

2013 HOUSE HUMAN SERVICES

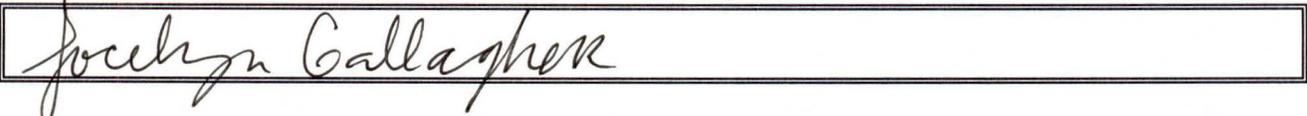
HB 1274

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee Fort Union Room, State Capitol

HB 1274
January 30, 2013
18018

Conference Committee



Explanation or reason for introduction of bill/resolution:

A bill relating to electronic drug prior authorization.

Minutes:

attached testimony 1,2,3,4,5

Chairman Weisz called the hearing on HB 1274 to order.

Rep. Weisz: Introduced and sponsored the bill. The bill is for electronic prior authorization. Certain medications require prior authorization before they can be prescribed by the doctor for the patient. This bill will move it from the paper process to be totally electronic. A bill was passed in 2011 saying the date of August 1, 2013 when state providers were supposed to be compliant. We also set up a work group because there were a lot of issues of there being a national standard or lack thereof for prior authorization. The national group did not come up with standards approved by all the entities, so this bill extends that date for August 1, 2014. We want a uniform standard so everyone is on the same page.

Sheldon Wolf, The ND Health Information Technology Director: testified in support of the bill. (See Testimony #1) (4:45 - 9:20)

Rep. Fehr: (9:26) When you talk about one year from a date to when ONC publishes, how is that triggered, who registers it, and how would that take place?

Sheldon Wolf: The Office of National Coordinator develops standards for electronic health records systems. They have a 2011 and 2014 standard and they will develop more standards more standards that providers need to meet meaningful use requirements. Once there is a final rule they have an effective date.

Rep. Weisz: Do we need to wait for the ONC to require it to go forward or what is the rationale to wait until they go forward?

Sheldon Wolf: You don't have to wait to do that Once ONC makes it part of that certified system then all the systems need to incorporate it. If a vendor ND uses chose not to use it then the providers are going to have to ask vendors to build it into the system if they want it part of that electronic health records system.

Ken Tupa: Representing from American Cancer Society: in support of the bill. (No written testimony) (12:30- 14:13)

Carlotta McCleary, Executive Director of ND Federation of Families for Children's Mental Health: testified in support of the bill. (14:58 - 6:15) (See Testimony #2)

Vice Ch. Hofstad: Further support of HB 1274?

Harvey Hanel, Pharmacy Director at WSI: testified in support of the bill. (16:40-21:08) (See Testimony #3)

Rep. Weisz: (21:11) Currently under your system that patient came in with Lipitor prescription you would still need a prior authorization to determine if it is covered under your scenario or not correct?

Harvey Hanel: That is correct.

Rep. Weisz: What happens to the patient and medication?

Harvey Hanel: The pharmacy may choose to give them a limited supply. There are times injured worker needs to come up with the cash up front or bill it to an alternate insurer.

Dr. Brendan Joyce, Administrator of Pharmacy Services for Medical Services Division of the DHS: testified in support of the bill. (23:50-26:40) (See Testimony #4)

Rep. Laning: (26:46) On the physical note of one half million dollars, is the majority of that software?

Dr. Brendan Joyce: Mostly the software and the program surrounding it. The startup cost for the vendor is around \$150,000 at the low end. Ongoing operations are \$185,000.

Rep. Laning: Wouldn't this be a shared cost amongst all the users or is the state going to get saddled with the entire cost?

Dr. Brendan Joyce: This is specific to Medicaid. We built it to do a real time acceptance and adjudication of processing of prior authorization. For information purposes, Medicaid goes through 170-200 prior authorizations a month. So we are not a high volume state.

Rep. Weisz: The suggested language change by Sheldon Wolf, does that have any effect on the programming costs for you or is it irrelevant?

Dr. Brendan Joyce: The effective dates would just push the start-up costs down the road.

Patrick Ward, Attorney with Zuger Kirmis & Smith, Representing Express Scripts: In favor of amendments to the bill and repeal of a section of the ND century code. (32:45-39:00) (See Testimony #5)

Rep. Mooney: (39:10) There is system in place and essentially this is a duplication?

Patrick Ward: There was a system in place for electronic prescribing, that system has been growing rapidly over the past 4 years and will continue to. The prior authorization is the issue where there has not been standardization yet. There is a lot of work being done at the federal level and when the federal system is ready where it can work from Medicare and Medicaid. Companies which manage pharmacy benefits want this to be one integrated system that is the same nationally.

Vice Ch. Hofstad: Others in support 1247? Any opposition to 1274?

Robert Harms: represents CVS Caremark (41:00) (no written testimony) testified in support of the bill with the suggested amendments by Mr. Ward. To have some context two years ago the legislator adopted this bill and there was a lot of disagreement within the industry about whether the bill was necessary. The PBMs, which I represent, resisted the bill and argued against it for two reasons which were explained by Mr. Harms.

Vice Ch. Hofstad: Questions for Mr. Harms? Others here for 1274, against 1274? Closed hearing on 1274.

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee Fort Union Room, State Capitol

HB 1274
February 11, 2013
Job 18722

Conference Committee

Committee Clerk Signature

Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

A bill relating to electronic drug prior authorization.

Minutes:

.57

Chairman Weisz: 1274 committee. This is the electronic prior authorization and currently has a fiscal note because of Medicaid and the programming changes. There was a suggestion to change the date to August 1, 2015 and then the fiscal note would go away for this biennium.

Rep. Hofstad: I would move to amend the bill. First, take WSI out of the bill and second, move the date to August 1, 2015.

Chairman Weisz: Does everyone have that amendment? No one has that amendment. Actually they should be exempted in Section 1 of the bill. The proposed amendment would put in on page 1 line 17, after 2014 it would say, "The requirements in this section do not apply to Workforce Safety and Insurance."

Rep. Fehr: Second.

VOICE VOTE: MOTION CARRIED

Rep. Fehr: I move a Do Pass as amended on HB 1274.

Rep. Looyzen: Second.

ROLL CALL VOTE: 13 y 0 n 0 absent

MOTION CARRIED

Bill Carrier: Rep. Muscha

FISCAL NOTE
Requested by Legislative Council
01/20/2013

Bill/Resolution No.: HB 1274

- 1 A. **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.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$444,241		\$446,290
Expenditures			\$148,081	\$444,241	\$148,763	\$446,290
Appropriations			\$148,081	\$444,241	\$148,763	\$446,290

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1274 requires ND Medicaid to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. This will allow the Department to respond electronically to prescribers in real time.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

HB 1274 will require the Department to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. The costs incurred by the Department of \$592,322, of which \$148,081 is general fund, will include costs for the vendor to connect their system to the state's Point of Sale/Medicaid Management Information System, costs for the state to interface with the vendor's system, ongoing maintenance and operating costs, and the costs for an additional Pharmacist FTE to oversee implementation and ongoing operations.

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.*

The other fund revenue is additional Medicaid funding the state will be able to access.

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

The fiscal impact for the Department of Human Services for the 2013-2015 biennium is comprised of: a vendor contract for connection costs to the State's POS/MMIS \$150,000, of which \$37,500 is general fund, costs to interface vendor system to State's POS/MMIS \$100,000, of which \$25,000 is general fund, ongoing maintenance and support costs \$185,000, of which \$46,250 is general fund, costs for additional Pharmacist FTE \$157,322, of which \$39,331 is general fund. The fiscal impact of \$595,053, of which \$148,763 is general fund, for the 2015-2017 biennium would include the on-going maintenance and operating costs as well as the costs to retain the pharmacist FTE.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase of \$592,322 in the 2013-2015 biennium, of which \$148,081 would be general fund and \$444,241 would be federal funds. The Department will need an appropriation increase of \$595,053 in the 2015-2017 biennium, of which \$148,763 would be general fund and \$446,290 would be federal funds.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/25/2013

February 12, 2013

VR
2/12/13

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1274

Page 1, line 8, replace "2014" with "2015"

Page 1, line 14, remove "The health information technology advisory committee may"

Page 1, remove lines 15 and 16

Page 1, line 17, replace "2014" with "The requirements in this section do not apply to workforce safety and insurance"

Re-number accordingly

Date: 2-11-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1274

House Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Rep. Hofstad Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

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

*Delete WSI out of bill
Change date to August 1, 2015
Voice Vote
Motion Carried*

Date: 2-11-13
 Roll Call Vote #: 2

**2013 HOUSE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. 1274**

House Human Services Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Looyen

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓	✓	REP. MOONEY	✓	✓
VICE-CHAIRMAN HOFSTAD	✓	✓	REP. MUSCHA	✓	✓
REP. ANDERSON	✓	✓	REP. OVERSEN	✓	✓
REP. DAMSCHEN	✓	✓			
REP. FEHR	✓	✓			
REP. KIEFERT	✓	✓			
REP. LANING	✓	✓			
REP. LOOYSEN	✓	✓			
REP. PORTER	✓	✓			
REP. SILBERNAGEL	✓	✓			

Total (Yes) 13 No 0

Absent _____

Floor Assignment Rep. Muscha

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

REPORT OF STANDING COMMITTEE

HB 1274: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1274 was placed on the Sixth order on the calendar.

Page 1, line 8, replace "2014" with "2015"

Page 1, line 14, remove "The health information technology advisory committee may"

Page 1, remove lines 15 and 16

Page 1, line 17, replace "2014" with "The requirements in this section do not apply to workforce safety and insurance"

Re-number accordingly

2013 SENATE INDUSTRY, BUSINESS, AND LABOR

HB 1274

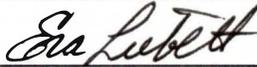
2013 SENATE STANDING COMMITTEE MINUTES

Senate Industry, Business and Labor Committee Roosevelt Park Room, State Capitol

HB 1274
March 12, 2013
Job Number 19794

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to electronic drug prior authorization

Minutes:

Testimony Attached

Chairman Klein: Called the committee hearing to order.

Representative Weisz: Introduced and explained the bill. (:18-6:40)

Discussion and questions (6:45-14:29)

Ken Tupa, American Cancer Society Cancer Action Network: Written Testimony (1).
(15:12-16:36)

Chairman Klein: Asked what the time frame would be on a paper prior authorization.

Ken Tupa: Said if I could step back and describe the difference between paper and electronic. Prior authorization is not new, it is a process used by payers right now and has been used for some time. They have criteria set up for that process. As healthcare evolves and electronic prescribing becomes the most efficient and preferred means for prescribing for the provider and the physician and for the pharmacist receiving that prescription, the prior authorization process has lagged and remains paper. You have a false barrier for the provider, the physician, who may feel along with the patient that the source of treatment or medication might be the best for him or her. That false barrier may be that they can prescribe electronically but they would still have to fill out this piece of paper and fax it in and wait for a fax back. It could take several hours to several days, in most cases it is hours. The intent with 1274 is to drive that discussion so that we bring that paper process into the electronic process so it is all seamless and so that it works quickly in a near real time environment. Written Testimony Attached, Carlotta McCleary, Executive Director of ND Federation of Families for Children's Mental Health (2).

Brendan Joyce, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services: Written Testimony Attached (3).

Discussion and questions (23:58-33:00)

Harvey Hanel, Pharmacy Director at WSI: Written Testimony Attached (4).

Patrick Ward, Attorney with Zuger Kirmis & Smith: Representing Express Scripts. Written Testimony Attached (5) and Handout from the Office of the National Coordinator for Health Information Technology (6).

Jack McDonald, Prime Therapeutics: Prime Therapeutics is another pharmacy benefits manager. They worked in the last session with Mr. Ward and Mr. Harm's on the same issues. Said their feelings are the same as Mr. Ward's, if you are going to change the date on one paragraph, you should also change the second date to 2015 as well to make them coincide. They also agree that there is a conflict that Dr. Joyce mentioned that should be resolved as far as the advertisements being either prohibited or allowed.

Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association Director: Said the association does not have an official position on the bill. They have been closely monitoring and tracking the bill. They believe that e-prior authorization is coming and it is a matter of when the NCPP develops their national standards, which will provide the guidance in terms of the details of how this process will take place. One of the main things they are watching is, e-prescribing pharmacist have to pay for the cost associated with e-prescribing. They are watching to make sure that the cost associated with e-prior authorization is that those pharmacists aren't on the hook having to pay for that process as well.

Discussion (43:16-48)

Chairman Klein: Closed the hearing. We have some work to be done as it relates to some amendments. We may bring the sponsor back to explain why this wasn't taken care of.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1274
March 25, 2013
Job Number 20417

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

Relating to electronic drug prior authorization

Minutes:

Discussion and Vote

Chairman Klein: Said he was going to have Representative Weisz to come and explain why they don't need any amendments but he is not available.

Senator Andrist: Moved a do pass and rerefer to Appropriations.

Senator Sorvaag: Seconded the motion.

Roll Call Vote: Yes - 7 No - 0 Absent - 0

Floor Assignment: Senator Klein

FISCAL NOTE
Requested by Legislative Council
02/13/2013

Amendment to: HB 1274

- 1 A. **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.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$224,493		\$446,290
Expenditures			\$74,831	\$224,493	\$148,763	\$446,290
Appropriations			\$74,831	\$224,493	\$148,763	\$446,290

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1274 requires ND Medicaid to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. This will allow the Department to respond electronically to prescribers in real time.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

HB 1274 will require the Department to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. The costs incurred by the Department of \$299,324, of which \$74,831 is general fund, will include costs for the vendor to connect their system to the state's Point of Sale/Medicaid Management Information System, costs for the state to interface with the vendor's system, and the costs for an additional Pharmacist FTE to oversee implementation.

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.*

The other fund revenue is additional Medicaid funding the state will be able to access.

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

The fiscal impact for the Department of Human Services for the 2013-2015 biennium is comprised of: a vendor contract for connection costs to the State's POS/MMIS \$150,000, of which \$37,500 is general fund, costs to interface vendor system to State's POS/MMIS \$100,000, of which \$25,000 is general fund, and costs for additional Pharmacist FTE and operating costs of \$49,324, of which \$12,331 is general fund. The fiscal impact of \$595,995, of which \$148,999 is general fund, for the 2015-2017 biennium would include the on-going maintenance and operating costs as well as the costs to retain the pharmacist FTE.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase of \$299,324 in the 2013-2015 biennium, of which \$74,831 would be general fund and \$224,493 would be federal funds. The Department will need an appropriation increase of \$595,995 in the 2015-2017 biennium, of which \$148,763 would be general fund and \$446,290 would be federal funds.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/20/2013

FISCAL NOTE
Requested by Legislative Council
01/20/2013

Bill/Resolution No.: HB 1274

- 1 A. **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.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$444,241		\$446,290
Expenditures			\$148,081	\$444,241	\$148,763	\$446,290
Appropriations			\$148,081	\$444,241	\$148,763	\$446,290

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

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- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

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Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/25/2013

**2013 SENATE STANDING COMMITTEE
 ROLL CALL VOTES
 BILL/RESOLUTION NO. Engrossed HB 1274**

Senate Industry, Business, and Labor Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: Do Pass Do Not Pass Amended Adopt Amendment
 Rerefer to Appropriations Reconsider

Motion Made By Senator Andrist Seconded By Senator Sorvaag

Senators	Yes	No	Senator	Yes	No
Chairman Klein	x		Senator Murphy	x	
Vice Chairman Laffen	x		Senator Sinner	x	
Senator Andrist	x				
Senator Sorvaag	x				
Senator Unruh	x				

Total (Yes) 7 No 0

Absent 0

Floor Assignment Senator Klein

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

REPORT OF STANDING COMMITTEE

HB 1274, as engrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends DO PASS and BE REREFERRED to the Appropriations Committee (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1274 was rereferred to the Appropriations Committee.

2013 SENATE APPROPRIATIONS

HB 1274

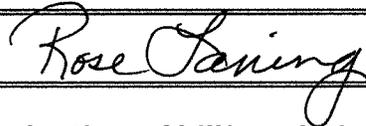
2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee Harvest Room, State Capitol

HB 1274
April 1, 2013
Job # 20716

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A Bill for an Act relating to electronic drug prior authorization

Minutes:

Testimony attached # 1

Legislative Council - Becky J. Keller
OMB - Lori Laschkewitsch

Vice Chairman Grindberg opened the hearing on HB 1274.

Ken Tupa, American Cancer Society Cancer Action Network, Inc.
Testified in favor of HB 1274
Testimony attached #1.

Senator Gary Lee: The fiscal note asks for pharmacist FTE, what is this for.

Ken Tupa: Human services will be able to address that because it is from their department.

Carlotta McCleary, ND Federation of Families for Children's Mental Health
Testified in favor of HB 1274

It's important to understand the relationship between the doctor and patient. It helps reduce errors and alleviates families having to go in again and have another appointment.

Maggie Anderson, DHS: The fiscal note does request a pharmacist position and that would be a position to support the efforts of implementing this and sustain it into the future. We have one pharmacist on staff now and that person would not be able to accomplish the extra workload. The other costs are for the vendor to contract with.

Senator Gary Lee asked if this was part of the governor's budget.

Maggie Anderson: The FTE was not part of the original request and not built into the budget.

Senator Kilzer asked if this was an OAR.

Maggie Anderson: No, it was not.

Patrick Ward, (Lobbyist # 026), Express Scripts Holding, Co.

Testified in favor of HB 1274

(9:15) We support the bill but we support moving the date on line 16, paragraph 2, change 2013 to 2015. And in paragraph 3, line 5 - remove the words "or make more difficult".

Vice Chairman Grindberg: Both the House and Senate policy committee heard your requests and didn't make changes.

Pat Ward: That is correct. If you did make changes, there would be no need for a fiscal note. It would not take place this next biennium.

Chairman Holmberg resumed chairmanship.

Jack McDonald, Prime Therapeutics, LLC

Testified in favor of HB 1274 but asked to change the date to 2015 and wait for national board standards (14:20).

Robert Harms, CVS Caremark Advanced Technology Pharmacy

Testified in favor of HB 1274

They agree with the date changes from 2013 to 2015 for the same reasons as the two previous speakers. If we leave the bill the way it is, we end up with three effective dates.

Chairman Holmberg: I don't think the committee is inclined to pass it now until they talk with the policy committee.

Senator Gary Lee asked Brendon Joyce if he agreed with delaying the date.

Brendon Joyce, Pharmacy Administrator for Medicaid Medical Services Division, DHS: The fiscal note is based on preparing to go live on August 1, 2015. There needs to be about a six month lead time for programming issues to get ready. That is the first part of the bill. Changing the date in the second part of the bill doesn't have any impact on that fiscal note.

Senator Gary Lee: In terms of implementation, is there a reason to change the effective date in paragraph two so there is some commonality across the country?

Brendon Joyce: Medicaid doesn't participate in E-prescribing. Therefore the impact on us does not happen. We can't speak to that until we start E-prescribing I have to defer to PBMs.

Senator Gary Lee: E-prescribing isn't available until 2015 or is it available now if we move the program forward.

Brendon Joyce: North Dakota Medicaid does not currently have E-prescribing in our budget. We have not had an appropriation for it nor have we spent any money toward E-prescribing. It is available, we just haven't done it. This bill is specifically for the E prior

authorization for it. He explained (20:00). The fiscal note is only for the E prior authorization piece. That is only in section 1 and if that remains the same, our fiscal note remains the same.

Senator Gary Lee: If we don't change the date and leave the money the same, you can't do it anyway.

Brendon Joyce: If the bill is funded, we'd be able to do it August. 1.

Discussed funding

Senator Carlisle asked if Mr. Tupa and Carlotta McCleary have changed their position after hearing further testimony.

Ken Tupa: American Cancer Society supports the bill as it is before this committee. (23:54)

Carlotta McCleary: We will continue to support the bill as it is written.

Chairman Holmberg closed the hearing on 1278.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee Harvest Room, State Capitol

HB 1274
04-03-2013
Job # 20795

Conference Committee

Committee Clerk Signature



Explanation or reason for introduction of bill/resolution:

A BILL relating to electronic drug prior authorization (DO PASS)

Minutes:

You may make reference to "attached testimony."

Chairman Holmberg called the committee to order on Wednesday, April 03, 2013 at 8:00 am. Roll call was taken. All committee members were present.

Sheila M. Sandness - Legislative Council
Laney Herauf-OMB

Chairman Holmberg is talking about the work they will do today and the bills that are still out in the House. There won't be any conference hearings for this committee for a time yet.

(3.20) Yesterday we heard a most interesting bill and that is HB 1274. If you recall that had to do with the e-prescribing for prescription, there is some angst over this bill over policy language in the bill but in checking with the policy committees that heard the bill in both the House and the Senate they were comfortable with the bill. There is another committee that didn't hear the bill that is uncomfortable with it, but that is over policy language. So If the committee wants to take some action on 1274, we can do that now.

Senator Carlisle it's a policy issue. I move a do pass. 2nd by Vice Chairman Grindberg.

Senator Mathern: Are you comfortable with the wording, it has no fiscal impact.

Chairman Holmberg I am comfortable to letting it go as it is. Call the roll on a Do Pass on 1274.

A Roll Call vote was taken. Yea: 13; Nay: 0; Absent: 0.

The bill goes back to IBL. **Senator Klein will carry the bill.** The hearing was closed on HB 1274.

FISCAL NOTE
Requested by Legislative Council
02/13/2013

Amendment to: HB 1274

- 1 A. **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.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$224,493		\$446,290
Expenditures			\$74,831	\$224,493	\$148,763	\$446,290
Appropriations			\$74,831	\$224,493	\$148,763	\$446,290

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1274 requires ND Medicaid to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. This will allow the Department to respond electronically to prescribers in real time.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

HB 1274 will require the Department to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. The costs incurred by the Department of \$299,324, of which \$74,831 is general fund, will include costs for the vendor to connect their system to the state's Point of Sale/Medicaid Management Information System, costs for the state to interface with the vendor's system, and the costs for an additional Pharmacist FTE to oversee implementation.

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.*

The other fund revenue is additional Medicaid funding the state will be able to access.

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

The fiscal impact for the Department of Human Services for the 2013-2015 biennium is comprised of: a vendor contract for connection costs to the State's POS/MMIS \$150,000, of which \$37,500 is general fund, costs to interface vendor system to State's POS/MMIS \$100,000, of which \$25,000 is general fund, and costs for additional Pharmacist FTE and operating costs of \$49,324, of which \$12,331 is general fund. The fiscal impact of \$595,995, of which \$148,999 is general fund, for the 2015-2017 biennium would include the on-going maintenance and operating costs as well as the costs to retain the pharmacist FTE.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase of \$299,324 in the 2013-2015 biennium, of which \$74,831 would be general fund and \$224,493 would be federal funds. The Department will need an appropriation increase of \$595,995 in the 2015-2017 biennium, of which \$148,763 would be general fund and \$446,290 would be federal funds.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 02/20/2013

FISCAL NOTE
Requested by Legislative Council
01/20/2013

Bill/Resolution No.: HB 1274

- 1 A. **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.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				\$444,241		\$446,290
Expenditures			\$148,081	\$444,241	\$148,763	\$446,290
Appropriations			\$148,081	\$444,241	\$148,763	\$446,290

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

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties			
Cities			
School Districts			
Townships			

- 2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1274 requires ND Medicaid to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. This will allow the Department to respond electronically to prescribers in real time.

- B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

HB 1274 will require the Department to accept electronic prior authorizations submitted by prescribers through their e-prescribing software. The costs incurred by the Department of \$592,322, of which \$148,081 is general fund, will include costs for the vendor to connect their system to the state's Point of Sale/Medicaid Management Information System, costs for the state to interface with the vendor's system, ongoing maintenance and operating costs, and the costs for an additional Pharmacist FTE to oversee implementation and ongoing operations.

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.*

The other fund revenue is additional Medicaid funding the state will be able to access.

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

The fiscal impact for the Department of Human Services for the 2013-2015 biennium is comprised of: a vendor contract for connection costs to the State's POS/MMIS \$150,000, of which \$37,500 is general fund, costs to interface vendor system to State's POS/MMIS \$100,000, of which \$25,000 is general fund, ongoing maintenance and support costs \$185,000, of which \$46,250 is general fund, costs for additional Pharmacist FTE \$157,322, of which \$39,331 is general fund. The fiscal impact of \$595,053, of which \$148,763 is general fund, for the 2015-2017 biennium would include the on-going maintenance and operating costs as well as the costs to retain the pharmacist FTE.

- C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation increase of \$592,322 in the 2013-2015 biennium, of which \$148,081 would be general fund and \$444,241 would be federal funds. The Department will need an appropriation increase of \$595,053 in the 2015-2017 biennium, of which \$148,763 would be general fund and \$446,290 would be federal funds.

Name: Debra A McDermott

Agency: Human Services

Telephone: 328-3695

Date Prepared: 01/25/2013

Date: 4-3-13

Roll Call Vote # 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1274

Senate Appropriations Committee

Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Adopt Amendment Do Pass
 Do Pass as Amended Do Not Pass

Motion Made By Carlisle Seconded By Grindberg

Senators	Yes	No	Senator	Yes	No
Chairman Ray Holmberg	✓		Senator Tim Mathern	✓	
Co-Vice Chairman Bill Bowman	✓		Senator David O'Connell	✓	
Co-Vice Chair Tony Grindberg	✓		Senator Larry Robinson	✓	
Senator Ralph Kilzer	✓		Senator John Warner	✓	
Senator Karen Krebsbach	✓				
Senator Robert Erbele	✓				
Senator Terry Wanzek	✓				
Senator Ron Carlisle	✓				
Senator Gary Lee	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment IBL Klein

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

REPORT OF STANDING COMMITTEE

HB 1274, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman)
recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING).
Engrossed HB 1274 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

HB 1274

#1

**TESTIMONY BEFORE THE HOUSE
HUMAN SERVICES
HOUSE BILL 1274
JANUARY 30, 2013**

Mr. Chairman, members of the committee, I am Sheldon Wolf, the ND Health Information Technology Director. I am here today to provide information on House Bill 1274 on behalf of the Health Information Technology Office and the Health Information Technology Advisory Committee (HITAC) (see attached).

House Bill 1422 from the 2011 legislative session required HITAC to work with stakeholders to establish an outline on how best to standardize drug prior authorization request transactions between providers and the payers, insurance companies, and pharmacy benefit managers responsible for adjudicating the authorization or denial of the prescription request. A group of stakeholders representing this group and a few legislators meet several times over the course of the biennium to outline a strategy of moving forward.

During the biennium, we learned that there were several electronic prior authorization pilots going on around the United States. Through the pilots, participants tested what worked, what did not and what standard was the best to get information quickly and efficiently between the providers and those responsible for claims adjudication. These pilots are now working with the National Council for Prescription Drug Programs (NCPDP) on the standard that may ultimately be approved to be used nationwide. It was the recommendation of our workgroup that we follow the working of these pilots and the standard setting process through NCPDP and adopt the nationwide standard rather than creating a set of standards only for North Dakota.

Based on the information that I have available to me, the NCPDP is going to meet in early February and the standard will be discussed at that time. The NCPDP website does not provide a timeline for approval of this standard; however, voting could start after that meeting, or there could be requests for additional information with voting of the standard delayed. We will continue to monitor the progress of this standard through NCPDP.

As a part of the workgroup, we all agreed that the timeline that was included in House Bill 1422 needed to be extended to allow more time for the standard to be developed, approved and implemented. The date was one year later than originally identified, August 1, 2014. However, due to the uncertainty that was identified, the bill now allows the HITAC to delay the effective date up to February 1, 2015 by publishing notice on our website by July 1, 2014.

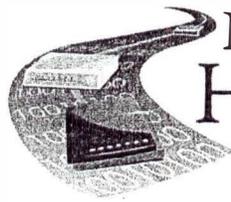
I anticipate that we will continue to have discussions during the next year with stakeholders, including payers and providers, and continue monitoring the progress of NCPDP regarding the standards and the ultimate effective date of this standard.

From a provider perspective, I do have a concern with the proposed timelines. The Office of National Coordinator determines what electronic health record systems have in place to be certified. The next version, what ONC is calling the 2014 Edition, to my knowledge does not have electronic prior authorization included in the certification standard. Since it is not included in the standard for 2014, electronic health record systems may not have this functionality available in their off the shelf system. Thus, for true system-to-system interfacing, providers may have to build this functionality into their systems if a date is established before this

is an ONC requirement. To compensate for this, I would suggest that the date on line 15-16 be changed to allow HITAC to identify the effective date to be one year after the ONC requires electronic prior authorizations in certified electronic health information systems.

The possible amendment could be (... no later than ~~February 1, 2015~~ one year after the Office of National Coordinator for Health Information Technology requires electronic drug prior authorizations in certified electronic health record systems, by publishing notice of the delay on the committee's website before July 1, of each year starting in 2014.)

Thank you for the opportunity to appear before you today, I would be happy to address any questions.



North Dakota Health Information Technology

Quality Healthcare for all North Dakotans - Anywhere, Anytime

MISSION

Advance the adoption and use of technology to exchange health information and improve healthcare quality, patient safety and overall efficiency of healthcare and public health services in North Dakota.

VISION

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Website: www.healthit.nd.gov

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#2

**Testimony
House Bill 1274
House Human Services Committee
Representative Robin Weisz, Chairman
January 30, 2013**

Chairman Weisz and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports changing the effective date of the electronic drug prior authorization and transmission system to August 1, 2014.

NDFFCMH continues to support the creation of electronic prescribing transmission standards. These standards will ensure that electronic prescribing in North Dakota will be a system that is safe for patients. This bill understands the importance of the relationship between the doctor and the patient in making decisions regarding medication.

In addition, NDFFCMH continues to support Electronic prior authorization process. This should speed up the prior authorization process. This process can be completed while the patient is still in the room with their physician. If changes need to be made as a result of the prior authorization process they can be discussed during the visit instead of through phone calls or at the pharmacy.

NDFFCMH understands that electronic prescribing can actually reduce errors and increase patient safety. Thank you for your time.

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ND Federation of Families for Children's Mental Health
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Bismarck, ND 58502

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Email: carlottamccleary@bis.midco.net

#13

2013 House Bill No. 1274
Testimony before the House Human Services Committee
Presented by: Harvey Hanel, Pharmacy Director
Workforce Safety & Insurance
January 30, 2013

Mr. Chairman, Members of the Committee:

My name is Harvey Hanel, Pharmacy Director at WSI.

WSI is supportive of the amendment to Section 23-01-38, but we are offering an amendment asking to be exempted from this legislation.

WSI does not currently, nor will it likely ever, have the capability of providing electronic medication prior authorization services of the kind contemplated in this statute. In order to do so it would require one of the following to occur to be able to comply with this legislation.

The first scenario would require the provider to send an electronic prior authorization request to US Script, our Pharmacy Benefit Management company, who, in turn would forward the electronic prior authorization request to WSI. Since over ninety-five percent of the agency's medication prior authorization determinations involve questions of liability for a specific medical condition, it would require WSI to make an immediate decision regarding the acceptance or denial of liability for that condition. The decision would be transmitted to US Script who, in turn, would forward the results of the electronic prior authorization to the provider.

The second scenario is very similar to the first but instead of the provider sending the prior authorization request to US Script, the request would instead be sent directly to WSI. Again, an immediate decision regarding the acceptance or denial of liability for the specific condition would need to be made by the claims adjustor and

the decision to accept or deny would be sent directly to the provider. In addition WSI would need to transmit a drug prior authorization notification to US Script.

In either scenario, real-time electronic communications for electronic prior authorization would need to be established between WSI and US Script and possibly the provider as well dependent upon which of the two would be most feasible.

It is because of this that WSI is asking to be made exempt from this legislation. Please allow me to explain why we feel this is necessary.

Unlike typical prescription coverage under a group health plan, the vast majority of our medication prior authorizations are related to whether or not WSI has liability for the medical condition for which that medication is being prescribed. For the group health plan the prior authorization is focused on cost savings and formulary management. I offer this example to help clarify this. Your physician prescribes Crestor to treat your high cholesterol. You take the prescription to the pharmacy and the pharmacy informs you that generic Lipitor is the preferred statin by your health insurer. Your physician then needs to determine whether you are able to take the generic Lipitor or, if there are reasons why your physician feels that you absolutely need to be on Crestor, he or she would submit the prior authorization request to your health plan with information supporting why you need Crestor. The health plan then makes a decision whether they will pay for the Crestor or not.

Let's change the example. You are an injured worker who sustained trauma and throughout the course of your treatment for the work injury it is discovered that you have high cholesterol. Your physician writes a prescription for Crestor. The pharmacy tries to fill the prescription and bill it to WSI and discovers that it requires a prior authorization. WSI needs to determine whether the high cholesterol is related to the work injury. The agency may need to obtain prior medical notes to see if you had an elevated cholesterol prior to the work injury. We may need to write to your treating physician to get an opinion as to whether your high cholesterol is a result of

the work injury or is it an incidental finding unrelated to the work injury. The agency may also need to request an additional medical opinion to validate the relationship of the work injury to the high cholesterol. It would be impossible for the agency to make an immediate determination of liability in this example.

In conclusion, WSI offers the attached amendment to HB 1274 which would exempt the agency from section 23-01-38.

Thank you for your consideration and I would be happy to answer any questions that the committee might have.

PROPOSED AMENDMENTS TO HB NO. 1274

Page 2, after line 8, insert:

"4. The requirements in this section do not apply to work force safety and insurance."

Renumber accordingly

HA

**Testimony
Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 30, 2013**

Chairman Weisz, members of the House Human Services Committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services. I am here to provide information regarding House Bill 1274 and the fiscal note submitted by the Department.

Given the effective dates in the bill, there will be a fiscal impact to the Department to comply with the requirements proposed in the bill. The dollar amounts are listed in the fiscal note for the following services:

- Vendor contract for electronic prior authorization processing.
- ITD services for Pharmacy Point-of-Sale (POS)/Medicaid Management Information System (MMIS) interface with vendor.
- Pharmacist FTE for design, implementation, and maintenance of e-prior authorization system and rules engine.

The fiscal estimates were determined based on the approach for implementation of rules-based prior authorization programs as are operated in many state Medicaid programs, including South Dakota and Minnesota. Also, we requested quotes for such services from vendors. All programming logic required for electronic prior authorization processing is the same as rules-based prior authorization programs. So it is a valid comparison given the fact that electronic prior authorization does not yet exist.

Within the bill language, there appears to be a conflict in paragraph 2. Lines 18-22 specifically do not allow advertising, commercial messaging, and popup advertisements. Lines 22-24 and lines 1-5 on page 2 place specific restrictions on these actions (advertising, commercial messaging, and popup advertisements) that are not allowed.

Finally, on page 2, paragraph 3, line 7, the statement “. . . or make more difficult . . .” is a concern, as the Department has been exploring participation in e-prescribing. Specifically, vendors have expressed large concern over that statement restricting the normal business practice for e-prescribing software as the statement is arbitrary. For instance, one vendor told the Department that if a drug is non-formulary for a payer, based on this language, they would not be able to provide a message to the prescriber as the extra click(s) to bypass the notification could be construed as “making it more difficult” to prescribe a particular pharmaceutical. The vendor suggested striking the words “or make more difficult” to allow them to continue to provide their normal e-prescribing solution for the payers.

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

#5

**TESTIMONY IN SUPPORT OF AMENDMENTS TO HB 1274
AND REPEAL OF § 23-01-38**

House Human Services Committee
Wednesday, January 30, 2013, 2:30 p.m.

Good Afternoon Chairman Weisz and Members of the House Human Services Committee.

My name is Patrick Ward. I am an attorney with Zuger Kirmis & Smith. I represent Express Scripts, a pharmacy benefits manager, in favor of amendments to HB 1274 and repeal of § 23-01-38, N.D. Cent. Code.

Express Scripts covers approximately 21,000 residents of North Dakota. In 2012, Express Scripts adjudicated approximately 1.1 million retail scripts in the state. We strongly support the development of electronic drug prior authorization such as would be permitted by HB 1274, however, we believe ¶ 2 of Section 1 of the bill and existing statute is bad law and should be repealed so that National Standards can be the norm for E-prescribing.

We urge you to amend this bill to repeal § 23-01-38 which was enacted last session. Doing so would eliminate all the objections, requests for amendments, and fiscal note you will hear about today.

This statute will not enable, but could hamper electronic prescribing. In fact, e-prescribing is available currently in all 50 states and the District of Columbia. According to a recent Office of the National Coordinator for Health Information Technology Data Brief, "twenty-three states had more than half of their physicians e-prescribing using electronic health records" and North Dakota was one of the five states that experienced the largest increases going from one

percent in 2008 to 67% in June of 2012, a 65% increase. The process is moving forward like we predicted last session and like you wanted it to.

Paragraph 2 of section 1 still in existing law is incongruent and illogical. This is designed to interfere with the operation of existing pharmacy networks like the one in your PERS plan, which use generic drugs, step therapy, and direct mail service and other speciality advice and formulary options to keep plan costs down. Providing your doctor with all available choices at the decision phase, by allowing multiple drug therapy options and important patient health information, leads to better care. I ask you, how would it benefit consumers or patients, if the doctor does not have the complete available patient and plan information from the health plan regarding its formulary and low cost alternatives, at the time of prescribing?

Plan formularies are carefully constructed based on consultation with independent clinical experts including physicians, nurses, pharmacists and academics. Drug management tools such as prior authorization and step therapy are put in place to insure appropriate clinical use of certain drugs that pose a safety risk, have a high potential for off label or experimental use, are very high in cost, or are prescribed at dosages exceeding the highest FDA approved dose. Offsetting this balance will fundamentally alter the nature of a benefit plan by essentially mandating coverage without regard to safety and cost factors. According to a study conducted by the Federal Trade Commission, "large PBMs and small or insurer owned PBMs have used step therapy and prior

authorization programs to lower prescription drug costs and increase formulary compliance.”

Simply put, this legislation is no longer necessary to encourage or enable electronic prescribing in North Dakota or anywhere else. In fact, piecemeal legislating in this area by states would more likely slow the process, resulting in a patchwork of different laws around the country inhibiting electronic prescribing.

As you know, a great deal of work has already been done on this at the federal level, using deliberative due process, and advice from many of the stake holders including the brand name drug manufacturers through the National Council for Prescription Drug Programs or NCPDP. NCPDP is devising an electronic prescribing system to work with Medicare and Medicaid, but which would also be applicable and useful in all 50 states and the District of Columbia. Modern electronic prescribing does not know state geographical borders. Pilot studies have been conducted and the NCPDP E-prescribing Workgroup will be taking their model to the full NCPDP meeting in February and it is anticipated it will be fully adopted in May of 2013. Upon adoption, it is expected to take 18 – 24 months for vendors and payors to develop.

We urge you to amend this bill to simply repeal § 23-01-38, or at a minimum, push this effective date back to August 1, 2015, so we can revisit this next session.

I will try to answer any questions.

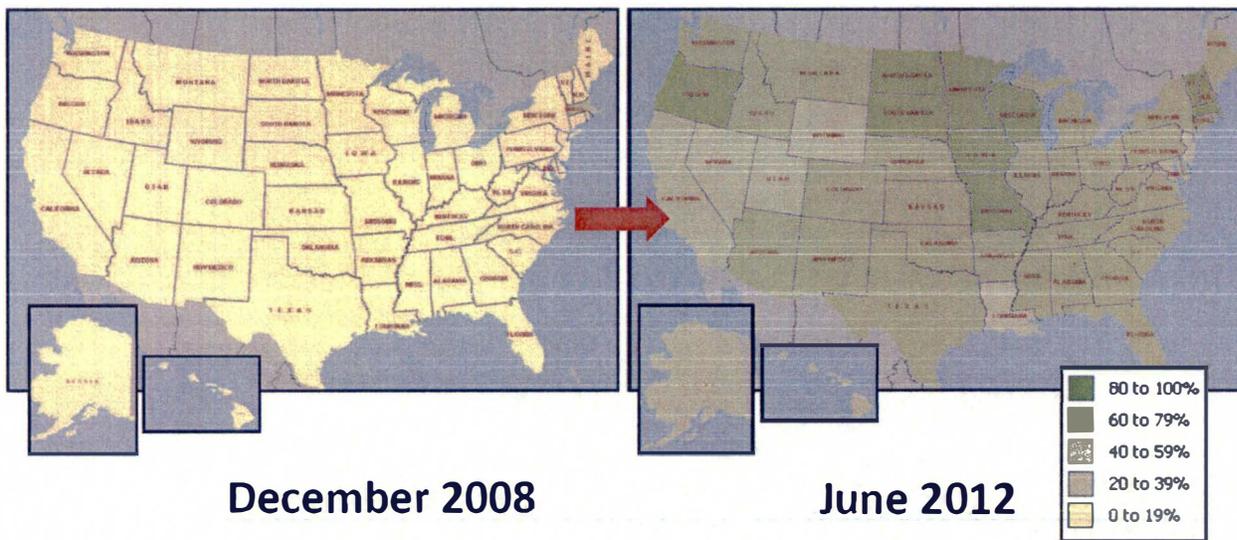
State Variation in E-Prescribing Trends in the United States

Meghan Hufstader, PhD; Matthew Swain, BBA; and Michael F. Furukawa, PhD

In 2000, the Institute of Medicine (IOM) published a report entitled “To Err is Human: Building a Safer Health Care System,” which described preventable medication errors associated with paper prescribing practices and called for the use of health information technology such as transmitting prescriptions electronically (e-prescribing) to improve patient safety.^{1,2} Recognizing the importance of e-prescribing in improving patient care, the Centers for Medicare & Medicaid Services requires certain eligible health care providers to electronically prescribe as part of meaningful use of certified electronic health record (EHR) technology for which they may qualify for incentive payments.³ This brief describes changes in e-prescribing at the national and state level between December 2008 and June 2012. We examined changes in rates of physician e-prescribing, pharmacy capability to accept e-prescriptions and the volume of e-prescriptions.

The percent of physicians e-prescribing using an EHR has increased in all 50 states and in the District of Columbia.

Figure 1. Percent of physicians e-prescribing using an EHR in December 2008 and June 2012

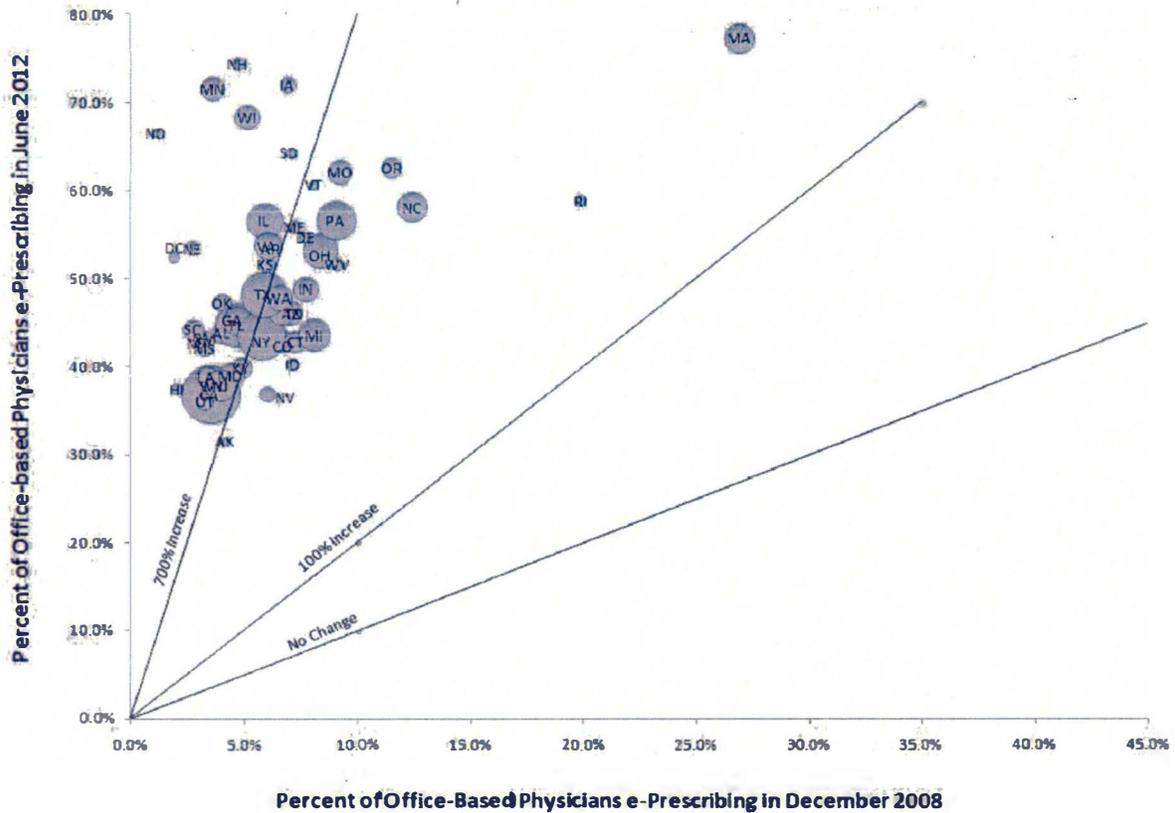


SOURCE: ONC analysis of physician prescriber data from Surescripts. Denominator from SK&A 2011 full-year file.

- ★ In December 2008, 7% of physicians in the U.S. were e-prescribing using an EHR; by June 2012, almost half (48%) of physicians were e-prescribing using an EHR on the Surescripts network (Figure 1).
- ★ As of June 2012, twenty-three states had more than half of their physicians e-prescribing using an EHR on the Surescripts Network.

All States showed double-digit increases in the proportion of physicians e-prescribing using an EHR between December 2008 and June 2012.

Figure 2. Percent of physicians e-prescribing using an EHR in December 2008 and June 2012, by state.



Bubble size represents the number of physicians within a state compared to other states
 SOURCE: ONC analysis of annual prescription data from Surescripts Data

- ★ States that had the highest growth in percent of physicians e-prescribing using an EHR include New Hampshire, North Dakota, Wisconsin, Iowa, and Minnesota from December 2008-June 2012. (Figure 2).
- ★ The range in growth in physicians’ e-prescribing at the state-level was between 28 to 70%.
- ★ States that had low rates of physicians’ e-prescribing as of December 2008, such as North Dakota (1%), Hawaii (2%), District of Columbia (2%), Utah (3%), and Louisiana (3%) all increased by at least 30 percentage points.

As of June 2012, almost half of physicians nationwide e-prescribe through an EHR, representing a 41% increase since December, 2008

Table 1: Growth in the percent of physicians e-prescribing through an EHR; December 2008 and June 2012

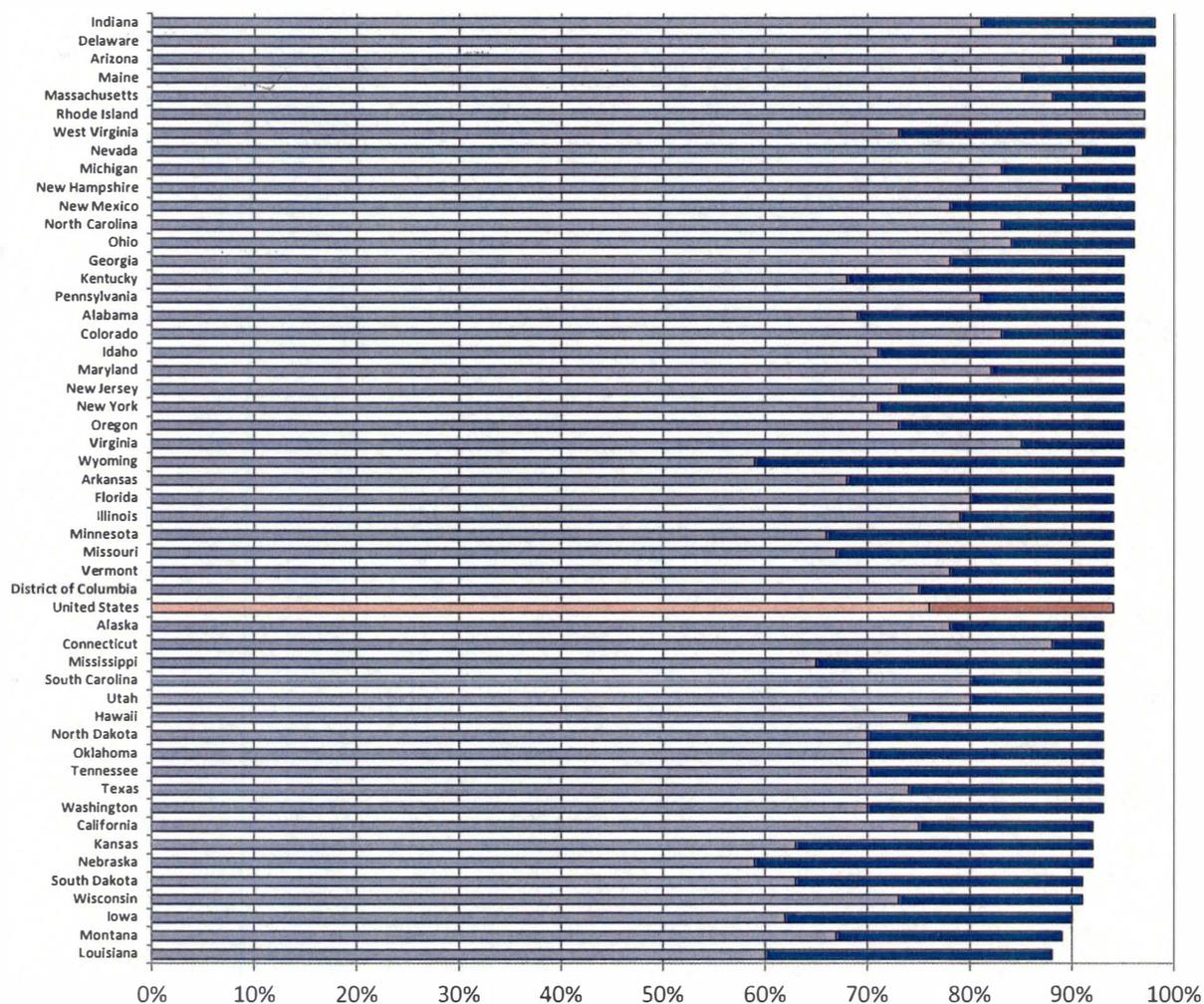
State	Dec 2008	June 2012	Percentage Point Increase	State	Dec 2008	June 2012	Percentage Point Increase
United States	7%	48%	41	Missouri	9%	62%	53
Alabama	4%	44%	40	Montana	3%	43%	40
Alaska	4%	32%	28	Nebraska	3%	53%	51
Arizona	7%	46%	39	Nevada	6%	37%	31
Arkansas	6%	54%	48	New Hampshire	5%	74%	70
California	4%	37%	33	New Jersey	4%	38%	34
Colorado	7%	43%	36	New Mexico	3%	43%	40
Connecticut	7%	43%	36	New York	6%	44%	38
Delaware	8%	55%	47	North Carolina	12%	58%	46
District of Columbia	2%	52%	50	North Dakota	1%	67%	65
Florida	5%	45%	40	Ohio	8%	53%	45
Georgia	5%	45%	40	Oklahoma	4%	47%	43
Hawaii	2%	38%	36	Oregon	11%	63%	51
Idaho	7%	41%	34	Pennsylvania	9%	57%	48
Illinois	6%	57%	51	Rhode Island	20%	59%	39
Indiana	8%	49%	41	South Carolina	3%	44%	41
Iowa	7%	73%	66	South Dakota	7%	64%	57
Kansas	6%	52%	46	Tennessee	7%	46%	40
Kentucky	5%	40%	35	Texas	6%	48%	42
Louisiana	3%	39%	36	Utah	3%	36%	33
Maine	7%	56%	49	Vermont	8%	61%	53
Maryland	4%	39%	35	Virginia	6%	54%	48
Massachusetts	27%	77%	50	Washington	7%	48%	41
Michigan	8%	44%	36	West Virginia	9%	52%	43
Minnesota	4%	72%	68	Wisconsin	5%	68%	63
Mississippi	3%	42%	39	Wyoming	4%	38%	34

SOURCE: ONC analysis of annual prescription data from Surescripts Data

- ★ In June 2012, states rates of physicians e-prescribing through an EHR ranged from 32% to 77% (Table 1).
- ★ Massachusetts (77%), New Hampshire (74%), and Iowa (73%) had the highest rate of physicians e-prescribing through an EHR.
- ★ From December 2008 to June 2012, nineteen states increased the percent of physicians e-prescribing through an EHR by 50% or more.

In 2012, the vast majority of community pharmacies across the country are enabled to accept e-prescriptions.

Figure 3: Growth in the percent of pharmacies enabled to e-prescribe; December 2008 to June 2012, by state.

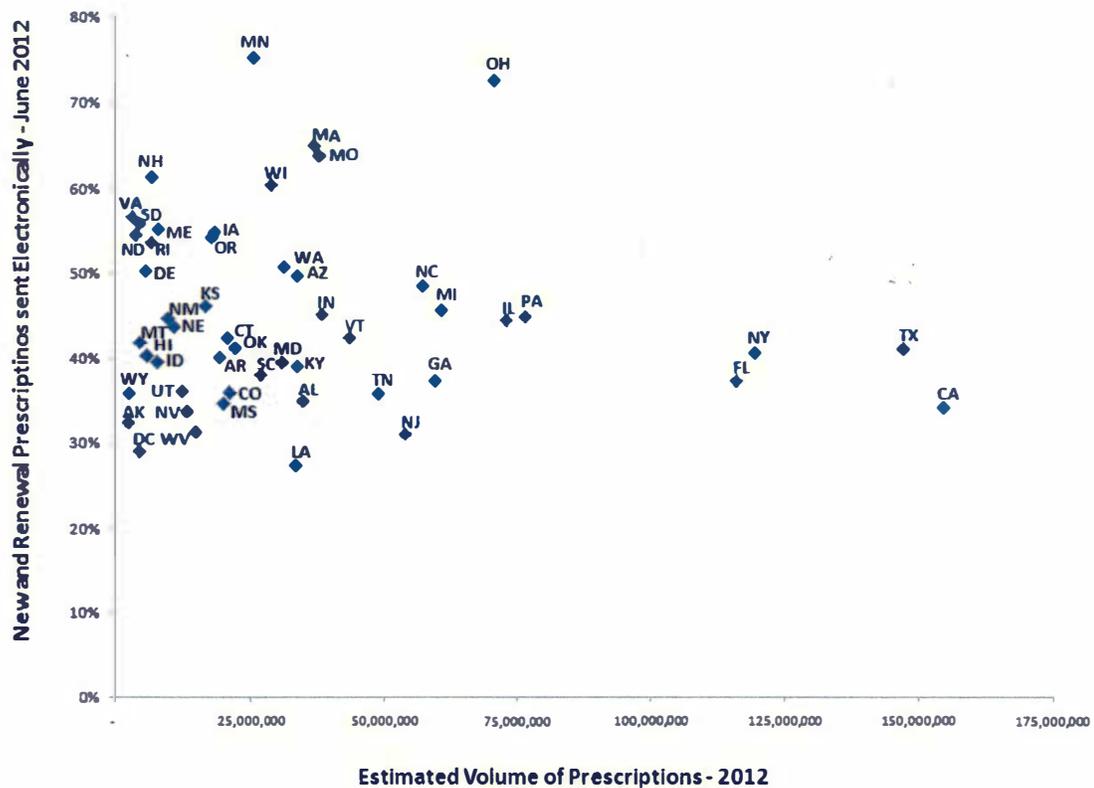


SOURCE: ONC analysis of pharmacy data from Surescripts

- ★ From December 2008 through June 2012, community pharmacies enabled to accept e-prescriptions increased from 76% to 94% (Figure 3).
- ★ Wyoming experienced the largest increase in community pharmacies enabled to accept e-prescriptions (36%); conversely, Rhode Island remained stable with 97% of pharmacies enabled to accept e-prescriptions.
- ★ As of June 2012, all states have a rate of at least 88%.

In 2012, approximately 45% of new and renewal prescriptions were sent electronically.

Figure 4: Percent of new and renewal prescriptions sent electronically in 2012, by state.



SOURCE: ONC analysis of annual prescription data from Surescripts, June 2012
Forecasting for 2012 based upon Surescripts data from the first half of 2012 (383 million new and renewal prescriptions sent electronically)

- ★ In 2012, all states have at least 20% transmitted electronically (**Figure 4**).
- ★ Sixteen states send over half of their new and renewal prescriptions electronically.
- ★ The four states with the highest volume of prescriptions are below the national average for new and renewal prescriptions sent electronically.

The volume of new and renewal prescriptions sent electronically has increased ten-fold.

Table 2: Volume of New and Renewal Prescriptions Sent Electronically in 2008 and 2012, by state.

State	New and Renewals 2008	New and Renewals 2012	Percentage Point Increase	State	New and Renewals 2008	New and Renewals 2012	Percentage Point Increase
United States	4%	45%	41	Missouri	4%	65%	61
Alabama	2%	35%	33	Montana	1%	42%	41
Alaska	2%	33%	31	Nebraska	2%	44%	42
Arizona	6%	50%	44	Nevada	9%	34%	25
Arkansas	2%	40%	39	New Hampshire	3%	61%	58
California	3%	34%	31	New Jersey	5%	31%	27
Colorado	4%	36%	32	New Mexico	2%	45%	43
Connecticut	6%	42%	36	New York	3%	41%	37
Delaware	7%	50%	43	North Carolina	6%	49%	42
District of Columbia	3%	29%	27	North Dakota	0%	55%	54
Florida	4%	37%	33	Ohio	4%	73%	68
Georgia	2%	37%	35	Oklahoma	2%	41%	39
Hawaii	1%	40%	39	Oregon	4%	54%	50
Idaho	4%	40%	35	Pennsylvania	6%	45%	39
Illinois	4%	44%	41	Rhode Island	17%	54%	36
Indiana	3%	45%	42	South Carolina	1%	38%	37
Iowa	2%	55%	53	South Dakota	1%	56%	55
Kansas	3%	46%	43	Tennessee	4%	36%	32
Kentucky	3%	39%	36	Texas	3%	41%	38
Louisiana	3%	27%	25	Utah	1%	36%	35
Maine	6%	55%	49	Vermont	4%	57%	52
Maryland	5%	40%	34	Virginia	3%	42%	39
Massachusetts	20%	64%	44	Washington	4%	51%	47
Michigan	8%	46%	37	West Virginia	3%	31%	28
Minnesota	4%	75%	72	Wisconsin	2%	60%	58
Mississippi	1%	35%	34	Wyoming	2%	36%	34

SOURCE: ONC analysis of annual prescription data from Surescripts Data Forecasting for 2012 based upon Surescripts data from the first half of 2012 (383 million new and renewal prescriptions sent electronically)

- ★ In 2012, states rate of new and renewal prescriptions sent electronically range from 27% to 75% (Table 2).
- ★ Minnesota (75%), Ohio (73%), and Missouri (65%) have the highest rate of new and renewal prescriptions sent electronically.
- ★ It is estimated that 45% of new and renewal prescriptions will be sent electronically in 2012.

Summary

The percent of physicians e-prescribing using an EHR increased from 7% in December 2008 to almost half of physicians (48%) in June 2012. Increases occurred in all fifty states and the District of Columbia. Twenty-three states had more than half of their physicians e-prescribing using an EHR, with New Hampshire, Minnesota, Iowa, North Dakota, and Wisconsin experiencing the largest increases since December 2008.

The growth in e-prescribing has not been limited to physicians. In the same period, the percent of community pharmacies enabled to accept e-prescriptions grew from 76% to 94%. Wyoming, Nebraska, and Kansas had the largest increases in community pharmacies enabled to accept e-prescriptions. The vast majority of pharmacies are enabled to accept e-prescriptions in Rhode Island (97%), Delaware (98%), and Nevada (96%). These three states also had the highest percentages in December 2008, and therefore showed the smallest increases in pharmacies enabled to accept e-prescriptions.

The growth of physicians and pharmacies e-prescribing has corresponded with a ten-fold increase in the growth of new and renewal prescriptions sent electronically. In 2008, only 4% of new and renewal prescriptions were sent electronically. Our forecasting using data through June 2012 predicts that 45% of new and renewals prescriptions will be sent electronically in 2012. Minnesota (75%), Ohio (73%), and Missouri (65%) have the highest rate of new and renewals sent electronically. However, the four states with highest volume of prescriptions: California, Texas, New York, and Florida, are all below the national average. This challenge presents an opportunity to increase the proportion of new and renewals sent electronically among these states.

Data Source and Methods

This study examined trends in e-prescribing using data from Surescripts, a leading e-prescribing network. Surescripts is an e-prescription network utilized by approximately 95% of all community pharmacies in the U.S. routing prescriptions, excluding closed systems such as Kaiser Permanente.⁴ All 50 states and the District of Columbia were included in the analysis. This analysis included chain, franchise, and independently owned pharmacies. Medical device manufacturers, nuclear, government/military, and infusion pharmacies are excluded using pharmacy type variables provided by National Council for Prescription Drug Programs.

Data for annual percentages of new and renewal prescriptions routed through the Surescripts network data exclude controlled substances, which are not yet permitted on the Surescripts network.

Physician denominators was developed with SK&A, a propriety data set using a combination of the title and specialty variables.⁵ The counts were de-duplicated to correct for individual providers who are observed at multiple sites.

Definitions

E-Prescribing: the electronic transmittal of a prescription to a pharmacy from the prescriber.

Enabled pharmacy: Pharmacy that has connected with the Surescripts network and is capable of receiving e-prescribing transactions.

Community pharmacy: A chain, franchise, or independently owned pharmacy. Medical device manufacturers, nuclear, government/ military, and infusion pharmacies are excluded.

New prescription: New prescriptions electronically routed from prescribers to pharmacies (including mail order).

Renewal prescription: Renewal responses electronically routed between prescribers and pharmacies (including mail-order).

Electronic health record: A collection of electronic health information that is capable of being shared across different health care settings. Electronic health records may include patient demographics, medical history, medications, allergies, immunization status, laboratory test results, radiology images, and vital signs.

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3. Blumenthal D, Tavenner M. *The "Meaningful Use" Regulation for Electronic Health Records*. 2010, NEJM, pp. 501-504.
4. Surescripts. <http://www.surescripts.com>
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About the Authors

The authors are with the Office of the National Coordinator for Health Information Technology, Office of Economic Analysis, Evaluation and Modeling.

Acknowledgements

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Suggested Citation

Hufstader M, Swain M, Furukawa MF. State Variation in E-Prescribing Trends in the United States. *ONC Data Brief, no. 4*. Washington, DC: Office of the National Coordinator for Health Information Technology, November 2012.

**23-01-38. Electronic drug prior authorization and transmission
— Limitations.**

1. Effective August 1, 2013, a drug prior authorization request must be accessible to a health care provider with the provider's electronic prescribing software system and must be accepted electronically, through a secure electronic transmission, by the payer, by the insurance company, or by the pharmacy benefit manager responsible for implementing or adjudicating or for implementing and adjudicating the authorization or denial of the prior authorization request. For purposes of this section, a facsimile is not an electronic transmission.
2. Effective August 1, 2013, electronic transmission devices used to communicate a prescription to a pharmacist may not use any means or permit any other person to use any means, including advertising, commercial messaging, and popup advertisements, to influence or attempt to influence through economic incentives the prescribing decision of a prescribing practitioner at the point of care. Such means may not be triggered by or be in specific response to the input, selection, or act of a prescribing practitioner or the prescribing practitioner's staff in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy. Any electronic communication sent to the prescriber, including advertising, commercial messaging, or popup advertisements must be consistent with the product label, supported by scientific evidence, and meet the federal food and drug administration requirements for advertising pharmaceutical products.
3. Electronic prescribing software may show information regarding a

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HEALTH AND SAFETY

payer's formulary if the software is not designed to preclude or make more difficult the act of a prescribing practitioner or patient selecting any particular pharmacy or pharmaceutical.

Source: S.L. 2011, ch. 183, § 1.

Effective Date.

This section became effective August 1, 2011.

Testimony

House Bill 1274

House Human Services Committee

Wed., January 30, 2013

Ken Tupa, American Cancer Society Cancer Action Network (ACS CAN)

*Turned
in
after
the minutes
were typed*

Chairman Weisz and members of the House Human Services Committee: I am Ken Tupa and I appear before the committee today to provide comment on HB 1274 on behalf of the American Cancer Society Cancer Action Network. ACS CAN supports HB 1274 and asks your favorable consideration for a Do Pass recommendation.

ACS CAN supports the ability of doctors to make the best medical decision in consultation with their patients. Prior authorization creates an additional administrative barrier, can discourage physicians from prescribing prior authorization drugs, even if they are the most appropriate option for the patient, and can deter beneficiaries from seeking the recommended care. Prior authorization in some cases can take several hours to several days. For cancer patients undergoing chemotherapy, such delays could be detrimental to their treatment success and quality of life.

Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. We do support HB 1274 as it establishes this process electronically within the electronic prescribing systems and will reduce the administrative burden on physicians and provide real-time or near real-time decisions that can increase access to treatment and medication for patients.

In closing, the ACS CAN strongly supports the right of cancer patients and their doctors to decide what is best based on the patient's medical and emotional needs and we again ask for your favorable consideration on HB 1274.

Thank you for the opportunity to speak with you today.

(1)

Testimony

House Bill 1274

Senate IBL Committee

Tues., March 12, 2013

Ken Tupa, American Cancer Society Cancer Action Network (ACS CAN)

Chairman Klein and members of the Senate Industry, Business and Labor Committee: I am Ken Tupa and I appear before the committee today to provide comment on HB 1274 on behalf of the American Cancer Society Cancer Action Network. ACS CAN supports HB 1274 and asks your favorable consideration for a Do Pass recommendation.

ACS CAN supports the ability of doctors to make the best medical decision in consultation with their patients. Prior authorization creates an additional administrative barrier, can discourage physicians from prescribing prior authorization drugs, even if they are the most appropriate option for the patient, and can deter beneficiaries from seeking the recommended care. Prior authorization in some cases can take several hours to several days. For cancer patients undergoing chemotherapy, such delays could be detrimental to their treatment success and quality of life.

Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. We do support HB 1274 as it establishes this process electronically within the electronic prescribing systems and will reduce the administrative burden on physicians and provide real-time or near real-time decisions that can increase access to treatment and medication for patients.

In closing, the ACS CAN strongly supports the right of cancer patients and their doctors to decide what is best based on the patient's medical and emotional needs and we again ask for your favorable consideration on HB 1274.

Thank you for the opportunity to speak with you today.

**Testimony
House Bill 1274
Senate Industry, Business and Labor Committee
Senator Jerry Klein, Chairman
March 12, 2013**

Chairman Klein and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH supports changing the effective date of the electronic drug prior authorization and transmission system, Section 1 to be effective August 1, 2015 and Section 2 to be effective August 1, 2013.

NDFFCMH continues to support the creation of electronic prescribing transmission standards. These standards will ensure that electronic prescribing in North Dakota will be a system that is safe for patients. This bill understands the importance of the relationship between the doctor and the patient in making decisions regarding medication.

In addition, NDFFCMH continues to support Electronic prior authorization process. This should speed up the prior authorization process. This process can be completed while the patient is still in the room with their physician. If changes need to be made as a result of the prior authorization process they can be discussed during the visit instead of through phone calls or at the pharmacy.

NDFFCMH understands that electronic prescribing can actually reduce errors and increase patient safety. Thank you for your time.

Carlotta McCleary, Executive Director
ND Federation of Families for Children's Mental Health
PO Box 3061
Bismarck, ND 58502

Phone/fax: (701) 222-3310
Email: carlottamccleary@bis.midco.net

Testimony
Engrossed House Bill 1274 – Department of Human Services
Senate Industry, Business, and Labor Committee
Senator Jerry Klein, Chairman
March 12, 2013

Chairman Klein, members of the Senate Industry, Business, and Labor Committee, I am Dr. Brendan Joyce, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services. I am here to provide information regarding Engrossed House Bill 1274 and the fiscal note submitted by the Department.

Given the effective date in the bill, there will be a fiscal impact to the Department, beginning in the 2013-2015 biennium, to comply with the requirements proposed in the bill. The fiscal note estimates expenditures for the following services:

- Vendor contract for electronic prior authorization processing.
- ITD services for Pharmacy Point-of-Sale (POS)/Medicaid Management Information System (MMIS) interface with vendor.
- Pharmacist FTE for design, implementation, and maintenance of e-prior authorization system and rules engine.

The fiscal estimates were determined based on the approach for implementation of rules-based prior authorization programs as operated in other state Medicaid programs, including South Dakota and Minnesota, as well as from quotes for services from vendors. All programming logic required for electronic prior authorization processing is the same as rules-based prior authorization programs, so it is a valid comparison in spite of the fact that electronic prior authorization does not yet exist.

Within the existing statutory language, there appears to be a conflict in subsection 2. On page 1, lines 18-22, the language specifically does not allow advertising, commercial messaging, and popup advertisements. This seems to conflict with the rest of the subsection found on page 1, lines 22-24 and lines 1-5 on page 2 which contains language that places specific restrictions on advertising, commercial messaging, and popup advertisements which are not allowed by the first sentence of that subsection.

Finally, on page 2, paragraph 3, line 7, the statement “. . . or make more difficult . . .” is a concern, as the Department has been exploring participation in e-prescribing. Specifically, vendors have expressed concern over the statement, which restricts normal business practice for e-prescribing software. The concern arises because “make more difficult” can be very subjective. For instance, one vendor told the Department that if a drug is non-formulary for a payer, based on this language, they would not be able to provide a message to the prescriber as the extra click(s) to bypass the notification could be construed as “making it more difficult” to prescribe a particular pharmaceutical. The Department suggests removing the language, which will hopefully allow e-prescribing vendors to use their standard solution, without having to customize it for North Dakota payers and providers.

The Department would be happy to suggest amendment language to the committee for the two items noted above.

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

2013 House Bill No. 1274
Testimony before the Senate Industry, Business and Labor Committee
Presented by: Harvey Hanel, Pharmacy Director
Workforce Safety & Insurance
March 12, 2013

Mr. Chairman, Members of the Committee:

My name is Harvey Hanel, Pharmacy Director at WSI.

WSI is supportive of the provision within the engrossed bill that exempts WSI from this legislation.

WSI does not currently, nor will it likely ever, have the capability of providing electronic medication prior authorization services of the kind contemplated in this statute. In order to do so it would require one of the following to occur to be able to comply with this legislation.

The first scenario would require the provider to send an electronic prior authorization request to US Script, our Pharmacy Benefit Management company, who, in turn would forward the electronic prior authorization request to WSI. Since over ninety-five percent of the agency's medication prior authorization determinations involve questions of liability for a specific medical condition, it would require WSI to make an immediate decision regarding the acceptance or denial of liability for that condition. The decision would be transmitted to US Script who, in turn, would forward the results of the electronic prior authorization to the provider.

The second scenario is very similar to the first but instead of the provider sending the prior authorization request to US Script, the request would instead be sent directly to WSI. Again, an immediate decision regarding the acceptance or denial of liability for the specific condition would need to be made by the claims adjustor and

the decision to accept or deny would be sent directly to the provider. In addition WSI would need to transmit a drug prior authorization notification to US Script.

In either scenario, real-time electronic communications for electronic prior authorization would need to be established between WSI and US Script and possibly the provider as well dependent upon which of the two would be most feasible.

It is because of this that WSI is asking to be made exempt from this legislation. Please allow me to explain why we feel this is necessary.

Unlike typical prescription coverage under a group health plan, the vast majority of our medication prior authorizations are related to whether or not WSI has liability for the medical condition for which that medication is being prescribed. For the group health plan the prior authorization is focused on cost savings and formulary management. I offer this example to help clarify this. Your physician prescribes Crestor to treat your high cholesterol. You take the prescription to the pharmacy and the pharmacy informs you that generic Lipitor is the preferred statin by your health insurer. Your physician then needs to determine whether you are able to take the generic Lipitor or, if there are reasons why your physician feels that you absolutely need to be on Crestor, he or she would submit the prior authorization request to your health plan with information supporting why you need Crestor. The health plan then makes a decision whether they will pay for the Crestor or not.

Let's change the example. You are an injured worker who sustained trauma and throughout the course of your treatment for the work injury it is discovered that you have high cholesterol. Your physician writes a prescription for Crestor. The pharmacy tries to fill the prescription and bill it to WSI and discovers that it requires a prior authorization. WSI needs to determine whether the high cholesterol is related to the work injury. The agency may need to obtain prior medical notes to see if you had an elevated cholesterol prior to the work injury. We may need to write to your treating physician to get an opinion as to whether your high cholesterol is a result of

the work injury or is it an incidental finding unrelated to the work injury. The agency may also need to request an additional medical opinion to validate the relationship of the work injury to the high cholesterol. It would be impossible for the agency to make an immediate determination of liability in this example.

In conclusion we support the provision within the engrossed bill which exempts WSI from this legislation.

Thank you for your consideration and I would be happy to answer any questions that the committee might have.

(5)

REGARD

TESTIMONY IN OPPOSITION TO ENGROSSED HB 1274
Senate IBL Committee
Tuesday, March 12, 2013, 2:30 p.m.

Good Afternoon Chairman Klein and Members of the Senate IBL committee

My name is Patrick Ward. I am an attorney with Zuger Kirmis & Smith. I represent Express Scripts, a pharmacy benefits manager, in opposition to HB 1274 ^{as written} Express Scripts covers approximately 21,000 residents of North Dakota. In 2012, Express Scripts adjudicated approximately 1.1 million retail scripts in the state. We strongly support the development of electronic drug prior authorization such as would be permitted by HB 1274, however, we believe the bill is unnecessary and National Standards should be the norm.

I urge you to either amend this bill to postpone all 3 paragraphs until 2015 or to simply repeal Section 23-01-08 that was enacted last session.

This bill will not enable, but could hamper electronic prescribing. In fact, e-prescribing is available currently in all 50 states and the District of Columbia. According to a recent Office of the National Coordinator for Health Information Technology Data Brief, "twenty-three states had more than half of their physicians e-prescribing using electronic health records" and North Dakota was one of the five states that experienced the largest increases going from one percent in 2008 to 65% in June of 2012.

Paragraph 2 of section 1 which will become law in August if not amended by this committee is incongruent and illogical. This paragraph is designed to interfere with the operation of existing pharmacy networks like the one in your PERS plan, which use generic drugs, step therapy, and direct mail service and other speciality advice and formulary options to keep plan costs down. Providing your doctor with all available choices at the decision phase, by allowing multiple drug therapy options and important patient health information, leads to better care. The doctor should have the complete available patient and plan information from the health plan regarding its formulary and low cost alternatives, at the time of e prescribing?

Plan formularies are carefully constructed based on consultation with independent clinical experts including physicians, nurses, pharmacists and academics. Drug management tools such as prior authorization and step therapy are put in place to insure appropriate clinical use of certain drugs that pose a safety risk, have a high potential for off label or experimental use, are very high in cost, or are prescribed at dosages exceeding the highest FDA approved dose. Offsetting this balance will fundamentally alter the nature of a benefit plan by essentially mandating coverage without regard to safety and cost factors. According to a study conducted by the Federal Trade Commission, "large PBMs and small or insurer owned PBMs have used step therapy and prior authorization programs to lower prescription drug costs and increase formulary compliance."

This legislation is not necessary to enable electronic prescribing in North Dakota or anywhere else. In fact, piecemeal legislation in this area by states will more likely slow the process, resulting in a patchwork of different laws around the country inhibiting electronic prescribing.

A great deal of work has already been done on this, at the federal level, using deliberative due process, and advice from many of the stake holders including the brand name drug manufacturers through the National Council for Prescription Drug Programs or NCPDP. NCPDP is devising an electronic prescribing system to work with Medicare and Medicaid, but which would also be applicable and useful in all 50 states and the District of Columbia. Modern electronic prescribing does not know state geographical borders. Pilot studies have been conducted and the NCPDP E-prescribing Workgroup will be taking their model to the full NCPDP. Upon adoption, it is expected to take 18 – 24 months for vendors and payors to develop .

I urge you to further amend this bill to postpone any of it going into effect for 2 more years or better yet to repeal Section 23-01-08 and revisit this issue in two years when national standards have advanced.

I will try to answer your questions.

ONC Data Brief ■ No. 4 ■ November 2012

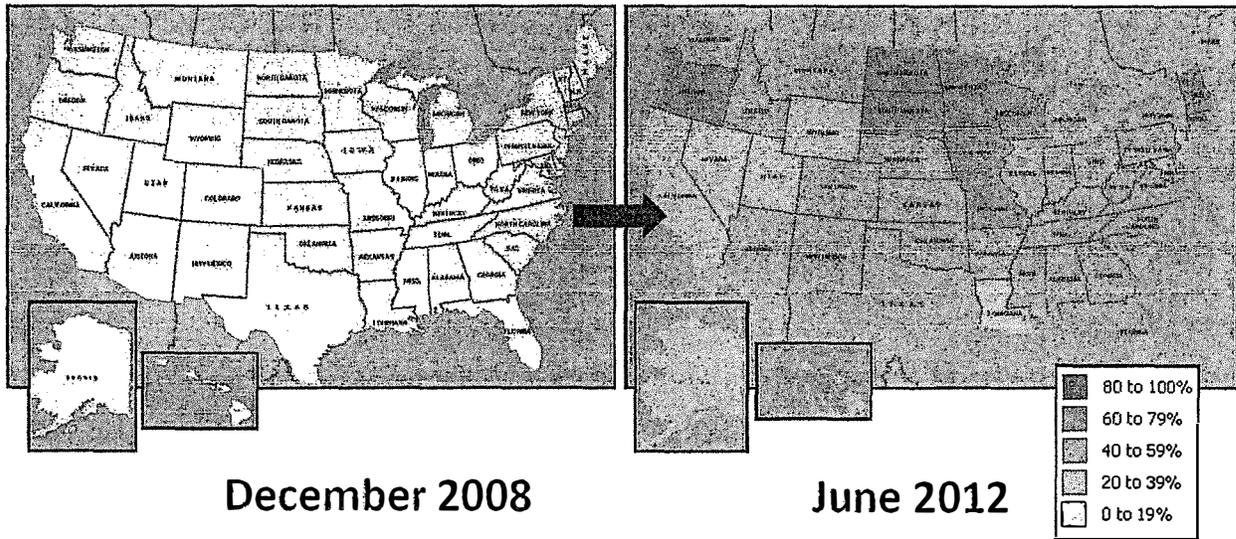
State Variation in E-Prescribing Trends in the United States

Meghan Hufstader, PhD; Matthew Swain, BBA; and Michael F. Furukawa, PhD

In 2000, the Institute of Medicine (IOM) published a report entitled "To Err is Human: Building a Safer Health Care System," which described preventable medication errors associated with paper prescribing practices and called for the use of health information technology such as transmitting prescriptions electronically (e-prescribing) to improve patient safety.^{1,2} Recognizing the importance of e-prescribing in improving patient care, the Centers for Medicare & Medicaid Services requires certain eligible health care providers to electronically prescribe as part of meaningful use of certified electronic health record (EHR) technology for which they may qualify for incentive payments.³ This brief describes changes in e-prescribing at the national and state level between December 2008 and June 2012. We examined changes in rates of physician e-prescribing, pharmacy capability to accept e-prescriptions and the volume of e-prescriptions.

The percent of physicians e-prescribing using an EHR has increased in all 50 states and in the District of Columbia.

Figure 1. Percent of physicians e-prescribing using an EHR in December 2008 and June 2012

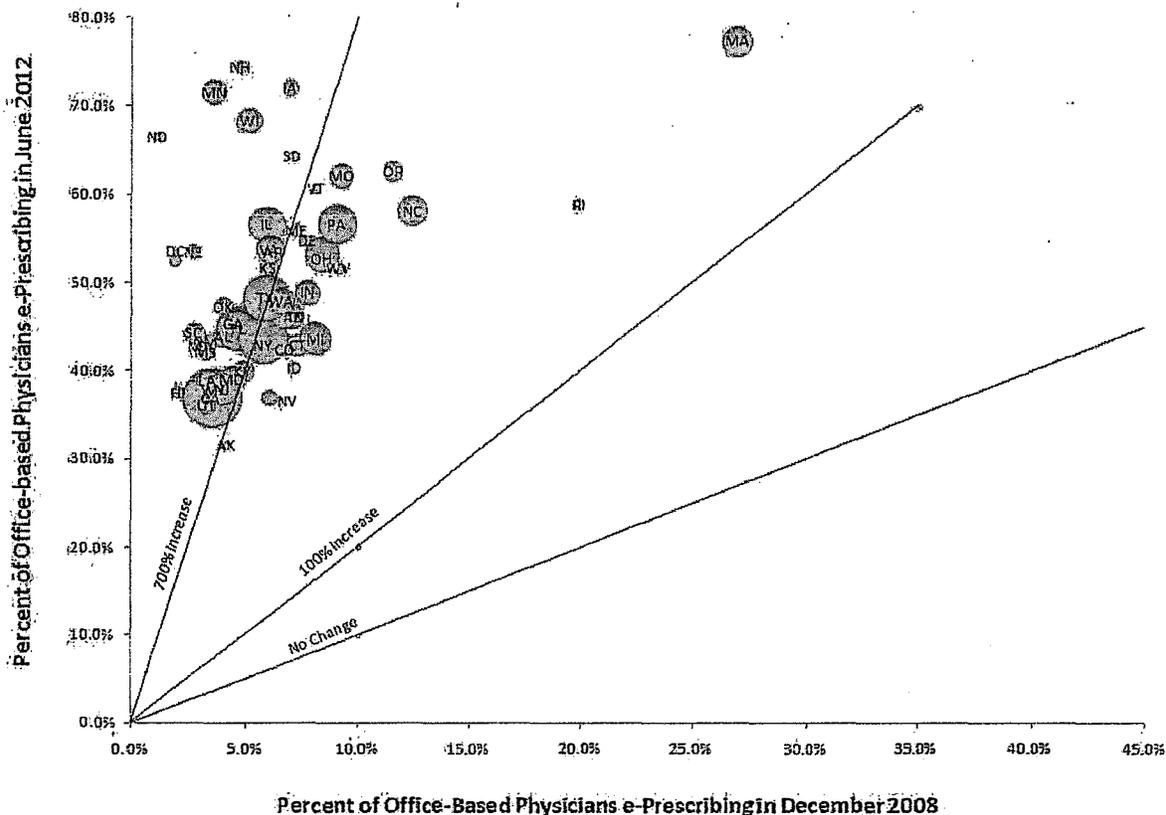


SOURCE: ONC analysis of physician prescriber data from Surescripts. Denominator from SK&A 2011 full-year file.

- ★ In December 2008, 7% of physicians in the U.S. were e-prescribing using an EHR; by June 2012, almost half (48%) of physicians were e-prescribing using an EHR on the Surescripts network (Figure 1).
- ★ As of June 2012, twenty-three states had more than half of their physicians e-prescribing using an EHR on the Surescripts Network.

All States showed double-digit increases in the proportion of physicians e-prescribing using an EHR between December 2008 and June 2012.

Figure 2. Percent of physicians e-prescribing using an EHR in December 2008 and June 2012, by state.



Bubble size represents the number of physicians within a state compared to other states
 SOURCE: ONC analysis of annual prescription data from Surescripts Data

- ★ States that had the highest growth in percent of physicians e-prescribing using an EHR include New Hampshire, North Dakota, Wisconsin, Iowa, and Minnesota from December 2008-June 2012: (Figure 2).
- ★ The range in growth in physicians' e-prescribing at the state-level was between 28 to 70%.
- ★ States that had low rates of physicians' e-prescribing as of December 2008, such as North Dakota (1%), Hawaii (2%), District of Columbia (2%), Utah (3%), and Louisiana (3%) all increased by at least 30 percentage points.

As of June 2012, almost half of physicians nationwide e-prescribe through an EHR, representing a 41% increase since December, 2008

Table 1: Growth in the percent of physicians e-prescribing through an EHR; December 2008 and June 2012

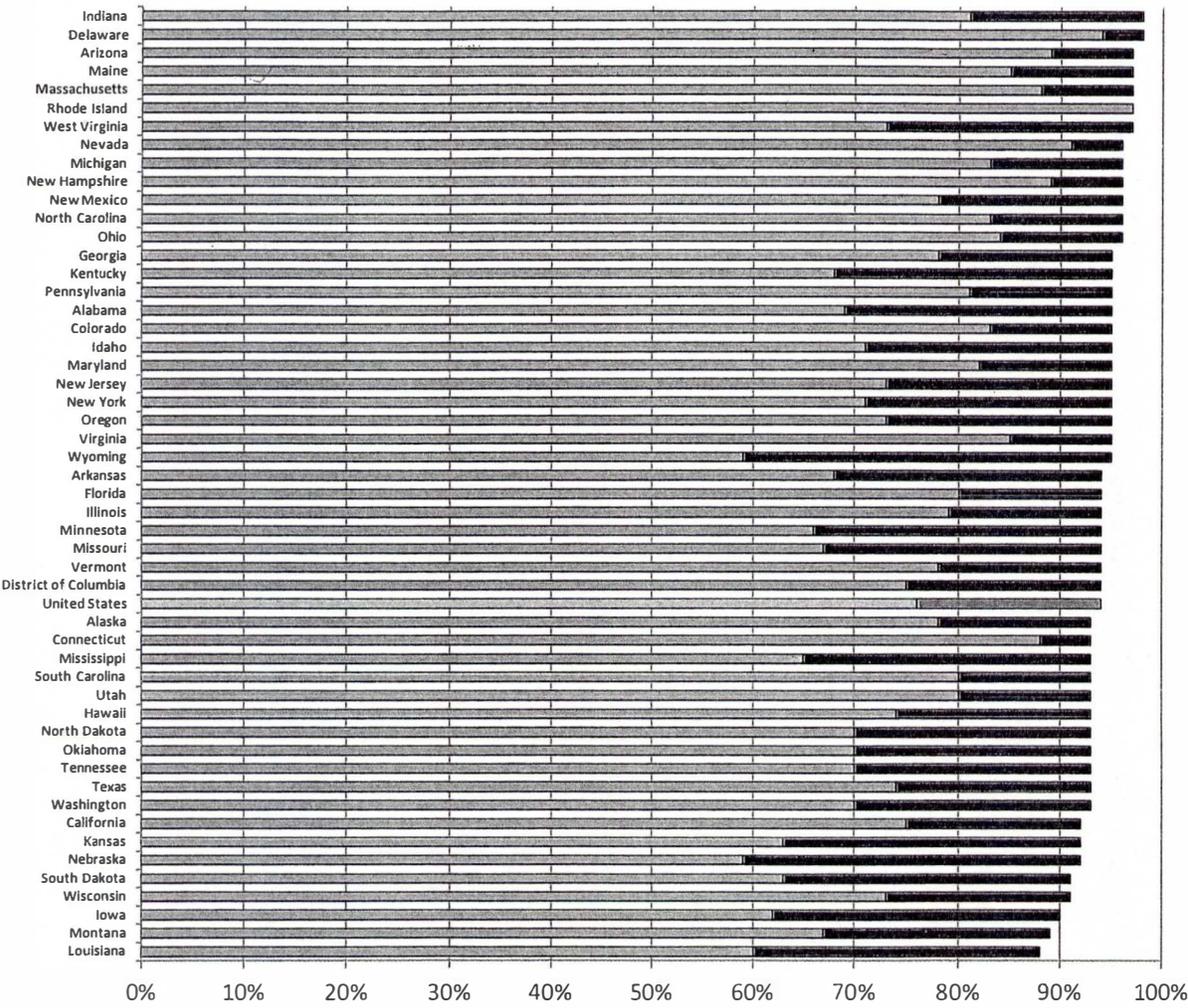
State	Dec 2008	June 2012	Percentage Point Increase	State	Dec 2008	June 2012	Percentage Point Increase
United States	7%	48%	41	Missouri	9%	62%	53
Alabama	4%	44%	40	Montana	3%	43%	40
Alaska	4%	32%	28	Nebraska	3%	53%	51
Arizona	7%	46%	39	Nevada	6%	37%	31
Arkansas	6%	54%	48	New Hampshire	5%	74%	70
California	4%	37%	33	New Jersey	4%	38%	34
Colorado	7%	43%	36	New Mexico	3%	43%	40
Connecticut	7%	43%	36	New York	6%	44%	38
Delaware	8%	55%	47	North Carolina	12%	58%	46
District of Columbia	2%	52%	50	North Dakota	1%	67%	65
Florida	5%	45%	40	Ohio	8%	53%	45
Georgia	5%	45%	40	Oklahoma	4%	47%	43
Hawaii	2%	38%	36	Oregon	11%	63%	51
Idaho	7%	41%	34	Pennsylvania	9%	57%	48
Illinois	6%	57%	51	Rhode Island	20%	59%	39
Indiana	8%	49%	41	South Carolina	3%	44%	41
Iowa	7%	73%	66	South Dakota	7%	64%	57
Kansas	6%	52%	46	Tennessee	7%	46%	40
Kentucky	5%	40%	35	Texas	6%	48%	42
Louisiana	3%	39%	36	Utah	3%	36%	33
Maine	7%	56%	49	Vermont	8%	61%	53
Maryland	4%	39%	35	Virginia	6%	54%	48
Massachusetts	27%	77%	50	Washington	7%	48%	41
Michigan	8%	44%	36	West Virginia	9%	52%	43
Minnesota	4%	72%	68	Wisconsin	5%	68%	63
Mississippi	3%	42%	39	Wyoming	4%	38%	34

SOURCE: ONC analysis of annual prescription data from Surescripts Data

- ★ In June 2012, states rates of physicians e-prescribing through an EHR ranged from 32% to 77% (Table 1).
- ★ Massachusetts (77%), New Hampshire (74%), and Iowa (73%) had the highest rate of physicians e-prescribing through an EHR.
- ★ From December 2008 to June 2012, nineteen states increased the percent of physicians e-prescribing through an EHR by 50% or more.

In 2012, the vast majority of community pharmacies across the country are enabled to accept e-prescriptions.

Figure 3: Growth in the percent of pharmacies enabled to e-prescribe; December 2008 to June 2012, by state.

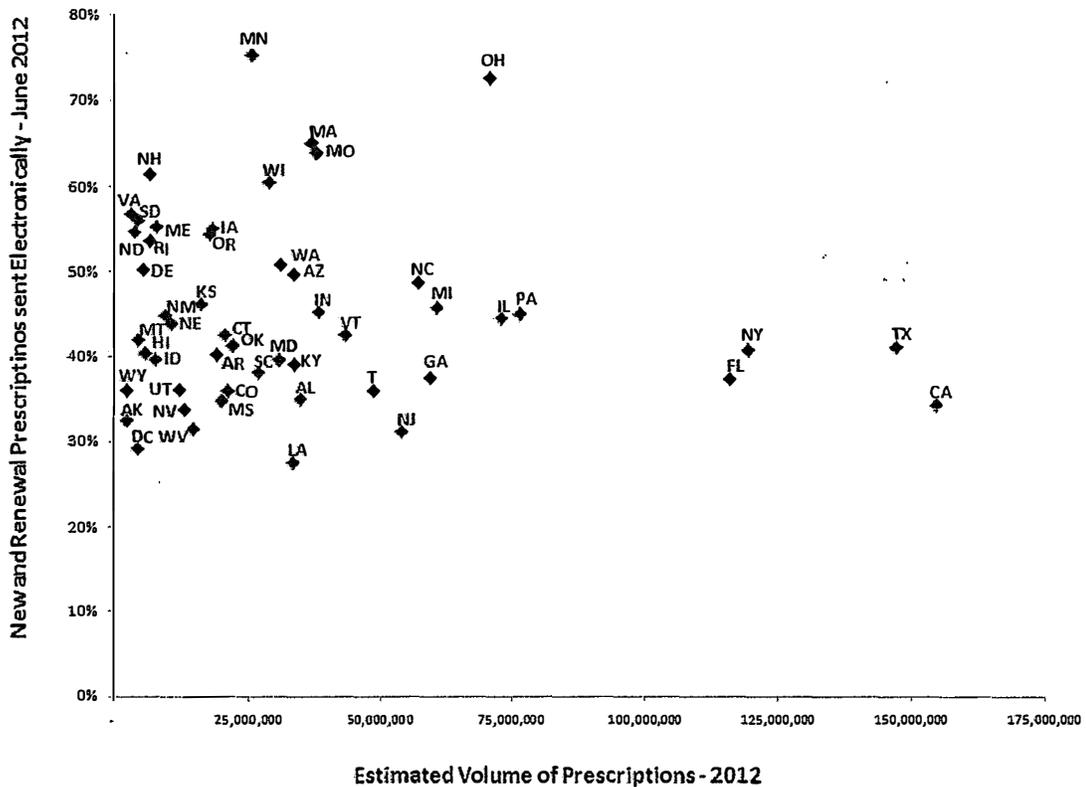


SOURCE: ONC analysis of pharmacy data from Surescripts

- ★ From December 2008 through June 2012, community pharmacies enabled to accept e-prescriptions increased from 76% to 94% (Figure 3).
- ★ Wyoming experienced the largest increase in community pharmacies enabled to accept e-prescriptions (36%); conversely, Rhode Island remained stable with 97% of pharmacies enabled to accept e-prescriptions.
- ★ As of June 2012, all states have a rate of at least 88%.

In 2012, approximately 45% of new and renewal prescriptions were sent electronically.

Figure 4: Percent of new and renewal prescriptions sent electronically in 2012, by state.



SOURCE: ONC analysis of annual prescription data from Surescripts, June 2012
 Forecasting for 2012 based upon Surescripts data from the first half of 2012 (383 million new and renewal prescriptions sent electronically)

- ★ In 2012, all states have at least 20% transmitted electronically (Figure 4).
- ★ Sixteen states send over half of their new and renewal prescriptions electronically.
- ★ The four states with the highest volume of prescriptions are below the national average for new and renewal prescriptions sent electronically.

The volume of new and renewal prescriptions sent electronically has increased ten-fold.

Table 2: Volume of New and Renewal Prescriptions Sent Electronically in 2008 and 2012, by state.

State	New and Renewals 2008	New and Renewals 2012	Percentage Point Increase	State	New and Renewals 2008	New and Renewals 2012	Percentage Point Increase
United States	4%	45%	41	Missouri	4%	65%	61
Alabama	2%	35%	33	Montana	1%	42%	41
Alaska	2%	33%	31	Nebraska	2%	44%	42
Arizona	6%	50%	44	Nevada	9%	34%	25
Arkansas	2%	40%	39	New Hampshire	3%	61%	58
California	3%	34%	31	New Jersey	5%	31%	27
Colorado	4%	36%	32	New Mexico	2%	45%	43
Connecticut	6%	42%	36	New York	3%	41%	37
Delaware	7%	50%	43	North Carolina	6%	49%	42
District of Columbia	3%	29%	27	North Dakota	0%	55%	54
Florida	4%	37%	33	Ohio	4%	73%	68
Georgia	2%	37%	35	Oklahoma	2%	41%	39
Hawaii	1%	40%	39	Oregon	4%	54%	50
Idaho	4%	40%	35	Pennsylvania	6%	45%	39
Illinois	4%	44%	41	Rhode Island	17%	54%	36
Indiana	3%	45%	42	South Carolina	1%	38%	37
Iowa	2%	55%	53	South Dakota	1%	56%	55
Kansas	3%	46%	43	Tennessee	4%	36%	32
Kentucky	3%	39%	36	Texas	3%	41%	38
Louisiana	3%	27%	25	Utah	1%	36%	35
Maine	6%	55%	49	Vermont	4%	57%	52
Maryland	5%	40%	34	Virginia	3%	42%	39
Massachusetts	20%	64%	44	Washington	4%	51%	47
Michigan	8%	46%	37	West Virginia	3%	31%	28
Minnesota	4%	75%	72	Wisconsin	2%	60%	58
Mississippi	1%	35%	34	Wyoming	2%	36%	34

SOURCE: ONC analysis of annual prescription data from Surescripts Data Forecasting for 2012 based upon Surescripts data from the first half of 2012 (383 million new and renewal prescriptions sent electronically)

- ★ In 2012, states rate of new and renewal prescriptions sent electronically range from 27% to 75% (Table 2).
- ★ Minnesota (75%), Ohio (73%), and Missouri (65%) have the highest rate of new and renewal prescriptions sent electronically.
- ★ It is estimated that 45% of new and renewal prescriptions will be sent electronically in 2012.

Summary

The percent of physicians e-prescribing using an EHR increased from 7% in December 2008 to almost half of physicians (48%) in June 2012. Increases occurred in all fifty states and the District of Columbia. Twenty-three states had more than half of their physicians e-prescribing using an EHR, with New Hampshire, Minnesota, Iowa, North Dakota, and Wisconsin experiencing the largest increases since December 2008.

The growth in e-prescribing has not been limited to physicians. In the same period, the percent of community pharmacies enabled to accept e-prescriptions grew from 76% to 94%. Wyoming, Nebraska, and Kansas had the largest increases in community pharmacies enabled to accept e-prescriptions. The vast majority of pharmacies are enabled to accept e-prescriptions in Rhode Island (97%), Delaware (98%), and Nevada (96%). These three states also had the highest percentages in December 2008, and therefore showed the smallest increases in pharmacies enabled to accept e-prescriptions.

The growth of physicians and pharmacies e-prescribing has corresponded with a ten-fold increase in the growth of new and renewal prescriptions sent electronically. In 2008, only 4% of new and renewal prescriptions were sent electronically. Our forecasting using data through June 2012 predicts that 45% of new and renewals prescriptions will be sent electronically in 2012. Minnesota (75%), Ohio (73%), and Missouri (65%) have the highest rate of new and renewals sent electronically. However, the four states with highest volume of prescriptions: California, Texas, New York, and Florida, are all below the national average. This challenge presents an opportunity to increase the proportion of new and renewals sent electronically among these states.

Data Source and Methods

This study examined trends in e-prescribing using data from Surescripts, a leading e-prescribing network. Surescripts is an e-prescription network utilized by approximately 95% of all community pharmacies in the U.S. routing prescriptions, excluding closed systems such as Kaiser Permanente.⁴ All 50 states and the District of Columbia were included in the analysis. This analysis included chain, franchise, and independently owned pharmacies. Medical device manufacturers, nuclear, government/military, and infusion pharmacies are excluded using pharmacy type variables provided by National Council for Prescription Drug Programs.

Data for annual percentages of new and renewal prescriptions routed through the Surescripts network data exclude controlled substances, which are not yet permitted on the Surescripts network.

Physician denominators was developed with SK&A, a propriety data set using a combination of the title and specialty variables.⁵ The counts were de-duplicated to correct for individual providers who are observed at multiple sites.

Definitions

E-Prescribing: the electronic transmittal of a prescription to a pharmacy from the prescriber.

Enabled pharmacy: Pharmacy that has connected with the Surescripts network and is capable of receiving e-prescribing transactions.

Community pharmacy: A chain, franchise, or independently owned pharmacy. Medical device manufacturers, nuclear, government/ military, and infusion pharmacies are excluded.

New prescription: New prescriptions electronically routed from prescribers to pharmacies (including mail order).

Renewal prescription: Renewal responses electronically routed between prescribers and pharmacies (including mail-order).

Electronic health record: A collection of electronic health information that is capable of being shared across different health care settings. Electronic health records may include patient demographics, medical history, medications, allergies, immunization status, laboratory test results, radiology images, and vital signs.

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About the Authors

The authors are with the Office of the National Coordinator for Health Information Technology, Office of Economic Analysis, Evaluation and Modeling.

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#1

Testimony

House Bill 1274

Senate Appropriations Committee

Monday, April 1, 2013

Ken Tupa, American Cancer Society Cancer Action Network (ACS CAN)

Chairman Holmberg and members of the Senate Appropriations Committee: I am Ken Tupa and I appear before the committee today to provide comment on HB 1274 on behalf of the American Cancer Society Cancer Action Network. ACS CAN supports HB 1274 and asks your favorable consideration for a Do Pass recommendation.

ACS CAN supports the ability of doctors to make the best medical decision in consultation with their patients. Prior authorization creates an additional administrative barrier, can discourage physicians from prescribing prior authorization drugs, even if they are the most appropriate option for the patient, and can deter beneficiaries from seeking the recommended care. Prior authorization in some cases can take several hours to several days. For cancer patients undergoing chemotherapy, such delays could be detrimental to their treatment success and quality of life.

Prior authorization programs limit the ability of patients and doctors to make medical decisions in an unimpeded manner. We do support HB 1274 as it establishes this process electronically within the electronic prescribing systems and will reduce the administrative burden on physicians and provide real-time or near real-time decisions that can increase access to treatment and medication for patients.

In closing, the ACS CAN strongly supports the right of cancer patients and their doctors to decide what is best based on the patient's medical and emotional needs and we again ask for your favorable consideration on HB 1274.

Thank you for the opportunity to speak with you today.