NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

BUDGET COMMITTEE ON HUMAN SERVICES

Thursday, March 9, 2006
Roughrider Room, State Capitol
Pride Manchester House
Bismarck, North Dakota

Senator Dick Dever, Chairman, called the meeting to order at 9:00 a.m. in the Roughrider Room, State Capitol.

Members present: Senators Dick Dever, Tom Fischer, Aaron Krauter, Judy Lee, Russell T. Thane, John M. Warner; Representatives William R. Devlin, Lee Kaldor, James Kerzman, Gary Kreidt, Ralph Metcalf, Jon O. Nelson, Vonnie Pietsch, Chet Pollert, Todd Porter, Louise Potter, Clara Sue Price, Sally M. Sandvig, Ken Svedjan, Gerald Uglem, Alon C. Wieland

Members absent: Senator Richard L. Brown; Representative Jeff Delzer

Others present: Lois Delmore, State Representative, Grand Forks

See attached appendix for additional persons present.

It was moved by Senator Krauter, seconded by Senator Fischer, and carried on a voice vote that the minutes of the previous meeting be approved as distributed.

PUBLIC HEALTH UNIT STUDY

Ms. Kelly Nagel, public health liaison, State Department of Health, presented information on other states' models of public health unit administration and accreditation. Ms. Nagel said Nebraska has a decentralized public health structure similar to North Dakota. In 2001, she said, the Nebraska Legislature approved legislation promoting the formation of multicounty health departments consisting of at least three contiguous counties or serving at least 30,000 people. She said the legislation requires each health department to provide the 10 essential services.

Ms. Nagel said Minnesota also has a decentralized public health structure similar to North Dakota. In 2003, she said, the Minnesota Legislature streamlined administrative requirements and combined several grants. She said the legislation requires community health boards to serve a population of at least 30,000 people. She said Minnesota health units deliver services and community health boards provide administration and management of the health units. In Minnesota, she said, state general fund support and maternal and child health block grant funds distributed to community health boards require a 75 percent local match, which is intended to encourage community health boards to develop other sources of funding for addressing public health needs in the communities. She said Minnesota has also created a committee of state and local public health representatives to advise, consult with, and make recommendations to the Commissioner of Health on matters relating to the development, maintenance, funding, and evaluation of public health services. As a result of these activities, community health boards are required to document their progress toward providing essential local health services.

Ms. Nagel said North Carolina is in the process of developing and implementing an accreditation process for public health units. A public health task force in North Carolina, she said, identified a uniform set of standards or specific activities that all local health departments are expected to meet. She said the standards are based on the core functions and 10 essential services of public health. She said the state has recently piloted the accreditation process with 10 local health departments. She said the basic process includes technical assistance from the State Health Department, self-assessment, site visits, action by an independent accreditation board, an appeals process, corrective action planning, and funding sanctions. A copy of the report is on file in the Legislative Council office.

In response to a question from Senator Warner, Ms. Nagel said North Dakota currently does not require the public health units to serve a minimum number of residents.

In response to a question from Senator Dever, Ms. Nagel said she believes the public health units would not support more state oversight; however, she said, there may be opportunities for enhancing collaborative efforts.

The Legislative Council staff presented a memorandum entitled *Public Health Units - Services and Funding*. The Legislative Council staff said the memorandum summarizes survey responses of public health units relating to funding, programs, demographics, and essential services.

The Legislative Council staff reviewed the 2005 funding sources of public health units and their estimated administrative costs. The Legislative Council staff reviewed demographic information of the populations served by each public health unit and identified the per capita funding, by funding source, for

each public health unit. The Legislative Council staff also provided information on the number of grant applications prepared by each health unit, the number of hours spent preparing the grant applications, and the number of grants awarded.

The Legislative Council staff reviewed the following schedule which identifies the 10 essential services as defined by the American Public Health Association and an administration component and provides a comparison of the units' average estimate of what they spent on each in 2005 to the average of the health units' responses for the "Best Practice" or "Ideal" percentage that should be spent on each.

	Essential Services	Average "Best Practice" or "Ideal" Percentage	Average Estimate of 2005 Budgets	Variance
1	Monitor health status to identify community health problems	12.7	9.6	3.1
2	Diagnose and investigate health problems and health hazards in the community	11.8	9.6	2.2
3	Inform, educate, and empower people about health issues	17.3	21.1	(3.8)
4	Mobilize community partnerships to identify and solve health problems	10.7	5.4	5.3
5	Develop policies and plans that support individual and community health efforts	8.2	4.9	3.3
6	Enforce laws and regulations that protect health and ensure safety	7.3	6.1	1.2
7	Link people to needed personal health services and assure the provision of health care when otherwise unavailable	13.6	28.5	(14.9)
8	Assure a competent public health and personal health care workforce	6.7	6.8	(.1)
9	Evaluate effectiveness, accessibility, and quality of personal and population-based health issues	4.0	1.7	2.3
10	Research for new insights and innovative solutions to health problems	.4	.3	.1
	Indirect or administrative costs	7.3	6.0[1]	1.3
	Total	100.0	100.0	0

[1]This amount does not include all units' administrative costs because some units allocated administrative costs to the 10 essential services.

Reasons why actual essential services percentages may differ from "Best Practice" or "Ideal" percentage and suggestions made by the health units to address these differences include:

1. The programs provided follow guidelines and funding levels of the grants the units receive.
2. Increasing demands for direct patient care, grant reporting and requirements, and required attendance at meetings make it difficult to provide other essential services.
3. Lack of private health care providers to meet the demand for health services, especially in rural areas, results in the health units arranging for or directly providing a wide variety of health services.
4. The development of new methods of gathering community input to prioritize services would be useful.
5. Additional funding flexibility is needed to address local priorities and needs.
6. The current formula for distributing state aid to health units should be changed to consider the socio-economic conditions of each unit's residents.
7. Additional funding for state aid to health units would allow the units more discretionary funding to address the essential services currently not being adequately provided.
8. Increased funding for additional staff is needed, especially for environmental health, school nursing, and administration.
9. Recruiting and retaining staff is difficult. Additional funding that could be used for salaries and benefits for existing staff would be beneficial.
10. Additional funding is needed for monitoring and understanding local health issues, analyzing local health data, and evaluating local public health services.
11. Consider developing a credentialing process for public health employees to assure a competent workforce.

The Legislative Council staff said additional information relating to the survey responses will be presented at a future committee meeting.

Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, provided information on the unit's services and funding. Ms. Clute said the First District Health Unit serves seven counties--Bottineau, Burke, McHenry, McLean, Renville, Sheridan, and Ward. She said the unit's primary office is in Minot with satellite offices in each of the counties the unit serves. She said the unit employs 52.8 full-time equivalent (FTE) positions, serves 88,000 residents, and has a $2.9 million annual budget.

Ms. Clute said federal grants administered by the unit that require a local match include maternal and child health, radon, tobacco, water pollution, water supply, and Women's Way. In 2005, she said, the unit subsidized all federal programs with $705,000 of local funds.

Ms. Clute said the First District Health Unit is comprised of six divisions--administration, emergency preparedness, environmental health, nursing,

nutrition, and tobacco prevention. She said the primary duties and responsibilities of the divisions are to:

1. Prevent epidemics and the spread of disease.
2. Protect against environmental hazards.
3. Prevent injuries.
4. Promote and encourage healthy behaviors.
5. Respond to disasters and assist communities in recovery.
6. Assure the quality and accessibility of health services.

Ms. Clute expressed concern regarding proposed changes by the Public Employees Retirement System that would no longer allow public health districts to pay the blended rate for their employees' health insurance premiums. She said the proposed change would cost the First District Health Unit an additional $82,000 annually. A copy of the report is on file in the Legislative Council office.

In response to a question from Senator Lee, Ms. Clute said the determination of environmental health regulations is the responsibility of each public health unit. She said currently these regulations vary across the state. To provide more consistency from one jurisdiction to another, she suggested a more standardized system of environmental health regulations be developed for all public health units to use.

Ms. Karen Pederson Halle, Administrator, Lake Region District Health Unit, Devils Lake, presented information on the health unit's services and funding.

Ms. Pederson Halle said the Lake Region District Health Unit serves the counties of Benson, Eddy, Pierce, and Ramsey. She said these counties have a combined population of 24,462.

Ms. Pederson Halle provided an overview of the programs offered by the health unit, including public health nursing; environmental health; emergency preparedness; tobacco prevention; women, infants, and children (WIC) program; family planning; and Women's Way.

Ms. Pederson Halle said the unit employs 20 FTE positions and the unit's 2005 budget totaled $1.2 million, 57 percent of which was federal funds.

Ms. Pederson Halle said the second largest source of funding for the unit is derived from county mill levies. She expressed concern that counties with tribal lands are unable to generate as much county funding because tribal lands are not subject to property taxes. A copy of the report is on file in the Legislative Council office.

Dr. Alana Knudson, Associate Director for Research, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information on the school's role and involvement with public health units. Dr. Knudson said the medical school and local public health units collaborate primarily in the following three areas:

1. Technical assistance and research.
2. Educational support.
3. Information dissemination.

Dr. Knudson provided examples of the medical school's role in providing technical assistance and research that benefits public health units; the medical school's educational programs for public health professionals and opportunities for medical school students and residents to work at public health units across the state; and examples of publications, online information, and conferences provided for public health workers. A copy of the report is on file in the Legislative Council office.

Ms. Nagel presented information on the essential services of public health units. Ms. Nagel said the State Department of Health and public health units have conducted health planning meetings to discuss public health core functions, infrastructure, and resources. She said the meetings have focused on funding, workforce, laws and regulations, services, structure, partnerships, communications, advocacy, and information and education.

Ms. Nagel said the following preliminary observations and recommendations have been identified:

1. The majority of local public health infrastructure services should be considered minimum essential services and be provided locally or regionally.
2. Population-based and personal health services, including those relating to communicable diseases, tobacco use prevention, maternal and child health, immunizations, prenatal and infant care, and clinical prevention screenings, should be considered minimum essential services. Services identified as not being adequately provided at the present time are violence prevention, asthma, mental health, alcohol abuse prevention, substance abuse prevention, infant care, and physical activity.
3. Infectious disease services were strongly considered to be classified as minimum essential services.
4. Promulgating rules and policies for environmental health services, enforcement, monitoring, and consultation were strongly considered to be minimum essential services. A local and state partnership to deliver environmental health services should be considered. Statewide consistency and rules regarding environmental health are needed.
5. Services for disaster preparedness and response had the highest scores for being adequately provided. These services have adequate funding and regional coordination. This system could serve as a model for other service delivery systems of public health units.
6. Quality and accessibility of health services were considered a minimum essential service with both local and state responsibility.

Ms. Nagel said an option discussed at the meetings to assure that minimum essential services are provided is for local public health units to enter

into joint powers agreements. A copy of the report is on file in the Legislative Council office.

The Legislative Council staff presented a memorandum entitled *Health Districts - History of Mill Levy Limits and State Aid*. The Legislative Council staff said that North Dakota Century Code Section 23-35-07 limits public health districts' budgets to an amount that does not exceed the amount of revenue that can be raised by a levy of five mills of the taxable valuation of the district. The statutory provisions limiting the mill levy of a health district began in 1943. The Legislative Council staff presented the following schedule showing the history of changes to the number of mills a health district may levy:

1943	.50 mill
1953	.75 mill
1965	1.00 mill
1975	1.50 mills
1981	2.50 mills
1991	5.00 mills

The Legislative Council staff said since 1977 each Legislative Assembly has appropriated funding from the general fund for state aid to public health units. The Legislative Council staff presented the following schedule of the funding appropriated for each biennium since 1977:

Biennium	General Fund Appropriation
1977-79	$600,000
1979-81	$525,000
1981-83	$1,000,000
1983-85	$1,000,000
1985-87	$1,000,000
1987-89	$950,000
1989-91	$600,000
1991-93	$975,000
1993-95	$1,000,000
1995-97	$950,000
1997-99	$990,000
1999-2001	$1,100,000
2001-03	$1,100,000
2003-05	$1,100,000
2005-07	$1,100,000

The Legislative Council staff said that state aid funds are distributed to each health unit pursuant to a formula developed by the State Department of Health. The formula provides each public health unit a $6,000 base allotment per biennium with the remainder of the funding being distributed on a per capita basis.

The Legislative Council staff presented a memorandum entitled *Selected County Mill Levies 2004 (Collected in 2005)*. The memorandum includes a schedule showing for 2004, by county, the value of one mill of property tax, the number of mills levied and the funding generated for each county's general fund, and the number of mills levied and funds generated for public health districts. The Legislative Council staff said that 46 counties levy mills for health districts with an average mill levy of 3.58 mills.

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, presented information on options for providing grant writing assistance to public health units. Ms. Smith said the department does not have a central function devoted to seeking out grant funding for the department. She said the department has identified this as a need in recent strategic planning sessions. She said individual division directors and program managers seek out new federal or other funding when a need arises in their area of responsibility, conduct necessary planning, obtain data, develop a budget, and write and submit the grant application.

Ms. Smith said the department conducted an informal survey of its managers to assess the current assistance that is provided to local public health units in obtaining grants. She said many program managers or division directors inform local public health workers of grant opportunities. She said many also offer assistance or training on how to prepare a grant or assistance in reviewing the grant proposal. She said often the assistance is provided directly to the local public health or other program coordinator rather than to the local public health director. In addition, she said, formal grant writing assistance training is provided through the University of North Dakota.

In discussions with local public health representatives, Ms. Smith indicated that areas of assistance identified as being needed by public health units include planning, training, obtaining community level data, and technical assistance for specific questions in grant applications.

Ms. Smith said the department, with its current staff and resources, may be able to:

1. Improve communications with local public health through the local public health liaison to formally make them aware of grant funding available, grant writing seminars, data available from the department, and other technical assistance available from the department.
2. Link local public health with other resources such as the University of North Dakota and Dakota Medical Foundation for possible grant writing assistance.
3. Continue to seek funding for community public health projects.

A copy of the report is on file in the Legislative Council office.

Representative Kaldor suggested the committee receive information on anticipated federal funds reductions affecting public health in North Dakota. Chairman Dever asked the department to provide this information, to the extent available, to the committee at its next meeting.

HEALTHY NORTH DAKOTA STUDY

Ms. Melissa Olson, Director, Healthy North Dakota, State Department of Health, provided information on the preliminary results of the Healthy North Dakota strategic assessment and proposals for the future of Healthy North Dakota.

Ms. Olson reviewed the preliminary strategic assessment recommendations, including:

1. Identify the long-term organizational structure of the Healthy North Dakota collaborative.
2. Select and focus on a few strategic health initiatives.
3. Prioritize the development of plans based on the selected strategic health initiatives.

Ms. Olson said Healthy North Dakota needs to have a sustainable funding source. She said as the organizational structure for the initiative is developed, a funding request will likely be made to the 2007 Legislative Assembly for administrative costs and seed money for projects. A copy of the report is on file in the Legislative Council office.

The committee recessed for lunch at 12:00 noon and reconvened at 1:00 p.m.

MEDICAID STUDY AND REPORTS

Ms. Maggie Anderson, Director, Medical Services, Department of Human Services, presented information on medical assistance-related expenditures, implementation of provisions of House Bill Nos. 1459 and 1460, activities of the prescription drug monitoring program, status of the Medicaid management information system (MMIS) project, and the status of the Medicare Part D implementation.

Regarding medical assistance expenditures through January 2006, Ms. Anderson said medical services-related expenditures have been more than anticipated while long-term care-related expenditures have been less than anticipated. Ms. Anderson presented a schedule showing actual medical assistance expenditures through January 2006 compared to appropriated amounts by major category.

Regarding management initiatives for the medical assistance program included in House Bill No. 1459, Ms. Anderson said the department has released a request for proposal for the disease management program with the proposals due by the end of April 2006. She said the department will need to receive a waiver from the federal Centers for Medicare and Medicaid Services prior to entering into a contract for the disease management program. She anticipates the program starting no earlier than September 2006.

Regarding risk-sharing agreements, Ms. Anderson said the department has contracted with an actuarial vendor to develop rates for its Program for All-Inclusive Care for the Elderly (PACE) which will provide a comprehensive package of acute and long-term care services for elderly ages 55 and older.

Regarding the Medicaid report required by House Bill No. 1460, Ms. Anderson said the department has contracted with an actuarial vendor to complete the Medicaid analysis which will include comparisons to other payers, including Medicare, Workforce Safety and Insurance, Blue Cross Blue Shield of North Dakota, and surrounding states. Ms. Anderson anticipates the report to be available by July or August 2006.

Chairman Dever asked that the Department of Human Services provide information to the committee on the estimated fiscal effect of making Medicaid payment rates equivalent to Medicare rates. Ms. Anderson said the department will provide this information to the committee at a future meeting.

Regarding the prescription drug monitoring program, Ms. Anderson said the working group has applied for a federal grant and is drafting legislation for consideration by the 2007 Legislative Assembly. She said the proposed legislation will relate to:

1. Allowing the program to require medications in addition to controlled substances to be submitted.
2. Addressing liability concerns.
3. Ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA).

In response to a question from Senator Lee, Mr. Harvey Hanel, Workforce Safety and Insurance and member of the prescription drug monitoring program workgroup, said the working group believes if the federal grant award is received, an effective program will be implemented in North Dakota.

Ms. Anderson commented on the status of implementation of the Medicare Part D prescription drug program. Ms. Anderson said since January 1, 2006, the department has paid $303,000 in Part D claims for approximately 1,900 recipients due to problems with recipients accessing their new prescription drug plan. She said the department submitted a federal demonstration project application, which was approved, authorizing the department to make these payments and be reimbursed by the federal government for any state costs incurred.

Ms. Anderson said North Dakota pharmacies have been very cooperative in making the transition to the Medicare Part D plans and in addressing problems and concerns during this transition period.

Ms. Anderson commented on the Medicare Part D clawback payment. Ms. Anderson said to date, the department has not received an invoice from the federal government for its first clawback payment. Ms. Anderson said the 2005-07 legislative appropriation for the clawback payment was $15,851,709. Because of revised federal clawback calculations, she said, North Dakota's clawback payment is now estimated to total $14,135,727 for the biennium, which is $1,715,982 less than the appropriation.

Ms. Anderson presented the following schedule showing Medicaid prescription drug expenditures since fiscal year 2000:

Fiscal Year	Expenditures	Percentage Increase From Previous Year
2000	$30,186,107	
2001	$35,162,327	16.5%
2002	$41,599,151	18.3%
2003	$40,759,110	(2.0%)
2004	$45,974,797	12.8%
2005	$47,031,726	2.3%

Ms. Anderson distributed testimony provided to the Budget Section on March 8, 2006, and a copy of the motion approved by the Budget Section relating to the MMIS replacement project. Ms. Anderson said the projected cost of the project is now $56.8 million, $500,000 less than previously reported to the committee in December. Ms. Anderson said the Budget Section approved a motion expressing the Budget Section's support for the department proceeding with preliminary work on the project with a final direction decision to be made by the 2007 Legislative Assembly. The motion encourages the Department of Human Services to begin preliminary work on the project that would be required for all of the following options:

1. Acceptance of the current Affiliated Computer Services, Inc., bid.
2. Rebidding of the MMIS project.
3. Joint development with another state.
4. Use of a fiscal agent.
5. Outsourcing the billing and payment components.

In addition, Ms. Anderson said the motion provides that the Department of Human Services is encouraged to contract for an independent analysis of the above options, including a cost-benefit analysis, and to arrange for the information to be available to the Legislative Assembly by January 8, 2007. The department is to report on the status of the preliminary project work and on the planned process to complete the cost-benefit analysis at each of the remaining 2006 Budget Section meetings. A copy of the report is on file in the Legislative Council office.

Senator Krauter asked why the federal government does not provide a base level system that all states could use to begin their project development in order to reduce costs for these systems that all states need. Mr. Curt Wolfe, independent consultant for the Department of Human Services, said that because each state's system is unique, customized code is required which is very expensive. He said as the department began the development of this project, it intended to begin with another state's system and to customize it; however, he said, since that time, the federal government began encouraging vendors and states to upgrade to newer software systems which has substantially increased the cost of these projects. Further affecting the high cost of these projects, he said, only a few vendors are available in the nation to perform this type of work.

Mr. David Peske, North Dakota Medical Association, Bismarck, provided the committee with a copy of a September 2005 resolution relating to medical assistance rates in North Dakota. Mr. Peske said the resolution, approved by the 2005 house of delegates of the North Dakota Medical Association, encourages the Governor and legislative leaders to address the unfairness of state Medicaid rates that do not cover practice costs for physicians and hospitals in North Dakota. Mr. Peske said the association is concerned with low medical assistance payment rates and the effect these low rates have on the viability of medical providers in North Dakota and the resulting effect on access to medical care in the state. A copy of the resolution is on file in the Legislative Council office.

Ms. Amy Armstrong, Project Director, North Dakota Real Choice Rebalancing Grant, North Dakota Center for Persons with Disabilities, Minot State University, provided information on the activities associated with the real choice rebalancing grant. Ms. Armstrong said the state received this grant in order to assist it in complying with the provisions of the Olmstead decision and the President's New Freedom Initiative, both of which are intended to improve access and choice of continuum of care services for the elderly and people with disabilities.

Ms. Armstrong said the goals of the grant are to:

1. Develop a mechanism to balance state resources for continuum of care services, including long-term care and home and community-based services.
2. Develop a system to provide a single point of entry for continuum of care services.
3. Develop practical and sustainable public information services for all continuum of care services in North Dakota.

Ms. Armstrong said the grant is provided through September 2007. To date, Ms. Armstrong said the committee overseeing the grant has gathered information and reviewed research relating to North Dakota's continuum of care services. She said the committee will be developing a plan, including action steps, recommendations, and legislation for consideration by the 2007 Legislative Assembly. A copy of the report is on file in the Legislative Council office.

Dr. Patricia Hill, North Dakota Pharmacists Association, Bismarck, expressed the support of North Dakota pharmacists for providing the highest quality of care for their patients while at the same time reducing the cost of the state's Medicaid program. She suggested that as the committee receives information from the Department of Human Services on the comparison of rates paid by the state's medical assistance program to other payers, the committee also receive information and review the actual costs of North Dakota pharmacies in relation to medical assistance payments for their services.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS STUDY

Ms. Anderson presented information on the status of the department's Medicaid waiver request to provide in-home services to children with extraordinary medical needs. Ms. Anderson said after passage of Senate Bill No. 2395 by the 2005 Legislative Assembly, the department convened a Medical Needs Task Force to assist it in gathering information to better understand the unmet special health care needs of children and to provide recommendations regarding a Medicaid waiver for children with extraordinary medical needs. She said the group has met several times and anticipates that it will continue to meet until the waiver process is complete.

Ms. Anderson said since the legislation was approved, other options have been discussed that may affect services for these children, including a Katie Beckett eligibility option which expands Medicaid eligibility and would need to be approved by the Legislative Assembly and an option for a Medicaid buyin program for disabled children with family incomes of up to 300 percent of the federal poverty level. She said this option would also need approval of the Legislative Assembly.

Ms. Anderson said the department anticipates submitting a waiver application during 2006 and the waiver will include an effective date after the beginning of the next biennium because Senate Bill No. 2395 did not include funding for additional costs associated with any potential reduction in recipient liability that would be covered by the waiver.

Senator Lee asked why the department has not yet submitted its waiver application. Ms. Anderson said the task force is still addressing a number of issues relating to the request, including how a waiver would interact with the Katie Beckett eligibility option if that is approved by the Legislative Assembly.

A copy of the report is on file in the Legislative Council office.

Ms. Donene Feist, Family Voices of North Dakota, Edgeley, provided information on the Medicaid buyin option approved by Congress. She said Medicaid buyin allows working families of children with special health care needs to purchase Medicaid. She said this would allow the Medicaid program to act as wraparound care for medically necessary services denied by the family's private health insurance program. A copy of the report is on file in the Legislative Council office.

FOSTER CARE FACILITY PAYMENT SYSTEM STUDY

Ms. Anderson presented information on the change in payment procedures for foster care facilities as required by the federal government.

Ms. Anderson said initially the federal government was requiring the department to transition providers to the new payment system by January 2006. However, she said, the federal government has now extended the deadline until July 1, 2006.

Ms. Anderson said the department has completed a financial impact analysis based on timestudy information submitted by providers. She said based on the information provided, the department believes that the residential child care facilities and PATH foster care homes will receive no less reimbursement for treatment services than under the current system. A copy of the report is on file in the Legislative Council office.

In response to a question from Senator Krauter, Ms. Anderson said the Ruth Meiers facility in Grand Forks and the Pride Manchester House in Bismarck are the two residential treatment centers that have not been accredited to receive payment by the federal Centers for Medicare and Medicaid Services. She said the department anticipates the facilities to be accredited by December 2006.

In response to a question from Senator Krauter, Ms. Joanne Hoesel, Department of Human Services, said she believes the facilities are currently meeting accreditation standards; however, she said, the accreditation process takes a number of months to complete.

COMMITTEE DISCUSSION

Representative Kerzman suggested the committee ask the Department of Human Services to include pharmacy services in the report it provides to the committee comparing Medicaid payment rates to provider costs and to other payers for various services. Chairman Dever said this request would be made of the department.

Representative Svedjan suggested the committee receive reports on the temporary assistance for needy families (TANF) program at future meetings since it has been reauthorized by Congress and may have a financial impact on the state, especially in relation to changes in work participation rates. He said a representative of the National Conference of State Legislatures has offered to make a presentation to the committee on potential state options under the TANF reauthorization. Chairman Dever said he had made a request to the Legislative Council chairman regarding this presentation and is awaiting a reply.

Chairman Dever said he anticipates the next committee meeting will consist of budget tours of state agencies and institutions in Jamestown, Lisbon, Grand Forks, and Grafton in late May and the following committee meeting will be in June.

PRIDE MANCHESTER HOUSE TOUR

The committee traveled to the Pride Manchester House for a presentation and tour. Ms. Susan Gerenz, Pride Manchester House, said the center serves eight children ages 5 through 13. She said the average length of stay for each child is from five to six months. She said during the last two years, the facility has had 100 percent occupancy and always

has a waiting list. Ms. Gerenz said the center has begun providing outreach services to children referred to the facility and of the 74 referrals in 2005, 36 were diverted because of the center's outreach program. Ms. Gerenz expressed concern that the center receives no financial reimbursement from the state for providing outreach services.

Ms. Gerenz also expressed the importance of providing transition services in each child's home upon discharge from the facility. She expressed concern that the center receives no financial reimbursement for the transition services it provides outside the facility.

The committee conducted a tour of the facility and adjourned subject to the call of the chair at 4:40 p.m.

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Allen H. Knudson
Assistant Legislative Budget Analyst and Auditor

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Jim W. Smith
Legislative Budget Analyst and Auditor

ATTACH:1