but does that mean ?????? on the implementation grant for planning.

Chairman Lee: Yes, and I looked back at 2312 and the fiscal note was $310,000 for the biennium if we'd done it the way the bill was stated before.

Senator Lyson read from the last page of Mr. Horton's testimony.

Sen. Lyson: Can we pass legislation with an effective date and if we can the do that, then we still can't make amendments can we?

Chairman Lee: It seems to me that there was a lesson to be heard from the gentleman from Wyoming when he talked about all the informational meetings that were held with the professionals that would be involved with this. There has to be ownership on the part of the people who are affected. We don't like to inflict things on people, we would rather have things that are collaborated on. So if we can figure out a way to put together legislation that doesn't just say that they're going to plan it, but if they get to the point that they're ready to begin the implementation that it was possible to do that, I don't know if we can do that. Maybe all we can do is plan for two years, but if they got it done in a year wouldn't it be great if they could move forward.

Sen. Lyson: We could make legislation to do exactly that, but at the end of the planning and meeting sessions, the implementation of this could go through by rule.

Chairman Lee: Isn't there something we could do so we don't have to wait two years before it gets the ball rolling.

Sen. Warner: I would like to see an emergency clause on this.

Chairman Lee: That's why I'm glad it has an emergency and I would want it to apply to everything.

David Zentner, Director of Medical Services, Department of Human Services: There are a couple provisions in the proposed bill that do make me nervous. On line 9 of the first page (read) I'm a little concerned that we have set this absolute limit to 2000. If I have the 2001 number that I think I can do something with, that might be able to save us some money and provide some efficiencies. I wouldn't want to be limited to not be able to move in that direction. So if we can do something along the lines with emphasis in this area or something, that would be helpful for us. I just hate to be so prescriptive that we couldn't move beyond that number. If it proves in our review that would be the way to go. We know who the top 2000 are, and we know a lot of what their diagnosis's are and we do find a lot of combinations of a chronic disease and a mental illness, primarily depression. We understand that you can't just look at one disease, you have to look at the whole individual, if you're going to try to improve processes. If we could have some language that would give us some flexibility so we would have the ability to move below the 2000 if we find that would be appropriate.

Sen. Brown: If we put an exception in here for burn patients, how close does that get you to the 2000?

Zentner: Not really. There are only about 5-10 burn cases. You could say 'with emphasis on the top 2000'

Chairman Lee: Then you wouldn't be locked into that number.

Zentner: We know that's where the money's at and where we'll concentrate initially on anyway.

Sen. Warner: Then you'd be somewhat limited by the appropriation anyway.

Zentner: And this is new territory for us too because we're going to have to contract out for it. What we hope to do is develop a homegrown system if we can, instead of give the money to an out-of-state entity.

Sen. Warner: Are you content with the words 'chronic disease'? To me a burn is not a chronic.

Zentner: Hopefully, we would have the flexibility. With a burn case you're not likely to case manage that case because they're in the facility, they're going to need what they need and for us to involve in case management process probably isn't going to make much difference. On the other hand, if you have a chronic disease like diabetes, asthma, chronic heart, congestive heart failure, renal failure, those types of things, there are some protocols out there that you can follow that will likely improve health and hopefully save some dollars. You do tend to concentrate on chronic conditions.

Sen. Brown: Would it help if we just identified like three of what you mentioned and just demonstrate it for a couple of years?

Zentner: That certainly is a possibility, we thought about that, on the other hand, when we first looked at this and put the $200,000 in the budget, we thought that our best bang for the buck would be to look at the most expensive cases. And some of them, about 850, didn't have a diagnosis of the top six or seven we looked at. We'll try to build based on what the intent of what the language is around that aspect.

Sen. Brown: Those 850 wouldn't lend themselves well to case management.

Zentner: We don't know that. We have to take a look at exactly what they're diagnoses are. Whether we can make some kind of case management. But there might be some that fall off that

will not be conducive to case management. So again, if we have the flexibility to look at. The other issue that concerns me a little bit is line 15 (read). Let me give you an example: We pay for services that most insurance companies won't. Someone needs to go to Minneapolis, we will pay for their transportation, food and lodging. We don't want to mandate that the EconoLodge in Rochester has to give us a diagnosis. What we do with that is we plug a miscellaneous type of diagnosis in there that has no relative relationship to what the actual individual has. But I don't think we want to have the little old lady who drives her friend to an appointment to have to have her submit a diagnosis. I don't think really what the intent was when Don Muse made that recommendation either.

Sen. Brown: I think what Don (Muse) was talking about was, for example: for asthma: are you using CPT codes.

Zentner: And the answer to that is yes.

Sen. Brown: That's the disease management part that I think we're looking at, and I have no trouble with those other miscellaneous ones.

Zentner: I would suggest that we have the language similar to what we do with the rest of this. The review and develop recommendations for looking at the issue of appropriate diagnosis and reasons and procedure codes, something along that line, I think would give us the flexibility. We can come back to the interim committee and talk about those issues. But the bottom line now, if we have a physician out there, their seeing a client of our, when they bill us, they're putting down the appropriate diagnosis. When someone goes to the hospital, they're coding all the diagnosis and procedure codes and we expect that. It's where we have nontraditional services that we have to deal with that we try to accommodate them and not force them to go through a lot of work to

get paid. I wouldn't want to force us to have that little old lady try to code a diagnosis in relationship to have her taking her friend to the doctor.

Vice Chairman Dever: What would happen if we deleted the word 'assistance' on line 15?

Sen. Brown: Couldn't we go one step further, and Dave, could you recommend language to us that would fit your needs.

Zentner: Yes. Those were our two concerns. We can work with the interim committee with the rest of the issues. We've already explored some of them, the post office box, those type of things.

Sen. Brown: What do you think about the pharmacy component?

Zentner: We are supportive of the idea of tracking especially narcotics, it's a good practice to do that.

Chairman Lee: After you visit with Brendan (Joyce), if he or you have any comments to bring back to us, we welcome those.

Zentner: I can get the language changes to you tomorrow.

Vice Chairman Dever: On line 9, does the word neonates apply to only preemies?

Sen. Brown: That was because there was such a high number of neonates showing up in Don Muse's report.

Zentner: We do pay somewhere between 20-30% of all the births in the state. We do have an interesting population to deal with. We do try to get them into the system in the first trimester. We do have targeted case management for pregnant women at risk. So we do make an attempt to get them into the process as early as possible. If they're drinking or smoking we try to get them to stop. Our best bet on the neonate side is, if you have a neonate baby, you have to treat them

initially in the hospital, I don't think case management is going to make any difference there. Where we might improve the process is after the fact. If we can get someone into that home to provide some guidance, we might be able to avoid some future costs and rehospitalization. But if you've got a two pound baby who initially is going to go into the hospital, there's not much you can case manage there. The only area you might want to look at is if they've been in there a period of time, if you have a case manager in there to see if we can hurry the discharge. But that's the only way I could see case management working in that initial period. The beauty of the process, is that sometimes you only need to make one visit, and see things are working fine and don't need to return. But you might find a family that is really struggling with the issue and the child is not thriving and you may want to have more involvement. It depends on an individual basis. That goes with all types of disease management.

You might have a case where a person with diabetes is following guidelines and doing fine, but another that is all over the place and doing poorly. The second is an example of a case you might want to follow more closely.

Sen. Brown: Neonates might not need case management, but utilization review instead.

Zentner: We do monitor that pretty close and look at a lot of those cases and sometimes make recommendations to change the coding. It has gotten better, but it's still not perfect.

Chairman Lee: Do you want to do something with the electronic monitoring part or do you want to wait to see what Dr. Joyce brings to us? What do you want to do to get the ball rolling with some sort of language for this bill?

Sen. Brown: I would like us to pursue this and we need to determine who can write it for us. What Mr. Anderson showed us this morning is way too specific and premature.

Chairman Lee: Yes, and one of the reasons we killed 2312 was because everyone wasn't in on the conference. But I want to make sure we get in line for the draft.

Vice Chairman Dever: Can we put the whole process in place and then authorize the department to implement the plan?

Sen. Lyson: We need to find out what the regulations are; find out how far we have to be to get a grant.

Chairman Lee: There was criticism of several of the choices of where it would come through. I don't know the right answer.

Sen. Warner: The criminal aspects of it could indicate the attorney general's office, although I'd prefer not.

Chairman Lee: I'd prefer not to have it there because I don't think that's appropriate. The perception would be, if it were put in the corrections or law enforcement side that it appears to be a punitive thing. I think there's a psychological disadvantage to having it come out of that area.

There was further discussion on the correct area to put this and the committee agreed that it was a health issue. Chairman Lee agreed to chat with Jennifer Clark to determine some language for this.

Sen. Brown: And we want to monitor the prescriptions of the Medicaid population. We've got to keep Brendan (Joyce) in the loop. It needs to revolve around the capabilities of his area.

Vice Chairman Dever: Mr. Horton mentioned that it wouldn't be perfect at the start.

Sen. Lyson: Law enforcement should only be a small part because they would only get involved if there's an investigation and then they can get subpoenas to get the information.

The committee agreed with Sen. Lyson.

Sen. Lyson: I don't think anyone is opposed to this, we just need to get things in the right spot.

Chairman Lee adjourned the meeting. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 2, 2005

Tape Number	Side A	Side B	Meter #
2	x		3120 - 4706

Committee Clerk Signature

Minutes:

Chairman Judy Lee opened the discussion on HB 1459.

Jennifer Clark, Legislative Council, appeared to discuss potential amendments by the committee on HB 1459.

Chairman Judy Lee said we want to be able to apply for the grant and we understand when the enabling legislation in introduced , we can begin the process. We need to find out what specifics need to be included. We will not need as much as will be available. Here's the rub, we haven't had time to do all the details, there is more than one way to do this. The proposal from Howard Anderson would have the Board of Pharmacy act as the public entity through which this would flow, we also have the potential to flow through the Pharmacy Medicaid computer and we are not sure that is the right answer either. All the stake holders need to have ownership of the outcome, including Department of Human Services, either the pharmacy director or our designee. We want

to have Department of Human Services involved because we want to see Medicaid have electronic monitoring.

Senator Dever asked if it is possible to put something together that we would enact now but would have an effective date after the next session so we would have time to work with it.

Jennifer Clark said that would be fine if it meets the requirements. If the committee wants to have enabling legislation, we can delay when the program goes into effect but we need to establish the groundwork now. It needs to be assigned to some state actor. There are many of options.

Senator J. Lee said she recognizes the importance of law enforcement in this issue but its more important from a public perception point of view to have it under Health or Human Services or Pharmacy because this is good for everyone. This not just a punitive monitoring, it is also meant to help people, in an emergency room setting for example or when a person sees more than one doctor.

Ms. Clark said she would envision an agency drafting administrative rules ahead of time so we need to give it to someone.

Senator Brown said this is a management tool, not a policeman, and on that basis he would like to see the Department of Human Services be the lead agency with other participants.

Senator Warner said his first inclination was Health, because the hospitals seem more involved with Health than with Human Services. When considering which agency has the most up to date computer system, Human Services has the worst and is the one that will be replaced the soonest so maybe that is the place to be.

Senator Brown said they have a good pharmacy.

Senator J. Lee said there is a module that would work for electronic monitoring so we do have vehicle.

Senator Lyson said he wouldn't mind seeing the Department of Health get it but he doesn't think they will because they are still in transition from moving to the Attorney General's office. We tried to put something else in the Health Department and they told us their plate is full.

Senator J. Lee said what if we made the Department of Human Services the host agency but all other stake holders would be involved. She certainly recognizes the importance of the Board of Pharmacy in this, her concern about making them the host is that all the entities should have an equal place in the discussion and they wouldn't if the Board of Pharmacy was the host.

Senator Lyson asked if we could designate the Department of Human Services and within the time of the planning, change it.

Senator J. Lee said in the fee for services program, as we progressed with the study, we discovered a better way to do it, maybe we could say we are adverse to a change if it becomes logical.

Ms. Clark asked if it is really going to take two years.

Senator J. Lee said hopefully not, she would like to get it reported to the Legislative Council, there is a fair amount of agreement.

Ms. Clark said if everyone gets together, makes status reports to Legislative Council, it could be up and running before the next session and it could be amended.

Senator J. Lee said she would like for them to have some history by next session so if we need to make any changes we can do it then. She doesn't want to wait until next session to start.

Senator Lyson said we have some background that we can start with, we can use it as a template. It doesn't matter who the host is.

Senator J. Lee asked if anyone thinks it is going to take two years to set this up because she doesn't think so. She thinks the emergency clause is already in there to be sure we can implement it. She wants a Legislative Council approval somewhere in that loop and she is not sure she wants the budget section. Interim committee on health care or human services and appropriations can be in on it also. This is not going to cost any money. We heard $50 per subscriber annually which is reasonable.

Senator Dever asked if we will designate an implementation date.

Senator J. Lee said she hesitates do that. Maybe we need to do legislative intent.

Ms. Clark said we should be able to make it clear enough. She has enough to get it going. She will send it directly to Legislative Council and make it a shall. The rule making process can be implemented. She can put an implementation date but it will drive itself.

Senator J. Lee said there is a great deal of enthusiasm for the concept.

Ms. Clark said she can specifically say that Department of Human Services should work with the Board of Pharmacy with Department of Human Services being the lead. She can't speak for the Board of Pharmacy but for a lot of the professional boards this would be too big a task.

Senator J. Lee said in Wyoming they only have a paper system and they don't include Medicaid. We want to include Medicaid right off the bat and we want it to be electronic.

Ms. Clark will get something together for the committee to consider and tweak.

Chairman Judy Lee closed the discussion on HB 1459.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

❑ Conference Committee

Hearing Date March 7, 2005

Tape Number	Side A	Side B	Meter #
2	X		31.4 - 58.0
Committee Clerk Signature			

Minutes:

Senator Judy Lee, Chairman of the Senate Human Services Committee opened discussion on HB 1459, relating to medical assistance program management; to provide for a report; and to declare an emergency.

All members of the committee were present.

Jennifer Clark representing the North Dakota Legislative Council explained the three provisions to the amendment (See attachment #1).

Senator Lee stated that because many are interested, it needs to be decided which entity will start the organization process to establish the program.

Senator John Warner stated he hopes that credence to the importance of pharmacists be included and asked if the committee would be interested in adding some sort of consumer input.

Senator Richard Brown responded the North Dakota Pharmacists Association is already on the committee. Between them and the North Dakota Society of Health Systems Pharmacists, every pharmacist in the state should be included.

Senator Warner agreed but there is only one representative from each organization and they are out number 12 to 1.

Senator Brown argued that this is a monitoring program and that law enforcement is a small part of the issue.

Senator Warner stated he did not have strong feelings about Human Services or Health but does not think it should be the Attorney General's department.

Senator Lee stated that even though it is recognized how extremely important the law enforcement component is, we do not want people to think that although the Attorney General's office is running it, that anyone who has a drug profile will be in violation of the law. We want them to know that their health out come is the major goal. She further stated that there is two parts, the law enforcement part and the health out come part.

Senator Brown stated that he felt the law enforcement should take second place and is only a small part.

Senator Lee asked Jennifer Clark to please be available if there were any questions for the next scheduled meeting.

Senator Warner asked Dave Zentner for a status report of the computer system and the appropriations process.

Dave Zentner answered that the Senate has heard his initial testimony and that the sub committee is going to start working on it later in the week. So at that time there should be more

discussion about the potential of them adding back in. He further stated the point of sale process within the medicaid payment system is a pretty good system and thinks it could be piggy backed onto it and how it could work.

Senator Warner asked what kind of time element there would be.

Dave Zentner answered it is real time. The pharmacists submits the information electronically and it is turned around in real time. They can be told if there is a liability, how much it is and if the claim itself is clean and then is passed along to the payment system. It works pretty well.

Senator Lee asked for an explanation from Bender??? of how he envisions the monitoring system because he is the expert about pharmacy. No details are needed, but a broad base summary of how he envisions this to work will help the committee.

Dave Zentner added that another issue with this bill is if the other amendment talked about will the bill pass.

Senator Lee stated that the committee did not want to mess this up and if there was another bill that would be more advantageous, than it should be done.

Dave Zentner stated there might be a problem with HB 1148 which is going to be heard by appropriations. That might be the bill to add the amendment to.

Senator Lee stated that it might be safer and he should investigate if that might be the route.

Senator Lyson asked for confirmation of the content of the amendment.

Senator Lee explained that the amendment being discussed is the emergency clause on the medicaid buy in, that had been forgotten earlier. It this is not added somewhere, there will be a month without any coverage.

Discussion was again held as to who is a part of this as many are interested and how it should be set up because it needs to be a partnership.

Senator Brown commented that BCBS wants to be involved but are not included in the amendment and they have more data than anyone else in the state.

Senator Lee gave a brief explaination as to the time schedule of the bills to be worked on.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

❑ Conference Committee

Hearing Date March 8, 2005

Tape Number	Side A	Side B	Meter #
2		x	745-4030
Committee Clerk Signature	Cathy Norvell		

Minutes:

Chairman Lee opened discussion on HB 1459. All members were present.

Chairman Lee: We have a couple of different amendments that are proposed, and Jennifer Clark went through the ones we asked her to do for us.

Arnold 'Chip' Thomas, President of the North Dakota Healthcare Association: Went over his proposed amendment. (Attachment 1)

Chairman Lee: Isn't peer review in the rules?

Thomas: Peer review is a statute.

Chairman Lee: Could it be included in the rules?

Thomas: I'm not sure what this group would come up with under peer review. What this is designed to do is give you latitude between now and the '07 session, what you could implement, you implement, and if you need to come back you can. So there's a work segmentation that we would envision happening here.

Sen. Warner: There was discussion about 'dispensers of medicine' and 'administers of medicine' and the committee seemed to be more interested in the dispensing of medicine; that we weren't interested so much in tracking the administration of a drug under the direct supervision of a doctor inside of a clinic or hospital. We were more interested in the illegal trade which presumable would mean some kind of porting or storage or illegal transfer of prescription. Is this a significant expansion of what the initial discussions were about?

Thomas: It may or may not, if I can go back in terms of what prompted the drafting of the proposal this way. The concept was provide as broad framework as possible and then when this group got together, if it needed to narrow the frame, which is basically the primary purpose for the dollars which came out of law enforcement initiative, if we wanted to shrink the focus, fine. Practically speaking, if you start with a narrow focus it is very difficult at time to expand your focus once you've gotten your project up and running. This enabled the group to say how broad a net do we wish to cast or how big is the frame? We have one opportunity to determine how broad of a project do we want to undertake. Looking at that, we thought these people would help to define what the breadth of the scope might be. There are about 7 million prescriptions written in North Dakota. From a health care/patient improvement perspective, it would be terrific if the practitioner had real-time access to the prescription history of an individual to make sure that what is being prescribed is not contraindicated by prescriptions being written by other practitioners. We don't have that capacity now. In our discussion, we think that should be part of the mix, right along with the drug enforcement provisions.

Chairman Lee: Mr. Anderson, are you on board with the amendments Chip provided? Should we use yours as a third draft to consider? Where do we go from here?

Howard Anderson: When we started this, I gave the committee something that could work right away and be put into place immediately. Obviously, we have a lot of people here that think we should study this further and look at it more carefully. The idea of expanding it to all prescriptions for example, to let the health department to do some monitoring of where we have health problems in the state. To give a physician access to all the prescriptions a patient is getting when they come to the emergency room or check into a hospital is certainly a laudable goal. If we can figure out how to do that, I'm all in favor of it. I think Chip's intention is to give us an opportunity to both implement a study period here and to look at everything that might be possible. I have no objection to that. From the beginning, I put the draft to the Board of Pharmacy in there, but I told you right at the start, I didn't have any particular to say that we should do it as opposed to somebody else. Obviously, if you're going to write an amendment to be adopted and work right away, we have to put somebody in there. In that respect, I think that any one of the options you have will work. Chip's idea of putting it in the health department, was that he looked at the health department as kind of a disinterested party here and maybe a good place to mediate from the beginning. I think they are very interested, and if we can put all the prescriptions into a real-time system so that they can do some health monitoring, and see if we're having a disease outbreak in particular area and the reason for it--from bioterrorism all the way to health care, that would be good. Nobody else does that in the country, so it certainly would be a step in a different direction, but certainly it has some real positive aspects.

Chairman Lee: Are there enough pharmacists on this board when that's who's primarily going to be working with this thing? It isn't that I don't think that the others shouldn't be involved, and

the bigger the committee, the less work gets done. But in this blend, it's the pharmacists who are the ones who are going to be doing the work most of the time.

Anderson: In think we'll have plenty of opportunity room for input. There's no intention here to leave people out.

Chairman Lee: Brendan (Joyce) can you tell us how you visualize this thing?

Brendan Joyce: In 2001, I started working with human services and HIPAA came out which was all about standardization, privacy came a little later. But it was standardization of electronic transactions. We had to rewrite our pharmacy claims system because it was not HIPAA compliant. They have four different general transactions for pharmacy transactions; now every pharmacy in North Dakota now has the electronic claims transaction system. The options are for billing, for prior authorization, for eligibility checking, and controlled substance reporting. When I learned these systems, I thought to myself, will we need this for Medicaid or for something else down the road, what's the cost of it? It essentially cost nothing additional, given the size of the reprogramming. I figured at some point in time, maybe the legislature would want to go for the prescription drug monitoring program of controlled substances such as John Horton from the White House talked about. So I made sure we had the capability to accept it. What this means is that every pharmacy in the state can submit to Medicaid the C1 transaction and this allows us to take in the data to see that gave out, for example, Oxycotin to Senator Brown. We would actually see, if we had the pharmacy submit it, on that C1 transaction, the data behind that transaction. The data sets are all HIPAA standards; we can accept through the Medicaid system, the doctor, the patient, date-of-birth, address, whether they're pregnant or not, whether they smoke, if the pharmacy would keep and save that infomation. The Board of Pharmacy has laws

that state the minimum required to keep track on a patient. Typically, they'll keep the address, birth date, those types of things. Those are easily transmittable from pharmacies.

Dispenser versus administrator question: The way I envision this, this only applies to pharmacies. These pharmacies are already billing Medicaid, they already have the HIPAA standard so they already have the program in place. They'll be a little additional programming needed to have them submit the C1 transaction, but all of the CHIPS hospitals that have pharmacies already have this billing software in place, so it's not an IT issue. I pulled a report from Carlee's computer that only took about 30 seconds. I pulled the top recipients of controlled substances for November 2004. I did the search on patients who had picked up controlled substances, who went to four or more pharmacies in one month period of time. This is the type of data that will be accessible beyond just the Medicaid population--it will help determine who needs assistance, who needs to be referred to pain specialist, etc. We're also talking about monitoring physicians and pharmacies and it helps out patient care wise.

The pharmacies would send in this data and the data warehouse would be there. The vendor that would be selected through an RFP (through the work group). One of the things would be that all of the prescribers, the pharmacies and the others that the committee determines should have access would have a password, to go to the Internet and pull up a report like I just did for Medicaid. Except they'd be pulling up a report, provided they have a patient/doctor relationship, a pharmacy/patient relationship or as a Medicaid payor/patient relationship and it's part of the normal activities of business for a payor, we're not going to look at someone unless we actually are actively investigating or if they pop up on one of these reports that could be preprogrammed to say, for example, I want to see people that go to more than 30 pharmacies--you'd want to put

them into a lock-in coordinated services program. There would be different levels of security, physicians would be able to see specific patients, payors would be able to see the other reports, board of pharmacy would be able to see pharmacy report, board of medical examiners would be able to see physician distributions. I would assume the board of nursing would have interest in nurse practitioners. It's simple and accessible. I would encourage, as far as amendment, to have everyone involved. I would like to make sure we keep moving forward during the interim. I wouldn't want the interim to just be a study; 24 months to study, when we know that these processes are in place in many other states, and that the White House is willing to work at funding us. I agree with Chip (Thomas), that the ideal system would be to have all prescriptions, like Medicaid has in our system.

Sen. Warner: Is there a diagnosis field in your data base and is it relevant to know that?

Joyce: In our data base, it's a combination of pharmacy claims as well as medical claims. I can also pull up diagnosis, patients by diagnosis. I could see everyone that had a GI bleed by ID number by a given month or a time period. That's much more robust than anything this is looking at. Pharmacies have the capability to send diagnosis codes. It is the standard format for transactions. Physicians don't typically write down the diagnosis codes--to move into that realm easily. The diagnosis codes probably won't come into play in the basic monitoring program because you're not going to be looking at the patients as a pair; you're already going to know what diagnosis someone will have. Those patients that tend to have severe problems, like cancer, to where they have pain control issues and may be seeing a specialist in Mayo and the regular doc in Bismarck and maybe another doc covered for them, they may have three or four doctors prescribing some narcotics. But they aren't typically the ones who go to different pharmacies.

Mike Mullen, on behalf of the Attorney General, I would like to reiterate what Sandy Tabor told the chairman yesterday--that the Attorney General would be interest in having his office designated as the lead agency for this project. I looked at some of the programs for over 20 states, and in six states, the office of Attorney General or the State Department of Justice is the lead agency that runs the controlled substances monitoring program. The Board of Pharmacy is the lead agency in five states, the Department of Health or the Department of Human Services is the lead agency in six states. And a division of licensing, some states license doctor and nurses and pharmacies all in one, a regulatory health care board, three states have that agency. Since these are department of justice funds, the office of Attorney General would be a suitable place to organize and be the lead agency for the program.

Chairman Lee: We want the Attorney General's office to be a part of this, but our concern, Mr. Mullen, we don't want it to be limited to just a law enforcement component, although that's an extremely important part of this whole thing, but we'd like it to be perceived as something that has a broader base and has positive health care ramifications as well. That's why we're considering the Health or Human Services or Board of Pharmacy. We're trying to develop a proper partnership here, we're not sure we want it to come out of the law enforcement area. I'm not expecting you to agree with me, I just wanted you to know where we started with our discussion about who would be implementing.

Mullen: I'm simply the messenger.

Chairman Lee: It will probably be whoever the work group comes up with.

Chairman Lee adjourned the meeting. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 14, 2005

Tape Number	Side A	Side B	Meter #
2		x	475-3460
Committee Clerk Signature			

Minutes:

Chairman Lee opened discussion on HB 1459. All members were present.

Sen. Warner: What is the nature of the implementation authority. Are they authorized to start this as soon as they reach an agreement.

Chairman Lee: They would not have to wait until the next session, but they would report to the appropriate interim committee of the legislative council. They can get together and get in the process of establishing an entity.

Sen. Lyson: The other difference in the amendments is where they ere going to locate the motherboard. Chip (Thomas) said he wanted it in the department of health.

Chairman Lee: Keep in mind, this isn't where it's going to end up, this is entity that calls the meetings of the working group; then the working group will decide where it ends up. It could be someplace entirely different. And Chip wanted it in the department of health because he thought they were not involved with it. The committee was focusing more on the department of human

services. I talked to Toby Mandigo and to Carol Olsen to see if it would be something they would be interested in or able to do. They said that definatly that was something that Krista Andrews or Melissa Hower - either of those ladies has training in mediation - Carol thought one of them could be an extremely capable moderator. If we wished to have the department of human services be the organizing entity, Carol is aware of it and felt they would have a couple of people that would be very skilled and able to facilitate.

Sen. Warner: It's very open-ended on how inclusive this would be and if this working group reached a decision that they could put every prescription into the state into a data base. And we can allow doctor, law enforcement and pharmacists and insurance companies and WSI access to this information; it seems open ended. There are a couple of components I don't have any objection to starting the Medicaid component right away and the schedule two drugs from the law enforcement aspect right away, before the legislature meets again, but I'm not sure I'd be crazy about going much beyond that.

Sen. Lyson: I have a problem with that. I think if law enforcement gets involved, you should have some probably cause, then you can get a supeona or a search warrant to come in there. And I think that's proper. If we do it otherwise, I think my case, as a law enforcement person, would be jeopardized in court if I came and got that without going through the right channels.

Vice Chairman Dever: There's a bill in IBL regarding work force safety 1119 that's generating some controversy that allows them to monitor prescription.

Sen. Warner: If they're overmedicating or under medicating.

Chairman Lee: I don't get the impression from this amendment, that we're opening it up to any of those. Because it says the working group shall consider the feasibility etc. The workforce

safety would have a representative on here and law enforcement would as well but it's up to that working group to figure out, it's my understanding, there will be hospitals and pharmacists, and other than that, they would need to have some kind of....

Sen. Lyson: Sometimes if a person runs out of their pain medicine, someone who really has a chronic condition, they'll go to a different pharmacy to get more drugs. And they need it. And that's where they should be checking on those things rather than working on a criminal....the criminal thing could come...

Senator Lyson gave an example of a doctor that was handing out prescriptions freely and was investigated. Senator Brown gave an example of an example of a person who has a few health problems and sees a different doctor for each condition. Then they have the prescriptions from those doctors filled at different pharmacies. With this monitoring, we're going to be able to tell where they're running into trouble.

The committee reviewed the amendments that were submitted in Chip Thomas' amendment and Jennifer Clark's (attachments 2 and 3). They talked about the members of the proposed board: specifically who should or should not be on the board, who should chair and who should moderate. They did not want the committee to be too large because then nothing would get done. Since the Attorney General's office really wanted to manage this but this committee will not do that, they suggested that there be a representative from the AGs office on the board. They also talked about the specific reports that would be needed.

Chairman Lee ended the discussion. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Human Services Committee

☐ Conference Committee

Hearing Date ~~April 14~~ March 15, 2005

Tape Number	Side A	Side B	Meter #
1	X		1310-3000
1	X		5731-END
2	X		1-200
Committee Clerk Signature			

Minutes: **Chairman Lee opened the meeting to discuss HB 1459. All Senators were present. The committee discussed the amendments to the bill.**

Senator Dever- One of the goals was that after three days of the birth of a child that a social worker comes to visit the family.

Chairman Lee explained the proposed amendments to the bill to the committee.

Senator Lyson- Is there any reason to put in that they can only spend what the grant allows?

Chairman Lee- It already says that the Dept shall seek federal grant funds for planning and implementing the program, and then adopt rules. I don't see a problem taking place with that. There is $50,000 in place for the planning.

Senator Dever- I think our intention now is to put the program in place and then fine tune it next session.

Action taken:

Senator Brown made a motion for a Do Pass recommendation on the amendments. Seconded by Senator Dever. The vote was 5-0-0.

Senator Brown made a motion to Do Pass as Amended and re-refer HB 1459 to Appropriations. Seconded by Senator Lyson. The vote was 5-0-0. Chairman Lee is the carrier of the bill.

Carlee McLeod, the intern informed the committee of some changes that were recommended by **Dave Peske of the ND Medical Association**. The committee agreed to the changes in adjusting the wording in that section of the bill.

Chairman Lee re-opened the meeting to discuss HB 1459.

Action taken:

Senator Brown moved to reconsider HB 1459, Seconded by Senator Warner. The motion to reconsider the bill passed unanimously, 5-0-0.

Chairman Lee informed the committee about information she had received from Representative Devlin concerning the bill.

Senator Brown moved to revise the amendments. Seconded by Senator Warner. The vote was 5-0-0.

Senator Brown moved a Do Pass as Amended and re-referring it to Appropriations. Seconded by Senator Dever. The vote was 5-0-0. Chairman Lee is the carrier of the bill.

Chairman Lee closed the meeting on HB 1459.

3/15/05

PROPOSED AMENDMENTS TO REENGROSED HOUSE BILL 1459

Amendments to the Legislative Council amendment 50695.0302:

Immediately before "Page 2, line 19, insert:" insert:

Page 1, line 9, overstrike "for neonates and the two" and insert immediately thereafter "to include a concentrated but not an exclusive emphasis for the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases and the families of neonates that can benefit from case management services."

Page 1, overstrike line 10

Page 1, line 11, overstrike "~~chronic diseases.~~"

Page 1, overstrike lines 15 through 18 and insert:

"2. Review and develop recommendations to identify any instances where providers of service are not properly reporting diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursement."

Page 2, subsection 2, after "law enforcement" insert "appointed by the attorney general", remove "North Dakota licensing boards regulating health care professions" and insert "the federally designated state peer review organization."

After subsection 3, insert:

"4. The department shall designate the chairman and vice chairman of the committee"

Page 2, after line 22, insert:

SECTION 5. Legislative Council Study. The legislative council shall consider studying, during the 2005-2006 interim, the Medicaid medical reimbursement system to include costs of providing services, fee schedules, parity among provider groups, and access.

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After subsection 3, insert:

"4. The department shall designate the chairman and vice chairman of the committee"

3/15/05
Latest

Attachment 2
3/14/05

House Bill 1459
Difference between Legislative Council Amendments and Arnold Thomas Amendments

There are four groups not explicitly mentioned in the LC amendments that the Thomas amendments reference. They are:

- a pharmacist appointed by the ND hospital pharmacy association
- one hospital administrator appointed by the ND healthcare association
- one representative appointed by the federally designated state peer review organization
- one representative appointed by a commercial health insurer as determined by the department (although the LC amendment does allow for individuals from the private sector, the language is not as explicit as it is in the Thomas amendment.)

The only other component of the Thomas amendment not included in the LC amendment is the inclusion of a chairman and vice chairman in the group.

Attachment 1 3/1

50695.0302
Title.

Prepared by the Legislative Council staff for
Senate Human Services
March 4, 2005

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1459

Page 1, line 1, after "chapter" insert "50-06 and a new section to chapter"

Page 1, line 2, after the first "to" insert "creation of a prescription drug monitoring program and" and replace "a report" with "reports to the legislative council; to provide an expiration date"

Page 1, after line 4, insert:

"**SECTION 1.** A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follow:

Prescription drug monitoring program. The department of human services shall seek federal grant funds for the planning and implementing of a prescription drug monitoring program. Upon receipt of federal grant funds, the department of human services shall adopt rules necessary to implement the prescription drug monitoring program and shall implement the program. State agencies shall cooperate with the department to ensure the success of the program."

Page 2, after line 19, insert:

"**SECTION 3. PRESCRIPTION DRUG MONITORING PROGRAM WORKING GROUP - REPORT TO LEGISLATIVE COUNCIL.**

1. The department of human services shall form a prescription drug monitoring program working group of interested individuals to:

   a. Identify problems relating to the abuse and diversion of controlled substances and how a prescription drug monitoring program may address these problems.

   b. Identify a strategy and propose a prescription drug monitoring program through which to address the identified problems, including consideration of how the program would fit into the overall strategy. Factors to be addressed in the program must include:

      (1) Determination of what types of prescription drugs will be monitored.

      (2) Determination of what types of drug dispensers will be required to participate in the program.

      (3) Determination of what data will be required to be reported.

      (4) Determination of what persons will be allowed to access data, what types of data will be accessible, and how to ensure appropriate protection of data.

      (5) Determination of the entity that will implement and sustain the program.

Jennifer Clark

n. 1

c. Establish how the program will be implemented, the fiscal requirements for implementation, and the timelines for implementation. In establishing how the program will be implemented, the working group shall consider the feasibility and desirability of formal or informal educational outreach to North Dakota communities and interested persons.

d. Consider possible performance measures the state may use to assess the impact of the program and whether special data collection instruments would be required to effectively monitor the impact of the program.

e. Provide to the department of human services a draft of proposed administrative rules to implement the proposed program.

2. The membership of the working group may include representatives from the private and public sectors, including the North Dakota medical association, the North Dakota nurses association, the North Dakota pharmacists association, the North Dakota society of health-system pharmacists, the North Dakota dental association, the North Dakota veterinary medical association, the North Dakota healthcare association, the North Dakota long term care association, the university of North Dakota school of medicine and health sciences, law enforcement, the department of human services, the state department of health, workforce safety and insurance, the information and technology department, and North Dakota licensing boards regulating health care professions.

3. During the 2005-06 interim, the department of human services and the prescription drug monitoring program working group shall provide the legislative council with periodic status reports on the activities of the working group and the implementation of the program."

Page 2, line 22, replace "1" with "2"

Page 2, after line 22, insert:

"**SECTION 5. EXPIRATION DATE.** Section 3 of this Act is effective through December 31, 2006, and after that date is ineffective."

Renumber accordingly

Date: 3-15-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as amended

Motion Made By Brown Seconded By Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson					

Total (Yes) _____ No _____

Absent _____

Floor Assignment Sen. J. Lee

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

re-refer to Approp

Date: 3-15-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass Amended bill

Motion Made By Sen Brown Seconded By Sen. Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No ϕ

Absent ϕ

Floor Assignment Sen J. Lee

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

re-re to approp

Date: 3-16-05
Roll Call Vote #: _____

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amendment

Motion Made By Sen Brown Seconded By Sen Warner

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

Date: 3-15-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass all three pages of amendments (+ delete and rep w/ are)

Motion Made By Sen Brown Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

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

Date: 3-16-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Reconsider amendment

Motion Made By Sen Brown Seconded By Sen Warner

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman			Sen. John Warner		
Sen. Dick Dever - Vice Chairman					
Sen. Richard Brown					
Sen. Stanley Lyson					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

voice - 5 yeas, 0 nays 0 absent

Date: 3-16-05
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amend in Bk of Pharm

Motion Made By Sen Lyson Seconded By Sen Brown

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment _____

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

Pass

Date: 3-16-05
Roll Call Vote #: 3

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1459

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass amendment

Motion Made By Sen Warner Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No ∅

Absent ∅

Floor Assignment Lee

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

We're for approp

REPORT OF STANDING COMMITTEE

HB 1459, as reengrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1459 was placed on the Sixth order on the calendar.

Page 1, line 1, after "chapter" insert "50-06 and a new section to chapter"

Page 1, line 2, after the first "to" insert "creation of a prescription drug monitoring program and" and replace "a report" with "reports to the legislative council; to provide for a legislative council study; to provide an expiration date"

Page 1, after line 4, insert:

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Page 1, remove line 10

Page 1, line 11, remove "chronic diseases"

Page 1, replace lines 15 through 18 with:

"2. Review and develop recommendations to identify any instances in which a provider of services is not properly reporting diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursement."

Page 2, after line 19, insert:

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(3) Determination of what data will be required to be reported.

(4) Determination of what persons will be allowed to access data, what types of data will be accessible, and how to ensure appropriate protection of data.

(5) Determination of the entity that will implement and sustain the program.

c. Establish how the program will be implemented, the fiscal requirements for implementation, and the timelines for implementation. In establishing how the program will be implemented, the working group shall consider the feasibility and desirability of formal or informal educational outreach to North Dakota communities and interested persons.

d. Consider possible performance measures the state may use to assess the impact of the program and whether special data collection instruments would be required to effectively monitor the impact of the program.

e. Provide to the department of human services a draft of proposed administrative rules to implement the proposed program.

2. The membership of the working group may include representatives from the private and public sectors, including representatives from the North Dakota medical association; the North Dakota nurses association; the North Dakota pharmacists association; the North Dakota society of health-system pharmacists; the North Dakota board of pharmacy; the North Dakota dental association; the North Dakota veterinary medical association; the North Dakota healthcare association; the North Dakota long term care association; the university of North Dakota school of medicine and health sciences; law enforcement agencies, appointed by the attorney general; the department of human services; the state department of health; workforce safety and insurance; the information technology department; and the federally designated state peer review organization.

3. During the 2005-06 interim, the department of human services and the prescription drug monitoring program working group shall provide the legislative council with periodic status reports on the activities of the working group and the implementation of the program.

4. The department shall designate the chairman and vice chairman of the working group."

Page 2, line 22, replace "1" with "2"

Page 2, after line 22, insert:

"**SECTION 5. LEGISLATIVE COUNCIL STUDY.** The legislative council shall consider studying, during the 2005-06 interim, the medicaid medical reimbursement system, including costs of providing services, fee schedules, parity among provider groups, and access. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly.

SECTION 6. EXPIRATION DATE. Section 3 of this Act is effective through December 31, 2006, and after that date is ineffective."

Renumber accordingly

2005 SENATE APPROPRIATIONS

HB 1459

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1459

Senate Appropriations Committee

☐ Conference Committee

Hearing Date March 24, 2005

Tape Number	Side A	Side B	Meter #
1	X		1-1700
Committee Clerk Signature			

Minutes:

Chairman Holmberg opened the hearing on House Bill 1459, relating to medical assistancce program management. All Senators were present with the exception of Senator Kringstad.

Senator Judy Lee introduced the bill. The bill came to the Human Services committee based on recommendations by a consultant on how to improve medical assistance programs.

There are $350,000 of federal funds available, and the White House Office of Drug Policy would be willing to help implement the program in North Dakota. There will not be an appropriation request for this, because it would be funded internally by the participants. The Medicaid population may be used for electronic drug monitoring, with an increase in the number of prescriptions. This program would not cover the entire population immediately. The Attorney General's office views this program as providing them with effective tools for law enforcement.

Howard Anderson, Executive Director of the Board of Pharmacy for the state of North Dakota, appeared before the committee. See written testimony.

Senator Bowman- What will be the costs in running the program once it is established?

Howard- The 2 year implementation grant is what is normally offered. There is a possibility the federal government could continue funding for the program. Many states issue a state controlled substances number, similar to what the drug enforcment number that pharmacies receive. They use that money for running those programs.

Senator Fischer- When you audit a nursing home, do you find drugs that should be changed for the patient? Sometimes staff in a nursing home are afraid to take a patient off of certain medications.

Howard- The practicioner is in control of what medications the patient gets prescribed. The pharmacist serves as a consultant while working together with the physician and the nurses, while the final decision is up to the physician. The intent of this bill goes beyond focusing on nursing home patients.

Senator Tallackson- There are many times that the prescription is left with the pharmacist, rather than with the patient to take to other pharmacies.

Howard- Occasionally a patient will make copies of the prescription to get it filled, which is committing fraud. When the pharmacist fills the prescription, it is required that they keep the original copy.

Dave Zentner, Director of Medical Services for the Department of Human Services- The Department had originally included $200,000 for disease management. The House added

$565,000 to the administration budget to help the process. We estimated that we would save

$1.5 million on the grant side.

Chairman Holmberg closed the hearing on HB 1459.

Action taken:

Senator Mathern moved a Do Pass recommendation. Seconded by Senator Fischer.

The vote was 14-0-1. The bill was re-referred to the Senate Human Services Committee.

Date 3-24-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. ~~SB~~ 1459 HB

Senate SENATE APPROPRIATIONS Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass, re-referred to Human Services Committee

Motion Made By Mathern Seconded By Fischer

Senators	Yes	No	Senators	Yes	No
CHAIRMAN HOLMBERG	X		SENATOR KRAUTER	X	
VICE CHAIRMAN BOWMAN	X		SENATOR LINDAAS	X	
VICE CHAIRMAN GRINDBERG	X		SENATOR MATHERN	X	
SENATOR ANDRIST	X		SENATOR ROBINSON	X	
SENATOR CHRISTMANN	X		SEN. TALLACKSON	X	
SENATOR FISCHER	X				
SENATOR KILZER	X				
SENATOR KRINGSTAD					
SENATOR SCHOBINGER	X				
SENATOR THANE	X				

Total (Yes) 14 No 0

Absent 1

Floor Assignment HMS JL

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

REPORT OF STANDING COMMITTEE

HB 1459, as reengrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Reengrossed HB 1459, as amended, was placed on the Fourteenth order on the calendar.

2005 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1459

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **HB 1459**

House Human Services Committee

X Conference Committee

Hearing Date **4-15-05**

Tape Number	Side A	Side B	Meter #
1	x		0 ---- 6.7
Committee Clerk Signature			

Minutes:

Committee Members:

House Chairman Price, Rep Devlin, Rep Sandvig

Senate Chairman Brown, Sen Lee, Sen Warner

Chairman Price: (.01) opened discussion on Conference Committee Meeting on HB 1459. We'll go through what we have, which is Sub Sect 2. We'll be replacing L. 53 & we'll also be adding the *(can't understand)* If there's anything as we go through this bill, we have the legislative rules here.

Sen Brown: We talked of the possibility of pharmacy products being added to the diagnostic code. I checked w/Blue Cross-Blue Shield & they don't said it would be next to impossible because often, when people are in for multiple issues, it would slow up the pharmacy process.

Chairman Price: The other issue is, if you have your drugs filled at a pharmacy in a different town then where you saw the physician, what's the incentive for the physician to do any of these

thing? Sometimes they're concerned about the paper work, some pharmacist could be held hostage by a physician that didn't put the code in.

Sen Lee: The patient's results are held hostage. I continue to have concern about this, I don't think anybody's sandbagging the dept about doing it & they'll do it wherever they're able to, especially when I hear that the Blue's are finding it very difficult. I don't think it will be easier to do in Medicaid then it is for the Blue's. I feel if it's possible to do it, fine but I think it's important not to be too rigid about this & we don't put something in place that's not able to be implemented.

Chairman Price: I think there's a safe guard in there, because it's diagnosis or procedure code, yesterday Mr. Zentner said that's not a problem, that's a 2 yr diagnosis code for the provider that it's appropriate, but they always use some kind of code on all claims they put in.

Sen Lee: Sen Brown was saying that the Blues don't even do it in drugs & we're talking about drugs.

Sen Brown: This includes all claims, not just pharmacy claims, we don't specifically say "add pharmacy to it".

Chairman Price: Sen Lee, I see what you're concerned about, on the 3rd sentence, we didn't say after provider, if there is someone out there, that there is a benefit from going down that road, we'll take a look at it & they'll take a look at it & recommend it, not saying it will be done immediately. We just wanted to make sure there's not a piece of information out there that we're not gathering. If I could go back, if I'm understanding this, it's not going to make any change, on that 1st sentence. Everybody comes in with some sort of code.

Maggie: *(per written minutes ... can't understand ... don't think she was at podium.)*

Sen Brown: I think it's in good shape.

Rep Sandvig: That was my main concern too, was with the providers having to put the code on there & I think that's been taken care of.

Chairman Price: Any other comments? We have no problems with the new language you added & thank you for explaining it to us on the previous joint meeting.

Rep Devlin: If the dept needs to do some rules, I just want to make sure that it's done properly & we've had a great relationship with the people, my concern is that we're changing the rule making process so some of them won't go into effect until the committee has heard them, which could delay. I don't think it will be a problem, but at least it's in there & we'll move ahead quickly if there is something, we're ready to go with it.

Sen Brown: I think that's a good idea, but where will it go?

Sen Brown moved that the Senate Recede to the House Amendments

Sen Warner Seconded it

Vote: 6-0-0 Passed.

Chairman Price: (6.7) closed the conference committee meeting.

Sample

Proposed Conference Committee Amendments to Reengrossed House Bill 1459

That the Senate recede from its amendments as printed on page 695 of the House Journal and pages 879-881 of the Senate Journal and that Reengrossed House Bill No. 1459 be amended as follows:

Page 1, line 1, after "chapter" insert "50-06 and a new section to chapter"

Page 1, line 2, after the first "to" insert "creation of a prescription drug monitoring program and" and replace "a report" with "reports to the legislative council; to provide for a legislative council study; to provide an expiration date"

Page 1, after line 4, insert:

"**SECTION 1.** A new section to chapter 50-06 of the North Dakota Century Code is created and enacted as follows:

Prescription drug monitoring program. The department of human services shall seek federal grant funds for the planning and implementing of a prescription drug monitoring program. Upon receipt of federal grant funds, the department of human services shall adopt rules necessary to implement the prescription drug monitoring program and shall implement the program. State agencies shall cooperate with the department to ensure the success of the program."

Page 1, line 9, replace "for neonates and the two" with "to include a concentrated, but not an exclusive, emphasis for the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases and the families of neonates that can benefit from case management services"

Page 1, remove line 10

Page 1, line 11, remove "chronic diseases"

Page 1, replace lines 15 through 18 with:

"2. Require medical assistance providers to use the appropriate diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursement. Review and develop recommendations to identify instances in which a provider of services is not properly reporting diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursements. Review and recommend any specific providers from which a potential benefit might be obtained by requiring additional diagnosis or reason and procedure codes."

Page 2, after line 19, insert:

"SECTION 3. PRESCRIPTION DRUG MONITORING PROGRAM WORKING GROUP - REPORT TO LEGISLATIVE COUNCIL.

1. The department of human services shall form a prescription drug monitoring program working group of interested individuals to:

a. Identify problems relating to the abuse and diversion of controlled substances and how a prescription drug monitoring program may address these problems.

b. Identify a strategy and propose a prescription drug monitoring program through which to address the identified problems, including consideration of how the program would fit into the overall strategy. Factors to be addressed in the program must include:

(1) Determination of what types of prescription drugs will be monitored.

(2) Determination of what types of drug dispensers will be required to participate in the program.

(3) Determination of what data will be required to be reported.

(4) Determination of what persons will be allowed to access data, what types of data will be accessible, and how to ensure appropriate protection of data.

(5) Determination of the entity that will implement and sustain the program.

c. Establish how the program will be implemented, the fiscal requirements for implementation, and the timelines for implementation. In establishing how the program will be implemented, the working group shall consider the feasibility and desirability of formal or informal educational outreach to North Dakota communities and interested persons.

d. Consider possible performance measures the state may use to assess the impact of the program and whether special data collection instruments would be required to effectively monitor the impact of the program.

e. Provide to the department of human services a draft of proposed administrative rules to implement the proposed program.

2. The membership of the working group may include representatives from the private and public sectors, including representatives from the North Dakota medical association; the North Dakota nurses association; the North Dakota pharmacists association; the North Dakota society of health-system pharmacists; the North Dakota board of pharmacy; the North Dakota dental association; the North Dakota veterinary medical association; the North Dakota healthcare association; the North Dakota long term care association; the university of North Dakota school of medicine and health sciences; law enforcement agencies, appointed by the attorney general; the department of human services; the state department of health; workforce safety and insurance; the information technology department; and the federally designated state peer review organization.

3. During the 2005-06 interim, the department of human services and the prescription drug monitoring program working group shall provide the legislative council with periodic status reports on the activities of the working group and the implementation of the program.

4. The department shall designate the chairman and vice chairman of the working group."

Page 2, line 22, replace "1" with "2"

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"**SECTION 5. LEGISLATIVE COUNCIL STUDY.** The legislative council shall consider studying, during the 2005-06 interim, the medicaid medical reimbursement system, including costs of providing services, fee schedules, parity among provider groups, and access. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly.

SECTION 6. EXPIRATION DATE. Section 3 of this Act is effective through December 31, 2006, and after that date is ineffective.

SECTION 7. LEGISLATIVE INTENT. It is the intent of the fifty-ninth legislative assembly that the department promptly initiate and conduct the rulemaking activity under chapter 28-32 that is deemed necessary to implement this Act."

Renumber accordingly

Conference Committee Amendments to Reengrossed HB 1459 (50695.0305) - 04/15/2005

That the Senate recede from its amendments as printed on pages 1563 and 1564 of the House Journal and pages 879-881 of the Senate Journal and that Reengrossed House Bill No. 1459 be amended as follows:

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Renumber accordingly

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number HB 1459 (, as (re)engrossed): Date: 4/14/05

Your Conference Committee Human Services

For the Senate:	YES / NO	**For the House:**	YES / NO
Sen Brown		Chairman Price	
Sen J Lee		Rep Devlin	
Sen Warner		Rep Sandvig	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) _____ -- _____

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: 4/14/05
CARRIER: Rep Price

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: _____

SECONDED BY: _____

VOTE COUNT ___ **YES** ___ **NO** ___ **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number HB1459 (, as (re)engrossed): Date: 4-15-05

Your Conference Committee Human Services

For the Senate:	YES	NO	For the House:	YES	NO
Sen Brown	✓		Chairman Rep. Price	✓	
Sen J. Lee	✓		Rep Devlin	✓	
Sen Warner	✓		Rep Sanvig	✓	

recommends that the ~~(~~SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 695 -- _____ (SJ - 879-881)

___, and place _____ on the Seventh order.

✓, adopt ~~(further)~~ amendments as follows, and place HB1459 on the Seventh order:

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LC NO.	of amendment
LC NO.	of engrossment
Emergency clause added or deleted	
Statement of purpose of amendment	

MOTION MADE BY: Sen Brown

SECONDED BY: Sen Warner

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1459, as reengrossed: Your conference committee (Sens. Brown, J. Lee, Warner and Reps. Price, Devlin, Sandvig) recommends that the **SENATE RECEDE** from the Senate amendments on HJ pages 1563-1564, adopt amendments as follows, and place HB 1459 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1563 and 1564 of the House Journal and pages 879-881 of the Senate Journal and that Reengrossed House Bill No. 1459 be amended as follows:

Page 1, line 1, after "chapter" insert "50-06 and a new section to chapter"

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SECTION 6. LEGISLATIVE INTENT. It is the intent of the fifty-ninth legislative assembly that the department promptly initiate and conduct the rulemaking activity under chapter 28-32 which is deemed necessary to implement this Act.

SECTION 7. EXPIRATION DATE. Section 3 of this Act is effective through December 31, 2006, and after that date is ineffective."

Renumber accordingly

Reengrossed HB 1459 was placed on the Seventh order of business on the calendar.

2005 TESTIMONY

HB 1459

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
REGARDING HOUSE BILL 1459
JANUARY 25, 2005

Madam Chairman -- Members of the Committee:

My name is Arnold R. Thomas. I am the President of the North Dakota Healthcare Association. I am here to urge a **Do Pass** on House Bill No. 1459.

For many sessions now, the state has acknowledged that we have a problem with Medicaid funding. We are experiencing decreasing federal dollars and increasing program enrollment. We are seeing an increase in the life span of Medicaid patients, together with an increase in specific diseases, such as diabetes, and obviously an increase in the care required for the chronic conditions of aging.

Although the funding of Medicaid program is a recognized challenge, there has been minimal success in addressing changing the configuration of medical service delivery or its method of reimbursing providers. As we stated in earlier testimony to the Budget Section, hospitals and physicians are at a crossroads. Continuing to provide the services you require at a reimbursement level estimated being below costs by 25 to 29%, excluding the obligations of the beneficiary ~~is realistic.~~ unrealistic

Therefore, this past summer, we took the initiative and called together physicians, clinic managers, and hospital executives and asked them to look at how the private sector can partner with the Department and jointly address the variety of challenges to the program.

We looked at facts. We separated out the anecdotal information and discredited a number of assumptions about who receives services, how they get qualified, and how our benefits compare to those of other states.

We concluded that what we need, first and foremost, is a system approach for delivery of acute medical services to the Medicaid population.

For the system to be effective and efficient requires information and exchange capability within the system to support management of services and insuring patients receive the right service, at the right time, whether in an acute or chronic condition, inpatient or outpatient status.

There are many different ways of accomplishing this. We can implement direct contracting. We can use consortia and healthcare cooperatives. We can expand managed care models and risk

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

sharing models. In all instances, our ultimate goal is to provide efficient and effective access to -- and delivery of -- services.

This bill seeks an appropriation of $1 million. Based on smaller experiences, we believe this amount will more than enable the department, in conjunction with the private sector, to establish the requisite infrastructure necessary to develop a more effective delivery of services and as a consequence, more efficiency in use of resources.

We will do our best to seek federal participation and matching funds to see if we can reduce the total appropriation. We have not been in a position to determine what other funding sources are presently available. In the event that we cannot find additional funds, I need to remind you that while the million dollars sounds high, it is only $1/10^{th}$ of one percent of what is currently being spent on the state's Medicaid program.

If enacted, I look forward to coming before you in the future and reporting on the increased efficiencies that we know will come from this investment and justify this expenditure many times over.

I will gladly answer any questions that you might have.

TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE

REGARDING HOUSE BILL 1459

JANUARY 25, 2005

Chairman Price, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this bill.

This proposed legislation is a result of a study of the Medicaid program by the Medicaid Working Group. While the Department provided information, the report represents the work of the committee and the recommendations are the result of their deliberations. We were not involved in the final outcome of the report.

This bill would establish a special fund that would be utilized by providers, health care cooperatives, or health care consortia to develop and implement integrated systems of care including managed care, and other risk sharing options. It would allow these entities to use the funds to build the infrastructure necessary to move into a managed care arena. Many entities are hesitant to move to a risk sharing payment process, and this bill is designed to encourage these entities to develop the internal processes necessary for the implementation of managed care in North Dakota.

Currently, the Department does have one fully "capitated" managed care contract in North Dakota. It is with Noridian Mutual Insurance Company. It operates in Grand Forks, with Walsh and Pembina counties, with the Altru network, as the primary deliverer of services. Medicaid recipients have a choice of joining this organization or selecting a primary care provider to manage their care. If the recipient chooses the "capitated" plan, the Department pays a monthly premium based on the age and gender of a recipient. The process encourages the entity to manage the delivery of care, and promote preventive health services in order to

ensure that enrollees receive appropriate care in a cost effective manner. We believe the process has saved about 2% over fee for service payments, since it was implemented in 1997.

The Department believes that managed care can be a partial solution to the increasing costs of delivering services to recipients of the Medicaid program. Many states have adopted this concept in their programs.

Section 2 of the bill appropriates $1.0 million that would be used for the purposes outlined in Section 1 of the bill. The Executive budget does not include funding for this project and therefore the Legislature would need to increase the Department's budget in order to implement the provisions of this bill.

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

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Statement of John C. Horton regarding SB 180
Associate Deputy Director for State and Local Affairs
White House Office of National Drug Control Policy
Before the Senate Human Services Committee
February 24, 2005

Chairman Morrisette, Vice-Chairman Kruse, and distinguished members of the Committee:

Thank you for the opportunity to testify before you today regarding prescription drug abuse. As members of the committee may be aware, the Office of National Drug Control Policy (ONDCP) is the arm of the Executive Office of the President which directs Federal efforts, and coordinates efforts among Federal, State and local agencies and organizations, to reduce illegal drug use in the United States. We believe that the Federal government cannot accomplish this task alone: State governments also play an critical role in setting policies and supporting programs designed to make America's drug problem smaller.

Reducing prescription drug abuse is a unique challenge that requires a continuing partnership between Federal, State and local governments, as well as with the medical and pharmaceutical communities. It is critical to note that our efforts to reduce prescription drug abuse must be balanced with the importance of several other important policy considerations, including the preservation of access by patients to needed medications; the avoidance of needless regulatory interventions; the protection of patient privacy; and respect of the legitimate practice of medicine, including the freedom of physicians to prescribe legitimate medications based upon their best professional judgment. The purpose of my testimony is to describe the Federal government's strategy in balancing these policy priorities, and to describe opportunities for partnership between Federal and State governments in making the problem of prescription drug abuse smaller.

Prescription Drug Abuse: America's Number Two Drug Problem
Since the inception of ONDCP in the late 1980s, our Nation's drug control efforts have traditionally been focused on illicit drugs like cocaine, heroin, marijuana and methamphetamine. The release of the President's *2004 National Drug Control Strategy* marked the first occasion in which prescription drug abuse was formally recognized as a significant problem by the Executive Office of the President. The President's 2005 *National Drug Control Strategy*, released yesterday (February 23, 2005), reinforces the Administration's commitment to focus efforts and resources on reducing the incidence of prescription drug abuse. The attention given to this issue is due, in part, to the fact that prescription drugs are now the second most frequently abused category of drugs in America, behind marijuana.

A quick survey of the data highlights the emergence of this drug threat. According to the National Survey on Drug Use and Health (NSDUH), in 2003, some 6.3 million Americans used psychotherapeutic drugs non-medically in the past month; about 1.9 million individuals were

considered to have been dependent on, or to have abused, psychotherapeutic drugs over the past year. The number of people who had used pain relievers non-medically at least once during their lifetime increased 5 percent, from 29.6 million to 31.2 million Americans from 2002 to 2003. Also from 2002 to 2003, the non-medical use of any psychotherapeutics in the past month increased from 5.4 to 6.0 percent among young adults; and in 2003, 13.4 percent of youth between the ages of 12 and 17 had abused prescription drugs at least once in their lifetime. Again among young adults, past-month non-medical use of pain relievers increased by 15 percent, from 4.1 to 4.7 percent. A separate study focusing on youth, Monitoring the Future, began collecting data on the non-medical use of Oxycontin in 2002. In 2004, there was a 24 percent increase in past year use of Oxycontin for all three grades monitored (grades 8, 10 and 12) combined compared to 2002, from 2.7 percent to 3.3 percent. Finally, from 1995 to 2002, emergency room visits resulting from the abuse of narcotic pain killers increased about 163 percent.

With respect to general drug abuse trends in Oregon, based on data from the NSDUH, in 2002 and 2003, Oregon was among 10 states showing the highest percentages for any illicit drug use in past month among persons aged 12 and older, exceeding the national average of 8.5 percent. Additionally, Oregon was one of the top 10 states with the highest percentage of any illicit drug use in past month among young adults, aged 18 to 25 (24.7% in Oregon versus 20.2% nationally).

The National Approach to Reducing Drug Abuse

The President's drug control strategy is a balanced one, based on the understanding that in any market, the driving forces are supply and demand. This principle holds true for any market, whether the product be textiles, automobiles, or an illicit drug. We seek to reduce the demand for illicit drugs through prevention and treatment efforts, and also make the supply and acquisition of illicit drugs more difficult.

However, the threat and nature of prescription drug abuse is of a different order than traditional drug threats. For example, we know that virtually all cocaine and heroin, and much of the marijuana and methamphetamine consumed in America, are smuggled into our borders from and through other countries. These drugs do not enter the United States legally, and with very rare exceptions, do not change hands legally. Prescription drugs are a different matter: in the vast majority of transactions, prescription drugs are legally possessed, manufactured, distributed, and sold to individuals. Preserving the ability of individuals who have a legitimate need for a prescription drug to manage pain or heal illness to acquire the prescription quickly and safely is an important policy objective. Existing as they do in every pharmacy in every city and town in America, prescription drugs are both more ubiquitous and more susceptible to regulatory control, with the mechanisms to reduce the threat of prescription drug misuse substantially within the scope of state and Federal regulatory authority.

A strategy for reducing prescription drug abuse requires understanding exactly how the otherwise-legal prescriptions are illicitly acquired. We know that prescription drugs are sometimes illicitly procured in the same manner as traditional drugs: through street-level drug dealing, and through social vectors such as schools. The internet plays a role, as do thefts from pharmacies. But one significant method of illicitly acquiring prescription drugs stands out in particular: a method of diversion simply referred to as "doctor shopping." This refers to the visit

by an individual, who may or may not have a legitimate medical condition, to numerous practitioners within a short amount of time to obtain more prescription medication than is clinically necessary, therefore putting the patient himself or herself at risk.

Reducing Doctor Shopping

Disrupting opportunities to engage in "doctor shopping" requires, by definition, the cooperation of the medical community, the pharmaceutical community, and regulatory or enforcement agencies where appropriate. Simply put, the "doctor shopper" relies on a lack of communication between the prescriber and the dispenser. Prescription Drug Monitoring Programs (PDMPs) seek to bridge that gap, ensuring that persons determined by a prescriber to have a legitimate need for prescription medication are provided with the help they need, without being presented opportunities to obtain more than is clinically necessary, putting themselves at risk of addiction, injury or even death.

State PDMPs typically track prescription drug sales at the pharmacy level, helping pharmacists ensure the validity of prescriptions and helping physicians confirm that would-be abusers of prescriptions are not doctor shopping for prescription drugs. In the end, everybody benefits: doctors can better assist a patient when they know the patient is not receiving prescriptions from other doctors; the potentially abusing patient can only be the beneficiary of an intervention when his or her abuse comes to light; and law enforcement has more accurate and reliable information with which to identify illegal activities.

It is important to note that PDMPs can influence both factors, supply and demand, in the illicit prescription drug market, without adversely impacting the legal market for prescriptions. On the demand side, a pharmacist or physician using a PDMP will be far less likely to unwittingly provide a controlled substance to an individual who is at risk. Moreover, the identification of doctor-shopping activities provides an important opportunity to help identify persons who need treatment opportunities. On the supply side, the sharing of information between physicians and pharmacists deters and prevents doctor shopping activities. And in more serious cases, it helps law enforcement more accurately identify individuals who are engaging in activities like forgery and fraud to acquire prescription medications – and also those who acquire prescriptions not for their own use, but to sell them at a profit to others.

There is an indication that these measures make a difference. From 2002 to 2003, rural America experienced a 58 percent decline in current use of illicit drugs in just one year. Those regions, which had been especially hard hit by the use of oxycodone-based drugs, including OxyContin, saw an 82 percent drop in the non-medical use of prescription drugs. The increase in the number of PDMPs over the last few years appear to have taken a leading role in detecting and deterring the diversion of popular prescription controlled substances, such as OxyContin and Vicodin. The Administration strongly supports the implementation of PDMPs as an effective way to address this problem. Accordingly, the President's fiscal year 2006 budget contains $5 million for prescription monitoring grants to States.

The mechanism through which PDMP support is provided to States is through the Hal Rogers Prescription Drug Monitoring Program, a grant program for states to study, implement, and enhance PDMPs. The program is run through the Department of Justice's Bureau of Justice

Assistance. Oregon is already the recipient of a FY 04 grant in the amount of $350,000, for supporting a planning phase for the development of a PDMP and an implementation phase, following the passage of legislation, for the building of an electronic database and development of policies and procedures. The operation of the more than twenty PDMPs in existence vary, but for the most part, annual operating costs for all but the most populous states tend to be lower than the amount of the implementation grant provided to Oregon.

Conclusion

Both Federal and State policymakers in our Nation are rightly concerned with continuing to reduce illicit drug use in America, and especially among our teens. As we continue our focus on traditional drugs like marijuana, methamphetamine, cocaine and heroin, we are also confronted with the emerging drug threat of prescription drug abuse. The threat is not an insurmountable one: we know that "doctor-shopping" is one of the primary methods in which prescription drugs are diverted. But we also know that the implementation of PDMPs in a state can curtail the activity, which in turn helps to interrupt the downward spiral of initiation, use and addiction. I urge the committee to favorably consider adding Oregon to the list of the more-than-twenty states already operating Prescription Drug Monitoring Programs.

Thank you for allowing me to testify, and I am happy to answer any questions the committee may have.

#4

BOARD OF PHARMACY
State of North Dakota

John Hoeven, Governor

OFFICE OF THE EXECUTIVE DIRECTOR
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Harvey J Hanel, PharmD, R.Ph.
Bismarck, Senior Member
Gary W. Dewhirst, R.Ph.
Hettinger
Rick L. Detwiller, R.Ph.
Bismarck
Bonnie J. Thom, R.Ph.
Granville
William J. Grosz, Sc.D., R.Ph.
Wahpeton, Treasurer

House Bill 1459
10:30 AM – TUESDAY – MARCH 1st, 2005
HUMAN SERVICES COMMITTEE – RED RIVER ROOM

For the Record, I am Howard C. Anderson, Jr, R.Ph., Executive Director of the North Dakota State Board of Pharmacy. Thank you for the opportunity to appear before you today.

I am here today to offer information and an amendment to House Bill 1459 to facilitate the creation of a Centralized Electronic Prescription Drug Monitoring System.

The North Dakota State Board of Pharmacy has considered the concept of a prescription monitoring program for some time now. Through your help, I just recently learned that the North Dakota Department of Human Services had capabilities, within the Department, to capture this data.

In the past, I have been reluctant to initiate a new program, with it's incumbent costs.

We have, and continue to work closely with physicians, pharmacists and law enforcement agencies, who are both trying to provide patients with adequate and appropriate care, as well as eliminate the inappropriate or illegal use of controlled substances through the prescribing and dispensing process. We currently ask pharmacies to submit profiles for patients under treatment plans with physicians, when those requests have the potential to enhance the patient care. We also gather profiles for law enforcement agencies, when specific investigations are under way. This is a time consuming, and somewhat cumbersome process, which also takes some considerable time for the pharmacies to provide a response.

An electronic monitoring system where prescription data is claims captured as the claim is transmitted through an electronic billing system would certainly make the gathering of this date easier. I believe enough time has passed so that these electronic systems can allow us to give a password and identification to physicians and pharmacists accessing the system for patient care reasons, which will both allow them real time access to the patient's controlled substances profile, as well as tracking those professionals access to the program. We can also establish a system for approval through, perhaps the Board of Pharmacy, for law enforcement agencies to receive patient profile information, based on specific active investigations. Law

enforcement is not usually in a hurry for this data, so there would be time to retrieve the profile information and forward it to law enforcement, if the information was already present on the computer system. Access could also be given, in specific cases, to the online data if that happened to be necessary.

We have a few things to work out with this legislation, and of course practitioners generating the prescriptions would need to be consulted, so we can obtain their input.

I have worked with many physicians who indicated they would be happy to come and testify in favor of such a proposal. This has been a little too short of notice, though we have the Association here today, we did not have time to gather the specific physicians.

I am attaching samples of the requests I regularly receive in the Board of Pharmacy office.

Thank you for your time and consideration.

BOARD OF PHARMACY
State of North Dakota

John Hoeven, Governor

OFFICE OF THE EXECUTIVE DIRECTOR
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Harvey J Hanel, PharmD, R.Ph.
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Dewey Schlittenhard, MBA, R.Ph.
Bismarck
Rick L. Detwiller, R.Ph.
Bismarck
William J. Grosz, Sc.D., R.Ph.
Wahpeton, Treasurer

February 10, 2004

To: Pharmacist-in-Charge

From: Howard C. Anderson, Jr, R.Ph.
Executive Director

The Board is assisting in a confidential investigation of . Please send me any profile you may have on from January 1, 2003 to the present.

Please provide any prescriptions she may have written as a Nurse Practitioner or Physician's Assistant during this time as well.

was licensed as both a Nurse Practitioner and Physician's Assistant for part of this time.

Thank you.

If you do not have any profile for this patient during this time period, kindly indicate by checking the appropriate box below and faxing this back to me, so I will know you / your pharmacy has responded.

SEABURG DRUG
990 Main Street Health Mart Ph. 652-2651
Carrington, ND 58421 1-866-833-2651
CAUTION: Federal law prohibits transfer of this drug to any person other than patient for whom prescribed.

NAME OF PHARMACY: _____
Please complete so we know who has responded

PLEASE MAIL OR FAX YOUR RESPONSE AS SOON AS POSSIBLE

No Profile(s) [X]

Profile(s) Enclosed [ ]

BOARD OF PHARMACY
State of North Dakota

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Bismarck
Bonnie J. Thom, R.Ph.
Granville
William J. Grosz, Sc.D., R.Ph.
Wahpeton, Treasurer

December 29, 2004

To: Pharmacist-In-Charge

(Please note our Fax # has changed – yes, too close to our phone – please try not to confuse them)

From: Howard C. Anderson, Jr., R.Ph.

The Board is assisting Dr Michael Martire in caring for the following patients.

Please send me a profile for the following individuals from January 1, 2004 to the present:

PERSON	DATE OF BIRTH	LAST KNOWN ADDRESS(s)

Please send the profiles to me, I will consolidate them and get them to appropriate person.

If you do not have any profile for these patients during this time period, kindly indicate by checking the appropriate box below and faxing this back to me, so I will know you / your pharmacy has responded.

HIPAA and the laws of North Dakota allow the release of this information to the State Board of Pharmacy. If you want added information call Eileen, or I and we can fax you a copy of the Attorney General's letter of explanation. Please keep this request as your record of to whom you released this information.

As always, I thank you very much for your help and cooperation.

NAME OF PHARMACY: _____
Please complete so we know who has responded

PLEASE MAIL OR FAX YOUR RESPONSE

No Profile(s) ☐

Profile(s) Enclosed ☐

North Dakota State
Board of Medical Examiners

ROLF P. SLETTEN
Executive Secretary and Treasurer

LYNETTE McDONALD
Administrative Assistant

May 29, 2003

Howard Anderson, R.Ph.
North Dakota Board of Pharmacy
PO Box 1354
Bismarck, N.D. 58502-1354

RE: , MD - Pharmacy Audit

Dear Howard:

This is a request for a pharmacy audit on :. Specifically we would like to see the prescriptions he has written for controlled substances during the period from July 1, 2002 through December 31, 2002. I think it will be sufficient to audit the pharmacies in the Grand Forks area. We have a little bit of a time crunch on this one so anything you can do to speed up the process will be great.

Thanks.

Sincerely,

ROLF P. SLETTEN
Executive Secretary
and Treasurer

RPS/md

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
PROBATION OFFICE

KEVIN D. LOWRY
Chief Probation Officer
300 S 4th St., Ste. 406
Minneapolis MN 55415-1320
612-664-5400
FAX 612-664-5350

316 N Robert St., Ste. 600
St. Paul MN 55101-1465
651-848-1250
FAX 651-848-1255

P.O. Box 1159
Bemidji, MN 56619
888-766-2110
FAX 218-333-0102

515 W 1st St., Ste. 206
Duluth MN 55802-1302
218-529-3550
FAX 218-529-3546

118 S Mill St., Ste. 304
Fergus Falls MN 56537-2576
218-739-0041 or
612-664-5410
FAX 218-739-0043

Reply to: **Fergus Falls**

January 24, 2005

Mr. Howard C. Anderson
Executive Director
North Dakota Board of Pharmacy
PO Box 1354
Bismarck, ND 58502-1354

RE: Request for Prescription Profile

Dear Mr. Anderson:

The U.S. Probation Office, District of Minnesota, is presently supervising an offender who is known to obtain prescriptions for narcotics within the Fargo, North Dakota area, through various pharmacies. The individual has admitted abusing these prescriptions, as well as selling them to other parties. As such, I am requesting assistance in obtaining a prescription profile for this individual from all pharmacies in Fargo and West Fargo, North Dakota. Please provide a prescription profile to include any prescriptions obtained between March 1, 2004 through the present date. The following is a information pertaining to the offender.

Name:
DOB:
SS#:
FBI#:

If you need additional information, please contact Aaron Rotering at 218-739-0042. My address is: U.S. Probation Office, 118 South Mill Street, Suite 304, Fergus Falls, Minnesota, 56537. My fax number is 218-739-0043. Your assistance is greatly appreciated.

Sincerely,

Aaron R. Rotering
U.S. Probation Officer

ARR:arr

(4A)

PREPARED FOR THE BOARD OF PHARMACY
By Michael J. Mullen
Modified by Howard C. Anderson Jr.
Draft #8 – 2/28/2005 2:59 PM

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1459

Page 1, line 3, add: And a new chapter to title 19 of the North Dakota Century Code, relating to the establishment of a centralized electronic prescription drug monitoring system.

Page 2, after line 23

SECTION 4. A new chapter to title of 19 of the North Dakota Century Code is created and enacted as follows:

Definitions.

1. "Controlled substance" has the meaning given to this tem in section 19-03.1.

2. "Patient" means the person who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

3. "Dispenser" means a person who delivers a Schedule II–V controlled substance as defined in subsection (4) of this section to the ultimate user, but does not include:

a. a licensed hospital pharmacy that distributes such a substance for the purpose of inpatient hospital care.

b. a practitioner, or other authorized person who administers such a substance; or

c. a wholesale distributor of a Schedule II–V controlled substance.

4. "Schedule II, III, IV and/or V controlled substance" mean a controlled substance that is listed in Schedules II, III, IV, and V of the Schedules provided under chapter 19-03.1.

5. "HIPAA privacy rule" means the regulation of the use and disclosure of health information set forth in parts 160 and 164 of title 45 of the Code of Federal Regulations.

Requirements for Prescription Monitoring Program.

1. The Board of Pharmacy shall establish and maintain a program for the monitoring of prescribing and dispensing of all Schedule II, III, IV and V controlled substances, and carisoprodal and tramadol.

2. Each dispenser shall submit to the Board of Pharmacy by electronic means information regarding each prescription dispensed for a drug included under subsection (1) of this section. The information submitted for each prescription must include:

a. Dispenser identification number.

b. Date prescription filled.

c. Prescription number.

d. Prescription is new or is a refill.

e. NDC code for drug dispensed.

f. Quantity dispensed.

g. Number of day's supply of drug dispensed.

h. Patient name.

i. Patient address.

j. Patient date of birth.

k. Prescriber identification.

l. Date prescription issued by prescriber.

m. Person who receives the prescription from the dispenser, if other than the patient.

n. Source of payment for prescription.

3. Each dispenser shall submit the information in accordance with transmission methods and frequency established by the Board of Pharmacy.

4. The Board of Pharmacy may issue a waiver to a dispenser that is unable to submit prescription information by electronic means. Any such waiver may permit the dispenser to submit prescription information by paper form or other means, if all of the information required in subsection (2) of this section is submitted in this alternative format.

Access to Prescription Information.

1. Prescription information submitted to the Board of Pharmacy is confidential.

2. The Board of Pharmacy shall safeguard the confidentiality of any confidential information received, maintained, or transmitted, and may not disclose confidential information except as permitted under subsections (3), (4), and (5) of this section.

3. The Board of Pharmacy may review the prescription information submitted to the monitoring program. If there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the Board of Pharmacy may, subject to the HIPAA Privacy rule, and any other federal or state law, notify the appropriate law enforcement, or professional licensing and certification or regulatory agency, and disclose any prescription drug information required for an investigation.

4. The Board of Pharmacy is authorized, subject to the HIPAA Privacy rule, and any other federal or state law, to disclose data in the prescription monitoring program to the following persons.

a. Any health care provider that: (i) is treating, or within the last year has treated, the individual by prescribing or dispensing a controlled or other substance covered by this chapter for any illness, disease, or condition; (ii) is the individual's primary care provider; or (iii) has been requested to treat the individual by prescribing or dispensing any controlled or other substance covered by this chapter for any illness, disease, or condition.

b. An individual who requests his or her own prescription monitoring information in accordance with procedures established under state and federal law.

c. The Board of Medical Examiners, Board of Nursing, the Board of Pharmacy, and any other board regulating practioners.

d. A local, state, and federal law enforcement official, including a probationer officer, or a prosecutor, engaged in the administration, investigation or enforcement of the laws governing controlled substances.

e. The medical services division of the department of human services and the workforce safety and insurance organization.

f. A district court or a tribal court under grand jury subpoena or court order.

g. Personnel of the Board of Pharmacy for purposes of administration and enforcement of this chapter, or chapters 19-03.1, 19-03.2 and 19-03.3.

5. The Board of Pharmacy may disclose data to public or private entities for statistical, research, or educational purposes if the information is de-identified in accordance with requirements for de-identification under subsection (a) or (b) of section 514, part 164, title 45 of the Code of Federal Regulations.

Authority to Contract

The Board of Pharmacy is authorized to contract with another agency of this state or with a private vendor to facilitate the effective operation of the prescription monitoring program. Any contractor is bound to comply with the provisions regarding confidentiality of prescription drug information in Section 3 of this Act and is subject to the penalties for unlawful acts specified in Section 6 of this Act.

The Board of Pharmacy may use the authority granted in NDCC Chapter 19-03.1 Subsections 01.1, 15,16, and 17 to fund the activities authorized in this section.

Immunity

Nothing in this chapter requires a practitioner or dispenser to obtain information about a patient from the prescription monitoring program database. A health care provider may not be held liable in damages to any person in any civil action for injury, death, or loss to any individual or property on the basis that the provider did or did not seek to obtain information from the prescription monitoring program database.

Extraterritorial Application

Nothing in this chapter shall be construed to prohibit the disclosure of information about a patient from the prescription monitoring program database to a practitioner or controlled substances monitoring system in another state, if the disclosure to a practitioner or the prescription monitoring program located in this state is authorized by this chapter.

Rules and Regulations.

The Board of Pharmacy may promulgate rules and regulations that set forth the procedures and methods for implementing this Act.

Unlawful Acts and Penalties.

1. A dispenser who knowingly fails to submit prescription monitoring information to the Board of Pharmacy as required by this Act or knowingly submits incorrect prescription information is guilty of a class B misdemeanor.

2. Any person, including a vendor, who uses or discloses prescription monitoring information in violation of this Act, is subject to the penalty provided in section 12.1-13-01."

Renumber accordingly

Attachment 1

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

Statement of John C. Horton: "Prescription Drug Abuse – the National Picture"
Associate Deputy Director for State and Local Affairs
White House Office of National Drug Control Policy
Before the House and Senate Human Services Committees, North Dakota State Legislature
March 1, 2005

Chairwoman Lee, Chairwoman Price, Vice-Chairman Dever, Vice-Chairman Kreidt, and distinguished members of the Committees:

Thank you for the opportunity to testify before you today regarding prescription drug abuse. As members of the committee may be aware, the Office of National Drug Control Policy (ONDCP) is the arm of the Executive Office of the President which directs Federal efforts, and coordinates efforts among Federal, State and local agencies and organizations, to reduce illegal drug use in the United States. We believe that the Federal government cannot accomplish this task alone: State governments also play an critical role in setting policies and supporting programs designed to make America's drug problem smaller.

Reducing prescription drug abuse is a unique challenge that requires a continuing partnership between Federal, State and local governments, as well as with the medical and pharmaceutical communities. It is critical to note that our efforts to reduce prescription drug abuse must be balanced with the importance of several other important policy considerations, including the preservation of access by patients to needed medications; the avoidance of needless regulatory interventions; the preservation of patient privacy; and respect of the legitimate practice of medicine, including the freedom of physicians to prescribe legitimate medications based upon their best professional judgment. The purpose of my testimony is to describe the Federal government's strategy in balancing these policy priorities, and to describe opportunities for partnership between Federal and State governments in making the problem of prescription drug abuse smaller.

Prescription Drug Abuse: America's Number Two Drug Problem
Since the inception of ONDCP in the late 1980s, our Nation's drug control efforts have traditionally been focused on illicit drugs like cocaine, heroin, marijuana and methamphetamine. The release of the President's *2004 National Drug Control Strategy* marked the first occasion in which prescription drug abuse was formally recognized as a significant problem by the Executive Office of the President. The President's 2005 *National Drug Control Strategy*, released yesterday (February 23, 2005), reinforces the Administration's commitment to focus efforts and resources on reducing the incidence of prescription drug abuse. The attention given to this issue is due, in part, to the fact that prescription drugs are now the second most frequently abused category of drugs in America, behind marijuana.

A quick survey of the data highlights the emergence of this drug threat. According to the National Survey on Drug Use and Health (NSDUH), in 2003, some 6.3 million Americans used

psychotherapeutic drugs non-medically in the past month; about 1.9 million individuals were considered to have been dependent on, or to have abused, psychotherapeutic drugs over the past year. The number of people who had used pain relievers non-medically at least once during their lifetime increased 5 percent, from 29.6 million to 31.2 million Americans from 2002 to 2003. Also from 2002 to 2003, the non-medical use of any psychotherapeutics in the past month increased from 5.4 to 6.0 percent among young adults; and in 2003, 13.4 percent of youth between the ages of 12 and 17 had abused prescription drugs at least once in their lifetime. Again among young adults, past-month non-medical use of pain relievers increased by 15 percent, from 4.1 to 4.7 percent. A separate study, Monitoring the Future, began collecting data on the non-medical use of Oxycontin in 2002. In 2004, there was a 24 percent increase in past year use of Oxycontin for all three grades monitored (grades 8, 10 and 12) combined compared to 2002, from 2.7 percent to 3.3 percent. Finally, from 1995 to 2002, emergency room visits resulting from the abuse of narcotic pain killers increased about 163 percent.

With respect to general drug abuse trends in North Dakota, based on data from the NSDUH, in 2002 and 2003, drug use among youth and young adults mirrored the national trend, although North Dakota appears to have more positive statistics compared to other states. For 12-17 years olds, past-month drug abuse was 11.64% (27th out of 51); for 18-25 year olds, the figure was 18.02% (40th out of 51).

The National Approach to Reducing Drug Abuse

The President's drug control strategy is a balanced one, based on the understanding that in any market, the driving forces are supply and demand. This principle holds true for any market, whether the product be textiles, automobiles, or an illicit drug. We seek to reduce the demand for illicit drugs through prevention and treatment efforts, and also make the supply and acquisition of illicit drugs more difficult.

However, the threat and nature of prescription drug abuse is of a different order than traditional drug threats. For example, we know that virtually all cocaine and heroin, and much of the marijuana and methamphetamine consumed in America, are smuggled into our borders from and through other countries. These drugs do not enter the United States legally, and with very rare exceptions, do not change hands legally. Prescription drugs are a different matter: in the vast majority of transactions, prescription drugs are legally possessed, manufactured, distributed, and sold to individuals. Preserving the ability of individuals who have a legitimate need for a prescription drug to manage pain or heal illness to acquire the prescription quickly and safely is an important policy objective. Existing as they do in every pharmacy in every city and town in America, prescription drugs are both more ubiquitous and more susceptible to regulatory control, with the mechanisms to reduce the threat of prescription drug misuse substantially within the scope of state and Federal regulatory authority.

A strategy for reducing prescription drug abuse requires understanding exactly how the otherwise-legal prescriptions are illicitly acquired. We know that prescription drugs are sometimes illicitly procured in the same manner as traditional drugs: through street-level drug dealing, and through social vectors such as schools. The internet plays a role, as do thefts from pharmacies. But one significant method of diversion stands out in particular: a method of diversion simply referred to as "doctor shopping." This refers to the visit by an individual, who

may or may not have a legitimate medical condition, to numerous practitioners within a short amount of time to obtain more prescription medication than is clinically necessary, therefore putting the patient himself or herself at risk.

Reducing Doctor Shopping

Disrupting opportunities to engage in "doctor shopping" requires, by definition, the cooperation of the medical community, the pharmaceutical community, and regulatory or enforcement agencies where appropriate. Simply put, the "doctor shopper" relies on a lack of communication between the prescriber and the dispenser. Prescription Drug Monitoring Programs (PDMPs) seek to bridge that gap, ensuring that persons determined by a prescriber to have a legitimate need for prescription medication are provided with the help they need, without being presented opportunities to obtain more than is clinically necessary, putting themselves at risk of addiction, injury or even death.

State PDMPs typically track prescription drug sales at the pharmacy level, helping pharmacists ensure the validity of prescriptions and helping physicians confirm that would-be abusers of prescriptions are not doctor shopping for prescription drugs. In the end, everybody benefits: doctors can better assist a patient when they know the patient is not receiving prescriptions from other doctors; the potentially abusing patient can only be the beneficiary of an intervention when his or her abuse comes to light; and law enforcement has more accurate and reliable information with which to identify illegal activities.

It is important to note that PDMPs can influence both factors, supply and demand, in the illicit prescription drug market, without adversely impacting the legal market for prescriptions. On the demand side, a pharmacist or physician using a PDMP will be far less likely to unwittingly provide a controlled substance to an individual who is at risk. Moreover, the identification of doctor-shopping activities provides an important opportunity to help identify persons who need treatment opportunities. On the supply side, the sharing of information between physicians and pharmacists deters and prevents doctor shopping activities. And in more serious cases, it helps law enforcement more accurately identify individuals who are engaging in activities like forgery and fraud to acquire prescription medications – and also those who acquire prescriptions not for their own use, but to sell them at a profit to others.

There is an indication that these measures make a difference. From 2002 to 2003, rural America experienced a 58 percent decline in current use of illicit drugs in just one year. Those regions, which had been especially hard hit by the use of oxycodone-based drugs, including OxyContin, saw an 82 percent drop in the non-medical use of prescription drugs. The increase in the number of PDMPs over the last few years appear to have taken a leading role in detecting and deterring the diversion of popular prescription controlled substances, such as OxyContin and Vicodin. The Administration strongly supports the implementation of PDMPs as an effective way to address this problem. Accordingly, the President's fiscal year 2006 budget contains $5 million for prescription monitoring grants to States.

The mechanism through which PDMP support is provided to States is through the Hal Rogers Prescription Drug Monitoring Program, a grant program for states to study, implement, and enhance PDMPs. The program is run through the Department of Justice's Bureau of Justice

Assistance. North Dakota, if it passes legislation enabling a PDMP, would be eligible to receive a grant up to $350,000, for supporting a planning phase for the development of a PDMP and an implementation phase for the building of an electronic database and development of policies and procedures. The operation of the more than twenty PDMPs in existence vary, but for the most part, annual operating costs for all but the most populous states tend to fall in the $100,000 to $300,000 range; states with populations approaching North Dakota's tend to be in the $150,000 or less expensive category.

Conclusion

Both Federal and State policymakers in our Nation are rightly concerned with continuing to reduce illicit drug use in America, and especially among our teens. As we continue our focus on traditional drugs like marijuana, methamphetamine, cocaine and heroin, we are also confronted with the emerging drug threat of prescription drug abuse. The threat is not an insurmountable one: we know that "doctor-shopping" is one of the primary methods in which prescription drugs are diverted. But we also know that the implementation of PDMPs in a state can curtail the activity, which in turn helps to interrupt the downward spiral of initiation, use and addiction. I urge the committee to favorably consider adding North Dakota to the list of the more-than-twenty states already operating Prescription Drug Monitoring Programs.

Thank you for allowing me to testify, and I am happy to answer any questions the committee may have.

(2)

NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS
MODEL PRESCRIPTION MONITORING ACT
AUGUST 2002

SECTION 1. SHORT TITLE.

This Act shall be known and may be cited as the "Model Prescription Monitoring Act".

SECTION 2. LEGISLATIVE FINDINGS.

[insert state-appropriate findings]

SECTION 3. PURPOSE.

[insert state-appropriate mission/purposes]

SECTION 4. DEFINITIONS.

(a) "Board" means the advisory board established under Section 6 of this Act.

(b) "Dispenser" means a person authorized in this state to distribute to the ultimate user a substance monitored by the prescription monitoring program, but does not include:

(I) a licensed hospital pharmacy that distributes such substances for the purposes of inpatient hospital care or the dispensing of prescriptions for controlled substances at the time of discharge from such a facility;

(II) a licensed nurse or medication aide who administers such a substance at the direction of a licensed physician; or

(III) a wholesale distributor of a substance monitored by the prescription monitoring program.

(c) "Prescriber" means a licensed health care professional with prescriptive authority

(d) "Prescription monitoring information" means information submitted to and maintained by the Prescription Monitoring Program.

(e) "Prescription Monitoring Program (PMP)" means a program established under Section 5 of this Act.

SECTION 5. ESTABLISHMENT OF A PRESCRIPTION MONITORING PROGRAM.

(a) The [designated state agency or entity] shall establish and maintain, with the consultation of the Board, an electronic system for monitoring the following substances dispensed in the state: [insert all or any combination of the following: federally controlled substances, additional state specified controlled substances, and drugs of concern documented to demonstrate a potential for abuse, particularly those identified by law enforcement and addiction treatment professionals.]

(b) The [designated state agency or entity] may contract with a vendor to establish and maintain the electronic monitoring system pursuant to guidelines which the [designated state agency or entity] shall promulgate.

SECTION 6. ADVISORY BOARD.

(a) The Advisory Board shall have the following members:

(I) [insert appropriate designees of state health, law enforcement and prosecutorial agencies]
(II) [insert appropriate designees of occupational licensing, certification and regulatory entities]
(III) [insert appropriate designees of impaired professionals programs]
(IV) [insert appropriate pain management and addiction treatment representatives]
(V) [insert appropriate patient rights advocates]
(VI) [insert appropriate recovering community advocates]
(VII) [insert appropriate community leaders]

(b) The [designated state agency or entity] shall seek and the Board shall provide input and advice regarding the development and operation of the electronic monitoring system, including but not limited to:

(I) which state controlled substances should be monitored,
(II) which drugs of concern demonstrate a potential for abuse and should be monitored,
(III) design and implementation of educational courses identified in Section 9,
(IV) proper analysis and interpretation of prescription monitoring information,
(V) design and implementation of an evaluation component, and
(VI) potential nominees to the Board.

SECTION 7. REPORTING OF PRESCRIPTION MONITORING INFORMATION.

(a) Each dispenser shall submit to the [designated state agency or entity], by electronic means, or other format specified in a waiver granted by the [designated state agency or entity], information specified by the [designated state agency or entity], including:

(I) A patient identifier,
(II) The drug dispensed,
(III) The date of the dispensing,
(IV) The quantity dispensed,
(V) The prescriber, and
(VI) The dispenser.

(b) Each dispenser shall submit the required information as frequently as specified by the [designated state agency]

(c) The [designated state agency or entity] may grant a waiver of electronic submission to any dispenser for good cause, including financial hardship, as determined by the [designated state agency or entity]. The waiver shall state the format and frequency with which the dispenser shall submit the required information.

SECTION 8. ACCESS TO THE PRESCRIPTION MONITORING INFORMATION/CONFIDENTIALITY.

(a) Except as indicated in paragraphs (b), (c), and (d), prescription monitoring information submitted to the [designated state agency or entity] shall be confidential and not subject to public or open records laws.

(b) The [designated state agency or entity] shall review the prescription monitoring information. If there is reasonable cause to believe a violation of law [or breach of occupational standards] may have occurred, the [designated state agency or entity] shall notify the appropriate law enforcement and occupational licensing, certification or regulatory agency or entity, and provide prescription monitoring information required for an investigation.

(c)The [designated state agency or entity] may provide prescription monitoring information for public research, policy or education purposes, to the extent all information reasonably likely to reveal the patient or other person who is the subject of the information has been removed.

(d) The following persons, after successful completion of the educational courses identified in Section 9(a), may access the prescription monitoring information in the same

or similar manner, and for the same or similar purposes, as those persons are authorized to access similar confidential information under federal and state law and regulation.

(I) [insert prescribers]
(II) [insert dispensers]
(III) [insert all appropriate law enforcement personnel]
(IV) [insert all appropriate occupational licensing, certification and regulatory personnel]
(V) [insert all appropriate judicial authorities]
(VI) [insert all appropriate personnel of the designated state agency or vendor/contractor establishing and maintaining the prescription monitoring program]

NOTE: Patients have several traditional means other than a prescription monitoring program to access their medical information. However, some states' existing laws will require that patients have access to their prescription information which is maintained by a monitoring program. Those states will therefore need to include patients as a category of individuals able to access the prescription monitoring information under this section.

(e) The [designated state agency or entity] shall be immune from civil liability arising from inaccuracy of any of the information submitted to the [designated state agency or entity] pursuant to this Act.

SECTION 9. EDUCATION AND TREATMENT

(a) The [designated state agency or entity] shall, in consultation with the Board, implement the following education courses:

(I) An orientation course during the implementation phase of the PMP.

(II) A course for persons who are authorized to access the prescription monitoring information but who did not participate in the orientation course.

(III) A course for persons who are authorized to access the prescription monitoring information but who have violated laws or breached occupational standards involving dispensing, prescribing and use of substances monitored by the PMP.

(IV) A continuing education course for health care professionals developed by the American Society of Addiction Medicine and the state medical society on prescribing practices, pharmacology and identification, treatment and referral of patients addicted to or abusing substances monitored by the PMP.

When appropriate, the [designated state agency or entity], in consultation with the Board, shall develop the content of the education courses described in paragraphs (I) - (III).

(b) The [designated state agency or entity], in consultation with the Board, shall strongly recommend the application of a course to inform the public about use, diversion and abuse of, and addiction to, substances monitored by the PMP.

(c) The [designated state agency or entity], in consultation with the Board, shall, when appropriate:

(I) work with associations for impaired professionals to ensure intervention, treatment and ongoing monitoring and follow-up; and

(II) ensure that individual patients who are identified and who have become addicted to substances monitored by the PMP receive addiction treatment.

SECTION 10. UNLAWFUL ACTS AND PENALTIES

(a) A dispenser who knowingly fails to submit prescription monitoring information to the [designated state agency or entity] as required by this Act shall be subject to [insert appropriate administrative, civil or criminal penalty].

(b) A person authorized to have prescription monitoring information pursuant to this Act who knowingly discloses such information in violation of this Act shall be subject to [insert appropriate administrative, civil or criminal penalty.]

(c) A person authorized to have prescription monitoring information pursuant to this Act who uses such information in a manner or for a purpose in violation of this Act shall be subject to [insert appropriate administrative, civil or criminal penalty.]

SECTION 11. EVALUATION, DATA ANALYSIS AND REPORTING.

(a) The [designated state agency] shall, in consultation with the Board, design and implement an evaluation component to identify cost-benefits of the prescription monitoring program, and other information relevant to policy, research and education involving substances monitored by the PMP.

(b) The [designated state agency] shall report to the [insert appropriate state decisionmakers, e.g, legislature] on a periodic basis, no less than annually, about the cost-benefits and other information noted in paragraph (a).

SECTION 12. RULES AND REGULATIONS.

The [designated state agency] shall promulgate rules and regulations necessary to implement the provisions of this Act.

SECTION 13. SEVERABILITY.

If any provision of this Act or application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provisions or applications, and to this end the provisions of this Act are severable.

SECTION 14. EFFECTIVE DATE.

This Act shall be effective on [insert specific date or reference to normal state method of determination of the effective date].

Attachment 2

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE
REGARDING HOUSE BILL 1459
March 1, 2005

Madam Chairman -- Members of the Committee:

My name is Arnold R. Thomas. I am the President of the North Dakota Healthcare Association. I am here to urge a **Do Pass** on House Bill No. 1459.

For many sessions now, the state has acknowledged that we face a variety of challenges in managing and funding the Medicaid program. Some of these challenges include decreasing federal dollars and increasing program enrollment. Additional challenges are incurred by the increase in specific diseases, such as diabetes, due to in crease in the population's life spans and attendant health and medical requirements linked to chronic conditions of aging.

Although the funding of the Medicaid program receives the most attention, service structure and delivery have major impacts upon the quality and cost of services received by recipients. At best it is safe to say that funding challenges are increasing and efforts have been marginal in reconfiguring to a systems model for medical and health care services delivery.

This past summer, we took the initiative and called together physicians, clinic managers, and hospital executives and asked them to look at how the private sector can partner with the Department and jointly address the variety of challenges facing the program.

We looked at facts. We separated out the anecdotal information and discredited a number of assumptions about who receives services, how they get qualified, and how our benefits compare to those of other states.

We concluded that what we need, first and foremost, is a system approach for delivery of acute medical services to the Medicaid population. For this to occur we needed a firm information resource—proposed in HB 1460; broader options for structuring and delivering of acute medical services to the Medicaid population---HB 1459; and funding---currently being addressed in HB 1012.

HB 1459 recognizes that challenges facing the Medicaid program cannot be overcome with a single approach or strategy. HB 1459 proposes a strategy of workable options to address immediate and long range program challenges facing this important program.

We hope you favorably consider HB 1459 and ask for a "DO PASS".

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

Attachment 3

Testimony Presented By

James T. Carder, Executive Director

Wyoming State Board of Pharmacy

I am James Carder, Executive Director for the Wyoming State Board of Pharmacy. I appreciate the opportunity to address your committee concerning the implementation of an electronic prescription drug monitoring system in North Dakota.

Prescription drug abuse involving controlled substances is a problem in Wyoming. The magnitude of the problem was hard to quantify as there was not a program available which collected such data. The Wyoming Legislature authorized funds to study substance abuse issues in Wyoming, and a study was conducted by the Wyoming Department of Health and a document submitted to the Wyoming Legislature and Governor on October 1, 2001. This document was titled "*Reclaiming Wyoming: A Comprehensive Blueprint for Prevention, Early Intervention, and Treatment of Substance Abuse*". This document recommended to the Wyoming Legislature, among other items, that a statewide, computer database be created that would permit practitioners, pharmacist, and in certain cases law enforcement/licensing boards access to controlled substance prescription information. The Wyoming Legislature adopted a prescription drug monitoring

program during the 2003 Wyoming Legislature. The board of pharmacy is responsible for operating this program. The program became operational in July 2004.

The board prior to implementing this program spent considerable time in educating the practitioners/pharmacists in Wyoming regarding an electronic prescription drug monitoring program. Groups addressed included annual meetings for the Wyoming Hospice Association, Wyoming Medical Society, Central Wyoming Physicians Organization, Wyoming Pharmacy Association, Wyoming Dental Society, Wyoming Physician Assistant Association, Wyoming Veterinary Society, & Wyoming Advance Practice Nursing Association. Meetings were held with the board of medicine and nursing. In addition, presentations were given in sixteen Wyoming communities during the summer of 2004. In each community, both a morning (7-8am) as well as an evening (7-8pm) presentation was given. In five of these communities a pain specialist from Casper attended and gave a presentation on chronic pain management and utilization of the PMP. Through the month of January 2005 the board has received 305,863 controlled substance prescriptions and received request from 179 practitioners and pharmacists for patient profiles. Included with the patient profile returned to the practitioner or pharmacist is a brief survey. Through January 111 surveys have been returned. The comments have been positive. The board will continue to offer

information to practitioners/pharmacist on the electronic PMP. We feel this program provides accurate information to practitioners and pharmacists, and we believe this information will assist in optimizing their patients' drug therapy management as it relates to controlled substances

Funding is always an issue. In Wyoming, the board took advantage of federal dollars available through the Bureau of Justice Programs. Dollars are available for study, implementation, and enhancement of prescription drug monitoring programs. Wyoming did receive a grant in the amount of $214,000 to implement the program. Funding beyond the grant will come from controlled substance registration fees charged by the board to practitioners, pharmacies, and manufacturers/distributors who utilize controlled substances.

Our program is still in its infancy and data is not available to show if the program is having an impact on prescription drug diversion issues, but what we can report is an appreciation for the program from both practitioners and pharmacists. Each month, utilization of the PMP data by practitioners and pharmacists is increasing. Our goal is to receive approximately 10-15 requests per day for patient profiles from practitioners and pharmacists. In January, we averaged approximately 5 requests per day. Regarding prescription data, we projected approximately 500,000 schedule 2-4 controlled substance prescriptions

would be generated in a twelve month period and based on 7 months worth of data; we project approximately 524,000 prescriptions per 12 months.

The legislation you are considering is based on model language from The National Alliance for Model State Drug Laws and will protect the confidentiality of protected patient information yet allow those practitioners and pharmacists who have a valid patient/practitioner or patient/pharmacist relationship to access this data. This legislation will allow law enforcement access for legitimate investigations and of importance to states such as Wyoming, will allow sharing of information between states. This latter provision we feel is very important as patients tend to be very mobile. Both Idaho and Utah have prescription drug monitoring programs, and both the board as well as practitioners has taken advantage of accessing their programs to obtain information. In one case, a patient living in Wyoming had utilized 36 practitioners in both Wyoming and Utah. Sharing this information between states is important.

In summary, I would encourage you to seriously consider this legislation. Prescription drug diversion is a problem. This program is not the answer, but it is a vital tool that can be used by both practitioners and pharmacists in optimizing drug therapy management in their patients. The concerns that may be expressed by practitioners and pharmacists regarding implementation of a PMP can be minimized by education. Thank you for time and I would be glad to address any questions you may have.

Attachment 1
3/8/05

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1459

Page 1, line 1, after "Act" insert "to provide for the creation of a computerized pharmaceutical prescription drug data repository;"

Page 1, after line 4, insert:

"SECTION 1. COMPUTERIZED PHARMACEUTICAL PRESCRIPTION DRUG DATA REPOSITORY - DEVELOPMENT - IMPLEMENTATION.

1. The department of health shall coordinate the formation of a committee to develop a computerized pharmaceutical prescription drug data repository in the state. The committee includes at least:

a. One representative of the department;

b. One representative of the department of human services;

c. One computer system specialist appointed by the information technology department;

d. One representative of law enforcement appointed by the attorney general;

e. One physician appointed by the North Dakota medical association;

f. One advanced practice registered nurse with prescriptive authority appointed by the North Dakota nurses association;

g. One pharmacist appointed by the North Dakota pharmacists association;

h. One pharmacist appointed by the North Dakota hospital pharmacy association;

i. One dentist appointed by the North Dakota dental association;

j. One veterinarian appointed by the North Dakota veterinary medical association;

k. One hospital administrator appointed by the North Dakota healthcare association;

l. One nursing home representative appointed by the North Dakota long term care association;

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

m. One representative appointed by the federally designated state peer review organization;

n. One representative appointed by the school of medicine;

o. One representative appointed by a commercial health insurer as determined by the department; and

p. One representative of Workforce Safety and Insurance.

2. The department shall designate the chairman and vice chairman of the committee.

3. In creating the repository, the committee shall consider and address issues related to scope, access, privacy, technological capability, and cost and shall do all things necessary and proper to ensure, development of the repository.

4. The department shall draft any legislation required to implement the repository and introduce such legislation during the sixtieth legislative assembly.

5. The department of health may receive and expend moneys from public and private sources for the purpose of creating, in accordance with this section, a computerized pharmaceutical prescription repository in the state."

Page 2, line 22, replace "1" with "2"

Renumber accordingly

Arnold 'Chip' Thomas

Attachment 3

March 1, 2005

Proposed changes in House Bill 1459

Replace line nine beginning with "for" and ending on line 11 with "diseases" with the following language:

"to include a concentrated but not an exclusive emphasis for the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases and the families of neonates that can benefit from case management services".

Replace lines 15 through 18 with the following language:

Review and develop recommendations to identify any instances where providers of service are not properly reporting diagnosis or reason and procedure codes when submitted claims for medical assistance payment.

Anne Zenton

NCSL FAX

Date March 9, 2005

Number of pages including cover sheet 4

TO: Sen. Judy Lee

FAX :701-~~237-9109~~

Phone 328-2872

CC:

FROM: **Karmen Hanson, MA**
Policy Specialist

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Web www.ncsl.org/programs/health/list.htm

Hello Sen. Lee:

Here is the NABP chart on Controlled Substance Prescription Monitoring Programs.

If there is anything else I can help with, please let me know.

Thank you-

KARMEN

XX. Prescription Requirements (cont.)

State	Does State: Sell Schedule V Preparations OTC?	Have a Controlled Substance Prescription Monitoring Program?	Allow Use of Pre-Printed Rx Forms for Non-Controlled Prescriptions?	Require Expiration or Beyond Use Date on Rx Vial Labels in Community Practice?	How Long Must Prescription Records be Maintained?
Alabama	Yes A	No	Yes B	No	2 years
Alaska	Yes	No	Yes C	No	2 years
Arizona	Yes	No	Yes E	No	3 years
Arkansas	Yes	No	Yes F	No	2 years
California	No	Yes - Sch. II	Yes J	Yes K	3 years
Colorado	No	No	Yes C	No	2 years
Connecticut	No	No	Yes F	Yes	3 years
Delaware	No A	No	Yes	No RRR	2 years
District of Columbia	Yes	No	Yes O	Yes	2 years
Florida	Yes	No	Yes F	Yes	2 years
Georgia	Yes S	No	Yes F	Yes	2 years
Guam	Yes V	No	Yes	Yes	5 years
Hawaii	Yes Y	Yes Y (narcotics)	Yes Y	Yes Y	5 years
Idaho	Yes Z	Yes XXX	Yes F	No	3 years
Illinois	Yes Z	ZZ	Yes B	No	5 years
Indiana	Yes Z	Yes NN, WWW	Yes CC, DD	No N	2 years
Iowa	Yes Z	No	Yes O	No	2 years
Kansas	Yes	No	Yes	Yes	5 years
Kentucky	Yes S, Z	Yes UUU	Yes F, HH	No	5 years
Louisiana	VVV	No	Yes	No	2 years
Maine	Yes	No	Yes KK	Yes	5 years
Maryland	No	No	Yes F, LL	Yes	5 years
Massachusetts	No	NN	Yes F	Yes	2 years
Michigan	Yes	OO	Yes F, P	Yes	5 years
Minnesota	No	No	Yes F	Yes FF	5 years
Mississippi	Yes	No	Yes F	No	2 years; 5 years
Missouri	No	No	Yes F	No	5 years
Montana	No	No	PP	No	2 years
Nebraska	No	No	Yes F	No	5 years
Nevada	Yes Z, RR	Yes	Yes F	Yes	2 years
New Hampshire	Yes A	No	Yes C	No	4 years
New Jersey	Yes S, Z	Yes	Yes F	No	5 years
New Mexico	Yes Z	No	Yes F	Yes	3 years
New York	No	TT	Yes F	No	5 years
North Carolina	Yes	No	Yes	Yes	3 years
North Dakota	No	No	Yes F	No	5 years
Ohio	Yes	No	Yes F, WW, XX	No	3 years
Oklahoma	Yes	Yes ZZ, NN	Yes F	No	5 years
Oregon	No AAA, BBB	No	Yes CCC	Yes	3 years
Pennsylvania	No	Yes MMM	HHH	Yes OOO	2 years
Puerto Rico	Yes SS	No	GGG	Yes UU	—
Rhode Island	No	Yes NN	Yes	Yes	2 years
South Carolina	Yes	No	Yes GGG	No	2 years
South Dakota	No	No	No KKK	No	2 years
Tennessee	Yes	Pending	Yes F	No	2 years
Texas	Yes AAA	Yes Sch. II	Yes	No	2 years
Utah	No	Yes	Yes	Yes	5 years
Vermont	VVV	No	Yes	No	3 years
Virginia	Yes	No	Yes F	No	2 years
Washington	Yes V	No	Yes DD	Yes	2 years
West Virginia	Yes	Yes TTT	Yes	Yes	5 years
Wisconsin	Yes	No	Yes LLL	No	5 years
Wyoming	Yes Z, RR, NNN, A	No	Yes	PPP	2 years

NABP: 847-698-6227 Park Ridge, IL

XX. Prescription Requirements (cont.)

LEGEND

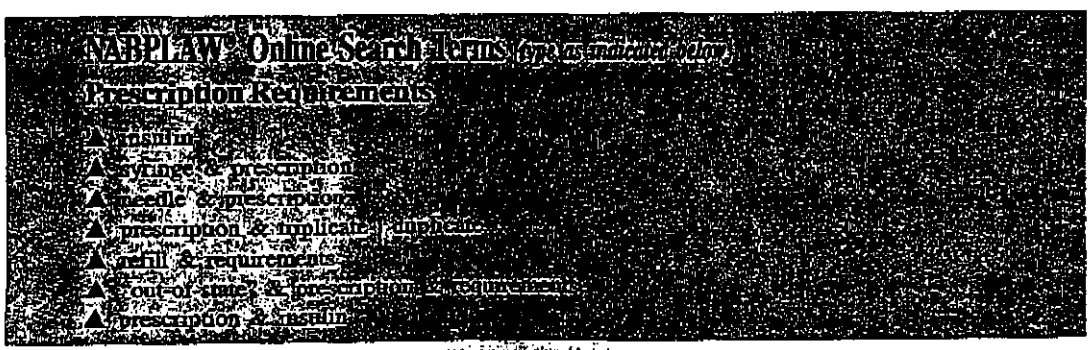
A — Cough syrups containing codeine shall not be dispensed without a prescription. (DE – All C-V products require a prescription.)
B — Only controlled substances may NOT be preprinted.
C — No restrictions.
D — Six months for non-C-II controlled substance prescriptions.
E — For non-controlled prescriptions, all elements may be preprinted.
F — Only prescriber's signature may NOT be preprinted.
G — May sell without prescription for human use in the administration of insulin or adrenaline or for use on animals under the following conditions: 1) furnisher must be able to identify purchaser; 2) a record of the purchase must be made. May also sell for industrial use.
H — May be sold for animal, poultry, or industrial use, but must obtain a permit from the Board.
I — Six months for Schedule III and IV controlled substance prescriptions.
J — Prescriber's signature may NOT be preprinted, and pharmacist may only dispense one prescription drug on a noncontrolled substances multiple check-off prescription blank.
K — Requires expiration date.
L — May dispense up to a quantity of 10 without a prescription.
M — Must verify Medical Doctor's DEA number and receive positive (photo) ID from presenter of prescription.
N — Exception – sterile pharmaceutical products.
O — No law or regulation that prohibits preprinted prescriptions.
P — Some restrictions.
Q — Cannot sell to minors.
R — Only if written at the office of the prescriber, not if in transit through the state.
S — Check state requirements.
T — Pharmacist professional judgment.
U — Insulin syringes may be sold without a prescription if the pharmacist knows the patient.
V — Frequency more stringent than federal DEA rules.
W — Under jurisdiction of the Department of Health, Food and Drug Branch (328, Hawaii Revised Statutes).
X — Under jurisdiction of the Department of Public Safety (329, Hawaii Revised Statutes).
Y — Prescription drugs, labeling, and dispens ing are under the jurisdiction of the Stat Department of Health, Food and Drug Branch. Narcotics and controlled substances are under jurisdiction of Stat Department of Public Safety, Narcotics Enforcement Division.
Z — Must be sold by pharmacist only in pharmacy.
AA — Also by veterinary suppliers.
BB — Check state requirements.
CC — Prescriber's signature and patient's nam and address may not be preprinted.
DD — May not preprint signature, and form must comply with generic substitution law (ie, two signature lines).
EE — Paraphernalia provisions of the Controlled Substance Act prohibit selling syringes with criminal intention.
FF — If meaningful (ie, a two-week supply of medication would not need three-year dating).
GG — If prescriber is licensed in Kentucky.
HH — Must comply with KRS 217.216.
II — Must meet the same requirements as an in-state prescription. (VA – Except two check-box format.)
JJ — If the prescriber has an individual DEA number.
KK — May not preprint prescriber's signature and address.
LL — Although not prohibited by law, the Board believes that preprinted prescrip tions are not good practice.
MM — Only from contiguous states.
NN — Electronic data transmission. (IN – C-II only. MA, OK – of C-II on RI – of C-II and C-III.)
OO — A state form required for Schedule IIs except for methylphenidate.
PP — Issue not addressed.
QQ — Out-of-state prescriptions are limited t prescribers with full prescribing autho in this state (i.e., MD, DO, DDS/DMD, DPM, DVM). The prescribing authorit for mid-level practitioners is so varied that it would be difficult for in-state pharmacists to be knowledgeable abo the restrictions in the other 49 states.
RR — Cannot sell to minors.
SS — Federal restrictions for selling Schedul preparation OTC apply.
TT — Schedule II and benzodiazepines mus be on an official New York State prescription form.

Legend continues on pag

XX. Prescription Requirements (cont.)

LEGEND – (cont.)

UU — Required by Department of Consumer Affairs regulations.
VV — If licensed in North Carolina.
WW — May not preprint "DAW" or "Dispense as Written."
XX — One prescription order per blank if preprinted.
YY — Local restrictions exist.
ZZ — Utilizes an electronic data capture system.
AAA— Codeine-containing products must be prescription only.
BBB— Preparations containing opium (paregoric) shall be dispensed with prescription only.
CCC— Except dentistry. No rules for what may or may not be preprinted.
DDD— From land border physician prescriber.
EEE — Must be sold by pharmacist only in pharmacy or by a certified or licensed durable medical equipment provider.
FFF — Two years on PRN refill prescriptions; no time limit on prescriptions with a specified number of refills.
GGG— Signature may not be preprinted or rubber-stamped; definition of "written Rx" includes "signed by the prescriber." Only one drug and set of instructions for each blank preprinted.
HHH— Not known (Board of Medicine). Prescriber's signature and DEA number may not be preprinted.
III — No legal limit (except for controlled substances). One year by custom and standard of practice.
JJJ — Prescription must enter Texas as a written, signed prescription.
KKK— No, if furnished to a practitioner. (TX – After June 1, 2002, no longer prohibited.)
LLL — Specific pharmacy and language regarding substitution may not be preprinted.
MMM—Through the Office of the Attorney General.
NNN— Follows DEA guidelines exactly.
OOO— If drug's potency is less than one year.
PPP — Guideline only – not a law or regulation.
QQQ— After one year, pursuant to certain conditions and restrictions, a "PRN" prescription may be refilled by an in-state pharmacy for a subsequent three-month period.
RRR— Exception – intravenous products.
SSS — From physician prescriber.
TTT — Beginning Sept. 1, 2002 – all CII, III, and IV prescriptions electronically reported.
UUU— Electronic transmission of all scheduled prescriptions and special, secure prescription blank required.
VVV— Only antidiarrheals.
WWW—Prescription pad with security features required.
XXX— Electronic tracking of all Schedule II, III, and IV prescriptions. All written CS Rx's must be written on non-copyable paper and must provide positive ID of prescriber.
YYY— If licensed in a state or territory in the United States.
ZZZ— Effective January 1, 2001, pharmacists, certain health care facilities, and health practitioners who are otherwise authorized to prescribe needles and syringes in the scope of their practice, may sell or furnish 10 or fewer hypodermic needles or syringes to persons 18 years or older without a prescription.
AAAA—Must meet same scope of practice requirements as in state practitioners.



BOARD OF PHARMACY
State of North Dakota

John Hoeven, Governor

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House Bill #1459
Senate Appropriations Committee
8:30 AM Thursday – March 24, 2005 – Harvest Room

For the record, I am Howard C. Anderson, Jr, R.Ph., Executive Director of the North Dakota State Board of Pharmacy.

I have no comments and no position on the appropriations portion of this Bill.

However, I wanted to let you know that I am available to answer any questions, should any arise, relative to the Controlled Substances Tracking Program that is proposed. The Board of Pharmacy, along with most providers in North Dakota, are in favor of providing access to prescription information for the patients under their care.

The concept here is to utilize the money through the Federal Office of Drug Control Policy to develop a system that would work for North Dakota. I believe the additions in this Bill can accomplish that.

Thank you.