NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH AND HUMAN SERVICES COMMITTEE

Tuesday, March 23, 2010
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Robin Weisz, Chairman, called the meeting to order at 8:30 a.m.

Members present: Representatives Robin Weisz, Larry Bellew, Tom Conklin, Kari L. Conrad, Jeff Delzer, Robert Frantsvog, Curt Hofstad, Richard Holman, Gary Kreidt, Chet Pollert, Louise Potter, Alon C. Wieland; Senators Robert S. Erbele, Tom Fiebiger, Ralph L. Kilzer, Tim Mathern, Jim Pomeroy

Members absent: Representatives Mary Ekstrom, Vonnie Pietsch; Senator Judy Lee

Others present: Jim W. Smith, Legislative Council, Bismarck

Senator David O'Connell, member of the Legislative Management, was also in attendance.

See Appendix A for additional persons present.

It was moved by Senator Mathern, seconded by Representative Kreidt, and carried on a voice vote that the minutes of the November 17-18, 2009, meeting be approved as distributed.

UNMET HEALTH CARE NEEDS STUDY

Dr. John Baird, Field Medical Officer and Section Chief, State Department of Health, provided information via teleconference regarding the 2004 State Department of Health survey of the uninsured in North Dakota, including whether veterans who access federal Department of Veterans' Affairs health services were identified as insured or uninsured. Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, provided Dr. Baird's written testimony (Appendix B). Dr. Baird said the State Department of Health conducted a state planning grant survey funded by the United States Health Resources and Services Administration in 2004. He said health insurance coverage includes both private plans and government-sponsored plans. He said the major categories of government health insurance are Medicare; Medicaid; the children's health insurance program (CHIP); military health care, including veterans' affairs; and state plans, such as the Comprehensive Health Association of North Dakota (CHAND). He said the Indian Health Service (IHS) is a health care program through the United States Department of Health and Human Services that provides medical assistance at IHS facilities to eligible American Indians and helps pay the cost of selected health care services provided at non-IHS facilities. He said in 1997, the United States Census Bureau modified its definition of insurance coverage and since then individuals who have access to IHS but no other insurance coverage have been considered uninsured.

Dr. Baird said the 2004 survey indicated that 8.2 percent of North Dakotans were uninsured. He said the uninsured are more likely to be young adult, unmarried, and male. He said American Indians were more likely to be uninsured (31.7 percent) than Caucasians (6.9 percent). He said the study showed 9.1 percent of individuals residing in small rural areas (less than 5,000 people) were uninsured. He said 7.4 percent in large rural areas (5,000 to 16,699 people) and 7.7 percent in urban areas (over 16,699 people) were uninsured. He said 71.7 percent of uninsured individuals over 17 years of age were employed. In addition, 82.3 percent of insured adults were employed. He said 21.3 percent of self-employed individuals were not insured, while individuals employed by a small business (2 to 10 employees) had a 10.6 percent uninsured rate, and individuals employed by a business with more than 500 employees had the lowest uninsured rate at 3.8 percent.

Dr. Baird said in 2005 the University of North Dakota Center for Rural Health partnered with Job Service North Dakota to survey North Dakota employers on health insurance coverage for employees and their family members. He said the survey indicated 64 percent of businesses provided health insurance coverage and the most common reason for not providing health insurance coverage to employees was the high cost of premiums, coverage by another source, high employee turnover, and too many low-wage workers.

In response to a question from Representative Frantsvog, Dr. Baird said IHS is not considered insurance because it is a provider of last resort similar to federally funded community health centers where individuals can receive services, but it is not considered insurance. He said IHS services are only available on the reservation and selected services are sometimes approved for non-IHS facilities.

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, presented information regarding the number of children provided continuous eligibility under Medicaid since the department implemented the 12-month continuous eligibility policy for children in June 2008 and the estimated fiscal impact of the cost of the change. She said the 2007 Legislative Assembly authorized the Department of Human Services to implement a 12-month continuous eligibility under Medicaid policy for children. She said some children may have qualified for 12-month continuous eligibility before the

policy was implemented because they were in an institution and on Medicaid waiver; however, most of the children on Medicaid were required to qualify monthly. She provided a summary of the number of continuously eligible children, including the federal and state expenditures and per member per month cost, by month for the period from November 2008 to October 2009 (Appendix C). She said the report includes only children enrolled in Medicaid under the 12-month continuous eligibility policy and that there are other children who receive services through the medically needy program and Medicaid waiver. She said the number of children continuously eligible increased from 23,953 in November 2008 to 33,112 in October 2009, and the increase in the number of children was expected because of the cumulative effect of the continuous eligibility. She said the per member per month cost, which is the average paid by the department for all of the children on Medicaid in this group, was $224.28 in October 2009 compared to $208.62 in November 2008. She said outreach activities may also contribute to the increase in the number of children on Medicaid. She said when the department does outreach for CHIP, also known as Healthy Steps, children are also reviewed for Medicaid eligibility.

In response to a question from Representative Delzer, Ms. Anderson said with the exception of IHS facilities, Medicaid is the payer of last resort. She said if a child covered under Medicaid is subsequently covered by health insurance, the insurance is responsible to pay first and then, to the extent the child is still eligible, Medicaid would cover the deductible and coinsurance. She said the department regularly contracts for third-party liability matches to identify insurance coverage not disclosed by the recipient.

Representatives Pollert and Bellew requested information on the department's cost to continue items for the 2011-13 biennium.

Chairman Weisz called on Ms. Shari Doe, Director, Burleigh County Social Services, and President, North Dakota Association of County Social Service Directors, to provide information regarding a summary report prepared by the counties regarding the effects of the change in income reporting for Medicaid resulting from the 12-month continuous eligibility for children (Appendix D). Ms. Doe said the continuous eligibility policy has been a positive change, but it has not resulted in substantial time-savings for eligibility workers. She said it has benefited children in foster care who can continue coverage when they leave foster care, enhancing reunification efforts, but because many cases involve other programs, such as the supplemental nutrition assistance program (SNAP) and child care assistance, incomes may still need to be reported and verified more often. She presented a summary of a survey completed by county social service offices regarding time saved by the continuous eligibility policy. She said the survey indicated the most time, from 5 minutes to 30 minutes per case, was saved on Medicaid-only cases. She said the number of Medicaid-only cases is approximately 5 percent.

In response to a question from Representative Pollert, Ms. Doe said the continuous eligibility policy has made it possible for the counties to manage increases in the number of Medicaid cases without adding staff.

Mr. Michael Fix, Life and Health Division Director and Actuary, Insurance Department, provided information regarding the study of unmet health care needs, including information on the number of insured and uninsured in the state and information on the CHAND program, including the number of North Dakotans covered by the program and the funding mechanism for the program (Appendix E). He said the Insurance Commissioner's information regarding the number of uninsured individuals in North Dakota is the same information provided to the committee by Dr. Baird. He said CHAND was established in 1981 to provide comprehensive health insurance to qualifying residents who have either been denied health insurance or have been given restricted coverage because of health issues. He said CHAND premiums are equal to 135 percent of the average amount charged for standard health insurance coverage in North Dakota. He said CHAND claims in excess of premiums collected are paid by assessments on accident and health insurance companies selling more than $100,000 of health insurance premiums annually in the state. He said in June 2009 an assessment was made for $5 million to cover excess claims and operating expenses and the CHAND Board of Directors anticipates an additional $5.5 million assessment will be made in April 2010. He said the assessments paid to CHAND by the insurance companies are allowed as a credit against premium tax due to the state; therefore, it reduces the amount of insurance premium tax deposited in the general fund. He said as of March 1, 2010, there were 1,407 individuals insured through CHAND.

Senator Mathern requested additional information regarding whether CHAND pays billed charges or negotiated rates to providers.

Chairman Weisz called on Mr. Brad Gibbens, Interim Co-Director, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, Grand Forks, to provide information regarding its recent report on health and health care in North Dakota as it relates to the needs of underinsured and uninsured individuals and families in the state, the availability and affordability of health care services in the state, the role of telemedicine in providing health care services in the state, and efforts to increase health care services in rural North Dakota (Appendix F). Mr. Gibbens said North Dakota's health and health care are affected by demographic, social, and economic factors. He said population characteristics, including age composition, income levels, educational achievement, and changes in the number and distribution of people, affect health status. He said as rural populations age and as the number of residents declines, the ability of providers to maintain

and sustain local health systems is challenged. He said rural populations also tend to have lower incomes, higher poverty rates, and lower rates of insurance coverage. He said in addition to the 8.2 percent rate of uninsured identified in the study summarized by Dr. Baird, the State Health Access Data Assistance Center reported 11.5 percent uninsured in North Dakota for 2005 and 2006, the Kaiser Family Foundation reported 12.5 percent uninsured for 2007 and 2008, the Center for American Progress reported 13 percent uninsured for 2009, and the United States Census Bureau preliminary estimate was 10.5 percent uninsured for 2008. He said the actual number of individuals without insurance in North Dakota is estimated to be between 50,000 and 70,000. He said 44 percent of the uninsured reside in very rural areas, 36 percent reside in the four urban communities, and about 20 percent live in large rural towns. He said young adults (ages 18-24) had the highest uninsured rate at 15.9 percent and 8.1 percent of children under the age of 18 do not have coverage. He said according to the Kaiser Family Foundation, 65 percent of employers in the state offered health insurance coverage to their employees in 2007 and 2008. He said the percentage of premiums contributed by employees increased by 10.5 percent from 2003 to 2005. He said in addition to financial access, availability and access to care are influenced by other factors, including the availability of health care systems, number of providers, and geographic considerations such as distance, terrain, weather, and transportation resources. He said access is not increased if individuals have financial access, but care is not available.

Mr. Gibbens said health information technology and telemedicine are legitimate efforts to not only improve access to care, but also to improve the quality of care through the collection and sharing of clinical information, the reduction of errors, computer-aided decisionmaking systems, and enhanced patient and clinician communication. He said health information technology includes practice management systems, disease registries, clinical messaging, personal health records, electronic prescribing, electronic medical records, and health information exchanges.

Mr. Gibbens provided information regarding efforts to improve and increase rural health care in the state, including federal rural health grants, a critical access hospital quality network, emergency medical services access critical grants, community-based outpatient clinics for veterans' care, health professional workforce development, and efforts to increase the viability of rural hospitals.

In response to a question from Senator Fiebiger, Mr. Gibbens said some aspects of the recently passed federal health care legislation will have a positive effect on rural health care. He said some of the issues addressed in the health care reform bill that will benefit rural North Dakota include health care workforce, reimbursements, and emergency medical services.

Ms. Susan Mormann, Director, Heart Disease and Stroke Prevention Program, State Department of Health, provided information regarding an overview of the heart disease and stroke program and funding, including the implementation of 2009 House Bill No. 1339 and an update on the status of the stroke registry (Appendix G). She said the department receives $350,000 per year and is in the second year of a four-year project period. She said, as directed in the bill, the State Department of Health has established a Stroke System of Care Task Force. She said the task force is reviewing nationally recognized stroke-triage assessment tools and is working to identify a tool that can be standardized for North Dakota. She said the 2009 Legislative Assembly appropriated $472,000 to the State Department of Health to implement a stroke registry program. She said the funding has been allocated to statewide technology, chart entry, training, regional coordinators/technical assistance, warning signs and symptoms public awareness campaign. She said slightly more than 21 percent of the appropriation has been distributed as grants to 9 of the state's 42 hospitals.

In response to a question from Representative Conrad, Ms. Mormann said stroke registry funding will be used to hire a vendor to provide two to four temporary coordinators assigned to different regions of the state.

In response to a question from Representative Potter, Ms. Mormann said one hospital in the state is certified by the Joint Commission on Accreditation as a primary stroke center, but this hospital has not yet applied to the department for designation as a primary stroke center. She said two other hospitals are in the process of certification.

Ms. June Herman, Senior Director of Advocacy and State Health Alliances, American Heart Association, said the representative of the Dakota Medical Foundation was unable to attend the meeting. She said the Dakota Medical Foundation provided funding for the American Heart Association to launch the Go Red for Women heart disease awareness campaign in two communities. She said based on the response, in 2006 the Dakota Medical Foundation committed $1.25 million for a four-year demonstration project.

Ms. Joan Enderle, Director, Go Red for Women in North Dakota, American Heart Association, provided information regarding the results of the heart disease project (Appendix H). She said the initiative seeks to:

- Address women's cardiovascular health issues at a statewide level.
- Educate health care providers on cardiovascular disease and related women-specific issues.
- Implement targeted interventions in Fargo, Bismarck, and Jamestown.
- Reach disparate populations.
- Evaluate the program's impact through specific outcome measures.

Ms. Enderle said a survey was conducted in 2009 to assess the impact of the initiative. She said the survey indicated 92 percent of women who joined Go Red for Women made at least one lifestyle change to reduce their risk, 64 percent increased their exercise, 60 percent made heart healthy dietary changes, and 40 percent lost weight. She said a men-specific initiative is being considered. In addition, she said, a combination of federal and local funding has made possible a project to provide heart screenings in conjunction with the Women's Way program in the Dickinson area.

Ms. Sherry Adams, Executive Officer, Southwestern District Health Unit, provided information regarding a pilot project to target Women's Way-eligible populations for cardiovascular screenings (Appendix I). She said the Pathways to Healthy Lives program has been a part of the Southwestern District Health Unit for seven years. She said the primary components of the Pathways to Healthy Lives program have been lung, prostate, skin, colorectal, and female breast cancers and the promotion of healthy lifestyles. She said the My Heart My Health program is a pilot project in collaboration with the American Heart Association Go Red for Women to assist Women's Way clients ages 40-64 in Stark County in accessing heart health screenings and lifestyle intervention services. She said enrollment began in January 2010 with planned enrollment of 50 women.

Ms. Herman provided information regarding the funding of heart disease and stroke program efforts in North Dakota, including foundation, federal and state resources (Appendix J). She said the Centers for Disease Control and Prevention (CDC) has provided funding for a heart disease and stroke program in North Dakota. She expressed concern that recent federal budget proposals reduce heart disease and stroke program funding, which could affect funding for North Dakota's program.

In response to a question from Senator Kilzer, Ms. Herman said the heart disease and stroke program has not yet received any funding from the Tobacco Prevention and Control Committee but said she would explore opportunities for requesting funding for the heart disease and stroke program from the Tobacco Prevention and Control Committee.

Mr. James Pfeifer, Chief Clinical Officer, Prairie St. John's, Fargo, provided information regarding obstacles encountered by Prairie St. John's when offering telemedicine, specifically telepsychiatry services. He said Prairie St. John's is lacking an adequate number of physicians to provide telemedicine services in addition to the regular services provided at the clinic. In addition, he said, most payers require regular onsite visits for the patient to qualify for reimbursement. He said often the remoteness of the patient results in substantial travel time for the physician and limits the ability of the clinic to offer the service.

Senator Mathern suggested the committee receive an update regarding the impact of national health care reform issues on the state.

VOUCHER USE AND PROVIDER CHOICE FOR CLIENTS STUDY

Ms. Nancy McKenzie, Director, Division of Vocational Rehabilitation, Department of Human Services, provided information regarding contracts with private providers for substance abuse services (Appendix K). She provided a summary by region of human service center contracts for substance abuse and mental health services totaling $14.1 million for the 2009-11 biennium, including provider name, contract start and end date, type of service provided, contract type, and contract amount.

In response to a question from Senator Mathern, Ms. McKenzie said when determining whether to provide or contract for a service in a region, the department considers the client demand for services and available providers in the region. She said when fewer providers exist in a region, the department will provide more services at the human service center. She said total contract costs vary among regions because some regions may contract for more services while other regions may provide the service at the human service center.

Representative Conrad suggested the Department of Human Services summarize, along with the contract costs provided to the committee, the cost of substance abuse and mental health services provided by the department in each human service center to provide a total cost of substance abuse and mental health services in each region. She suggested the information include the number of people served, including the number of Native Americans. Chairman Weisz said the Department of Human Services will be asked to provide this information to the committee at a future meeting.

Ms. Karen Tescher, Assistant Director, Long Term Care Continuum, Medical Services Division, Department of Human Services, provided information on behalf of Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, regarding an update on the money follows the person developmental disabilities service demonstration project and the status of the program of all-inclusive care for the elderly (Appendix L).

Ms. Tescher said the Department of Human Services was awarded an $8.9 million Money Follows the Person (MFP) demonstration grant in 2007. She said the grant funding is available through 2013 and is to assist persons with a developmental disability, a physical disability, and older adults in transitioning from an institutional setting to a community setting through the increased use of home and community-based services. She said 14 individuals have transitioned from nursing facilities. She said 3 of the 14 have completed their 365 days of MFP eligibility and are now receiving home and community-based services. She said another 10 individuals are in the process of transitioning from nursing homes. She

said nine individuals have transitioned from intermediate care facilities. She said three of the nine individuals have completed their 365 days of MFP eligibility and are now receiving services through the developmental disability waiver. She said another three individuals are in the process of transitioning from the Developmental Center. She said the original goal was to transition 110 individuals, but the department has adjusted its goal to transition 81 individuals by the end of the grant period, 48 individuals from nursing homes and 33 individuals with developmental disabilities. She said one of the primary barriers to the transition of individuals from either nursing facilities or intermediate care facilities is lack of accessible and affordable housing.

In response to a question from Representative Conrad, Ms. Tescher said the $8.9 million MFP grant was originally intended to transition 110 individuals. She said the MFP funding includes an enhanced federal medical assistance percentage for the first 365 days of the transition to provide home and community-based services and provides up to $3,000 in supplemental funding to transition back into the community. She said this funding is used for furniture, deposits, household supplies, and adaptive equipment. She said all of the grant funds may not be spent by the end of the grant period.

Senator Mathern suggested the Department of Human Services provide a comparison of the costs associated with transitioning these individuals from an institutional setting to a community setting compared to the costs associated with the individuals had they stayed in either a nursing facility or an intermediate care facility. Representative Delzer suggested the department include full-time equivalent positions associated with the program, the costs associated with the supplemental funding required to transition the individuals back into the community, and administration costs. Chairman Weisz said the information would be requested of the Department of Human Services for presentation at a future meeting.

Ms. Tescher said the program of all-inclusive care for the elderly (PACE) is a capitated benefit program that provides a comprehensive service delivery system. She said the system includes all needed preventative, primary, acute, and long-term care services so the individual can continue to live at home or in the community. She said PACE providers assume full financial risk for the participant's care without limits on amount, duration, or scope of services. She said the PACE program began operating in Bismarck and Dickinson in September 2008 under the oversight of Northland Healthcare Alliance. She said 29 participants are currently being served in Bismarck, and 19 participants are being served in Dickinson. She said since the program began, PACE has had two participant deaths and six disenrollments. She said the PACE program was reviewed by CMS and Department of Human Services personnel in September 2009 and will be reviewed annually for the first three years of the program. She said the review identified no major deficiencies, but did note minor deficiencies involving documentation, resulting in quality assurance process improvement plans to include chart document audits, care plan audits, and other improvement programs.

The Legislative Council staff presented a memorandum entitled *Licensed Clinical Therapists in the State*. The Legislative Council staff said addiction counselors must be licensed by the Board of Addiction Counseling Examiners and provided information regarding the requirements for licensure. The Legislative Council staff said 334 licensed addiction counselors were licensed in the state as of January 2010. In addition, the Board of Counselor Examiners offers three counseling licenses--licensed associate professional counselor (LAPC), licensed professional counselor (LPC), and licensed professional clinical counselor (LPCC). The Legislative Council staff provided information regarding the requirements for each counseling licensure and said 359 licensed professional counselors were licensed in the state as of January 2010.

The Legislative Council staff presented a memorandum entitled *Department of Human Services' Providers - Comparison of Costs and Outcomes*. The Legislative Council staff provided information regarding cost-based rates for services provided by staff at selected human service centers and the contract rate for the same services when the department contracts for the service in the same human service region. In addition, the Legislative Council staff provided information regarding the Department of Human Services' mental health block grant outcome report, substance abuse prevention treatment block grant outcome report, and outcome information for youth who receive services.

In response to a question from Chairman Weisz, the Legislative Council staff said the significant difference between the two contract rates for residential therapeutic adult serious mental illness group service in the Northeast region was the result of one of the contract providers securing federal Housing and Urban Development funding which substantially reduced their costs.

In response to a question from Senator Mathern, Ms. Brenda Weisz, Chief Financial Officer, Department of Human Services, said the contracted rates provided in the memorandum include all of the costs to operate the facility and provide the service. She said the human service center rate is computed statewide and is determined by dividing all of the costs the state incurs to provide that service, including designated staff and supervision by the total units provided by the state. She said the statewide rate and the contract rates are submitted to Medicaid for reimbursement.

In response to a question from Representative Conrad, Ms. Weisz said Medicaid requires the state determine a consistent rate based on cost. As a result, she said, the department calculates a statewide

rate rather than different rates for each region of the state.

The Legislative Council staff presented a memorandum entitled *Voucher Systems in Other States*. The Legislative Council staff provided information regarding lessons learned from Round 1 of a 2004 federal Substance Abuse and Mental Health Services Administration access to recovery grant. She said each state receiving the grant was asked to provide information regarding its experiences in operating a voucher model for providing substance abuse treatment services. She said these experiences were summarized in a report entitled *Access to Recovery: Lessons Learned From Round 1 Grantees' Implementation Experiences* issued in March 2008. She said key lessons identified include:

- Service provider base:
  - Treat outreach as marketing via communications.
  - Adopt a systems perspective.
  - Deliver targeted training.
- Client base:
  - Implement client outreach.
  - Ensure informed client choice.
  - Define an appropriate client base.
  - Take advantage of existing structures.
- Administrative systems and procedures:
  - Plan ahead.
  - Develop logical procedures.
  - Understand contextual issues.
  - Provide oversight.
- Outcomes of treatment and recovery support systems:
  - Assess the outcomes of treatment and recovery support services.

Representative Hofstad suggested the committee members be provided a copy of the report entitled *Access to Recovery: Lessons Learned From Round 1 Grantees' Implementation Experiences* to the committee. The Legislative Council staff distributed copies of the report to committee members later in the meeting. A copy of the information presented is on file in the Legislative Council office.

Mr. Pfeifer expressed support of the use of a voucher system for uninsured and underinsured North Dakota residents to access mental health and chemical dependency services (Appendix M). He said human service centers often have waiting lists for services and may not provide the most appropriate services. He said distance to human service centers may also be an impediment to individuals being able to access the services. He said implementing a voucher system would:

- Empower the patient by allowing the patient to choose the provider.
- Provide the opportunity to receive care closer to home.
- Improve the quality of care.
- Reduce strain on the state system.
- Allow the State Hospital to function as a long-term psychiatric facility.
- Offer patient access to a full continuum of care.
- Better match the level of care to the patient's psychiatric needs.
- Improve public/private partnerships by increasing the network of resources available.

In response to a question from Representative Conrad, Mr. Pfeifer said neither the public nor the private system can adequately meet the state's needs. He said the solution requires collaboration of public and private providers. He said if individuals who have access to private providers were allowed to use those providers, the department could use its resources to provide services to individuals that do not have access to services.

OTHER COMMITTEE RESPONSIBILITIES

Regional Public Health Network Report

Ms. Kelly J. Nagel, Public Health Liaison, State Department of Health, provided information regarding the development of the regional public health network pursuant to 2009 Senate Bill No. 2333 (Appendix N). She said goals identified for the pilot project are to determine whether it is possible to create an effective joint powers agreement within the network and whether a joint powers agreement has the potential to produce cost-savings and more efficient and effective service delivery systems. She said the regional public health network task force met in December 2009 to develop the grant application and formulate a timeline for the pilot project. She said a letter of interest was due by February 1, 2010; proposals must be submitted by May 1, 2010; and sites will be awarded by June 15, 2010. She said all proposals will be reviewed by a selection committee consisting of three local public health unit administrators and two individuals from the State Department of Health. She said the selection committee will provide recommendations to the Health Council for final approval. She said one or more sites may be awarded up to $275,000. She said two letters of interest were received--one from Southeast Central, with Central Valley Health District in Jamestown being the lead health unit and the other from Southwest Central, with Bismarck Burleigh Public Health being the lead health unit.

In response to a question from Chairman Weisz, Ms. Nagel said both of the regions submitting letters of interest have four counties participating.

SERVICES FOR PREGNANT MINORS STUDY

The Legislative Council staff presented a memorandum entitled *Services to Pregnant Minors Study - Requested Information*.

The Legislative Council staff provided information regarding the number of Medicaid-eligible women that receive health and parenting education services. The Legislative Council staff said individuals, including pregnant minors, eligible for the Medicaid program receive all medically necessary services. In addition,

the Legislative Council staff said Medicaid also covers targeted case management services for high-risk pregnant women. A pregnant woman age 17 or younger at the time of the assessment is considered high-risk and therefore, eligible for targeted case management services--targeted case management services include assessment, case planning and preparation, case monitoring, care coordination, case evaluation, case reevaluation, health and parenting education, and followup home visits after the birth of the baby. Information received from the Department of Human Services indicates that in calendar year 2008, 13 targeted case management assessments were completed for individuals 17 years of age and younger and 36 targeted case management assessments for individuals 18 through 20 years of age. Case management assessment services for health and parenting education are not separated from other case management services when submitted to the department; therefore, the department is unable to identify which of the services were health and parenting education-related only.

The Legislative Council staff provided information regarding evidence-based outcome data on programs and their relationship to services provided. The Legislative Council staff provided information regarding the alternatives-to-abortion services program, the child care assistance program, and the maternal and child health Title V performance measures. The following is a summary of the services provided and the outcomes of the alternatives-to-abortion services program:

		Outcomes Reported[1]						
	Clients Receiving Services	Negative Pregnancy Test or Data Not Provided[2]	Client Still Pregnant	Miscarriage or Stillbirth	Abortion or Postabortion Counseling	Live Birth	Adoption or Foster Care	Client Parenting
November 1, 2006, to June 30, 2007	490	139	321	0	1	0	17	12
Fiscal year 2008	666	181	418	4	3	1	18	41
Fiscal year 2009	663	146	380	22	4	48	12	51

[1]Outcomes were identified based on the last service the clients received.

[2]In March 2008 the Department of Human Services revised the payment voucher. The department no longer tracks outcomes for a negative pregnancy test. In addition, some forms are submitted without outcome data. In fiscal year 2008, 119 women reported a negative pregnancy test and 62 forms did not include outcome data. In fiscal year 2009, negative pregnancy tests were no longer tracked and 146 forms did not include outcome data.

The Legislative Council staff said the child care assistance program allows for the payment of the actual cost of child care up to a maximum monthly amount for young parents who are age 20 years or under, are the primary caretaker of their child, and are pursuing their high school diploma or general educational development. Evaluations prepared each semester for participants in the child care assistance program are reviewed by the Department of Human Services, but the information is not compiled. The State Department of Health reports on several federal performance and state-negotiated measures relative to the maternal and child health grant, including the rate of birth (per 1,000) for teenagers ages 15 through 17 and the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester. Data included in the grant document was provided by the Division of Vital Statistics of the State Department of Health and the United States Census Bureau. The Legislative Council staff said based on data included in the grant document, the birthrate for teenagers ages 15 through 17 has increased from 2004 to 2008 as follows:

	2004	2005	2006	2007	2008
Birthrate per 1,000 teenagers ages 15 through 17[1]	10.2	10.5	10.6	11.3	12.3

[1]The census estimate of teenagers ages 15 through 17 remained consistent from 2004 to 2008.

Data in the grant document also indicates the percentage of infants born to pregnant women (all ages) receiving prenatal care beginning in the first trimester increased in 2005 and then began to decrease as follows:

	2004	2005	2006	2007	2008
Percentage of infants born to women receiving prenatal care beginning in the first trimester	84.9%	85.1%	83.2%	82.3%	82.0%

The Legislative Council staff also distributed information provided by the Division of Vital Records, which identifies births to teenagers under age 20 by ethnic group.

The Legislative Council staff provided information regarding a history of the number of births to minor mothers in the state. The following summary provides the number of births among North Dakota women and those younger than age 19, based on information received from the Division of Vital Records:

Year	Births to North Dakota Residents Age 18 and Under	Births to All North Dakota Residents	Births to North Dakota Residents Age 18 and Under as Percentage of Total Births to All North Dakota Residents
2000	393	7,676	5.12%
2001	384	7,664	5.01%
2002	350	7,755	4.51%
2003	340	7,976	4.26%
2004	347	8,179	4.24%
2005	366	8,381	4.37%
2006	373	8,616	4.33%
2007	382	8,818	4.33%
2008	369	8,931	4.13%

Ms. Carol Cartledge, Director, Public Assistance, Department of Human Services, appeared later in the meeting to address the committee's questions regarding the alternatives-to-abortion services program.

In response to a question from Representative Conrad, Ms. Cartledge said the department monitors the client services as long as the client receives services. She said when women receive a pregnancy test, they are also provided counseling and the counseling continues until the pregnancy is complete. She said if the women continue to seek services, the department will continue to receive information and will eventually know the outcome. She said if the client does not continue to receive services, the department does not have access to outcome information.

Representative Conrad asked the Department of Human Services to provide information on the number of women who do not continue receiving services of the program, the number of agencies providing services, and the number of clients served by each agency.

Senator Fiebiger suggested the committee receive information regarding the relationship of the rate of teen abortions to the rate of teen pregnancies.

In response to a question from Senator Mathern, Ms. Cartledge said agencies providing services other than abortion may enter into a memorandum of understanding with the department to be reimbursed for services. She said the memorandum outlines the services the department will reimburse and the reimbursement rate.

Senator Mathern asked the department to provide information regarding the memorandum of understanding it enters with providers, including services reimbursed and reimbursement rates.

Chairman Weisz asked the Department of Human Services to provide information regarding the postabortion counseling identified as an outcome in the alternatives-to-abortion services program.

In response to a question from Senator Mathern, Ms. Cartledge said the department intends to compare abortion statistics prior to the implementation of the alternatives-to-abortion services program to statistics after the program has been operational for a number of years to determine the effectiveness of the program.

Mr. Curtis Volesky, Director of Medicaid Eligibility, Medical Services Division, Department of Human Services, provided information on behalf of Ms. Anderson regarding the number of pregnant women who are denied Medicaid coverage because of excess income and, to the extent available, information on prenatal care services provided to these women, the household size of the individuals receiving Medicaid prenatal or delivery services and the income level of these households for 2007 and 2008, the number of teens receiving prenatal services through North Dakota CHIP in 2009, and a comparison of eligibility requirements, including income disregards and deducts of Medicaid and North Dakota CHIP (Appendix O).

Mr. Volesky said the department reviewed eligibility information for 2007, 2008, and 2009 and found no women were denied coverage. He said, however, certain pregnant women may have a recipient liability. He said if the recipient liability is more than the medical cost, the pregnant woman may be responsible to pay for the cost of services.

Mr. Volesky provided information regarding the number of pregnant women approved for Medicaid coverage by household size and the maximum monthly income allowed for coverage (133 percent of the federal poverty level). He said women may qualify at income above 133 percent of the federal poverty level, but would be required to pay a recipient liability equal to the amount greater than the medically needy income level, plus the amount of income they have that exceeds the 133 percent income level.

In response to a question from Chairman Weisz, Mr. Volesky said a pregnant minor in a Medicaid-eligible household continues to be part of the household and does not create a separate household for Medicaid eligibility reporting purposes.

Mr. Volesky said for 2009, CHIP provided prenatal services to 28 of 795 CHIP members during this period who were female ages 14 to 19.

Mr. Volesky provided information regarding Medicaid and CHIP eligibility requirements, including lists of income disregarded and income deductions.

Ms. Marilyn Rudolph, Director, North Central Human Service Center, Department of Human Services, provided information regarding the services and outcomes of the Oppen Home program (Appendix P). She said the Oppen Home, located in Minot, is now referred to as Kay's Place. She said the home has seven beds and serves girls 12-19 years of age. She said during fiscal year 2009, Kay's Place provided services to 17 girls. She said eight of these girls were pregnant. She said seven of the eight girls kept their babies, and one girl placed her baby for adoption.

In response to a question from Senator Mathern, Ms. Rudolph said Kay's Place is licensed as a group home by the state.

In response to a question from Representative Conrad, Ms. Rudolph said girls may be referred by county social services, but they also serve girls placed by the court and self-referrals.

Ms. Doe provided information regarding county services provided to pregnant minors (Appendix Q). She said all economic assistance programs, including SNAP, Medicaid, and temporary assistance for needy families (TANF), are available to pregnant minors. She said, however, in most cases eligibility for the programs is based on the pregnant minor's parent's income. She said most pregnant minors live with their parents, but if the pregnant minor has lived apart from her parents for at least three months, federal rules allow the use of the minor's income for determining eligibility. She said even though TANF eligibility is

based on the pregnant minor's parent's income, once the baby is born, the minor parent may apply for TANF for the child without regard to the grandparent's income.

Ms. Doe provided information regarding the Crossroads program, which is a child care assistance program to help minor parents finish high school. She said some county social service agencies use parent aides to work with the pregnant minor. She said the parent aides can assist the pregnant minor with a variety of tasks, including transportation to prenatal appointments and budgeting. She said other services include women, infants and children (WIC) supplemental food program; Health Tracks; Healthy Families, which is a home visiting program for pregnant and post partum minors and their infants available in Grand Forks, Nelson, Burleigh, and Morton Counties; and the Optimal Pregnancy Outcome Program.

In response to a question from Senator Mathern, Ms. Doe said the county directs the pregnant minor to programs and receives referrals from nonprofit agencies, human service centers, and physicians.

Ms. Valerie J. Fischer, Director, School Health, Department of Public Instruction, provided information regarding services for pregnant minors, and whether additional education and social services would enhance the potential for a healthy child and a positive outcome for the minor. She said the Department of Public Instruction does not require schools to report pregnant minors; therefore, the department does not have information regarding their success or graduation rate. She said the department does not have programs specifically relating to pregnancy, but does have information available to school counselors. Regarding education, she said, the state requires one credit of physical education, which can include up to one-half credit of health education. She said health education is offered at the discretion of the school district, and it is the district that determines the content of the health education class.

In response to a question from Senator Fiebiger, Ms. Fischer said because state law does not require information to be collected on the number of school districts providing sex education courses, school districts do not report the information to the department.

Chairman Weisz asked the Legislative Council staff to arrange for an alternatives-to-abortion services program provider to provide information to the committee at a future meeting regarding the services provided and information regarding the number of women who chose abortion.

Representative Frantsvog suggested the committee receive information regarding funding for abortions.

STUDY OF THE EFFECT OF FEDERAL, STATE, AND COUNTY GOVERNMENT FUNDING AND ADMINISTRATION ON THE SOCIAL SERVICE PROGRAMS OF TRIBAL GOVERNMENTS

Chairman Weisz called on Mr. Vincent N. Gillette, Director, Sioux County Social Services, to provide information regarding a history of social services and related funding on tribal lands, the involvement of the tribes in the budget development process of Sioux County Social Services, collaboration with the tribes and the Department of Human Services in providing services on the reservation, and the child abuse and neglect referral process in Sioux County (Appendix R). He said Sioux County is unique because it is one of only eight counties in the nation that are entirely encompassed on an Indian reservation. He said funding for child welfare services on the reservation is provided from different sources, including Bureau of Indian Affairs (BIA) 638 contracts, gaming compacts with the state, Medicaid targeted case management, and Title IV-E foster care funding. He said in calendar year 2009, the state paid $491,745 for the foster care of Standing Rock Sioux Tribe children.

Mr. Gillette said 99 percent of the caseload in Sioux County is Native American. He said the Standing Rock Sioux Tribe is not contacted in the development of the county social services budget, but the tribe may provide input at the budget hearings.

Mr. Gillette said the Department of Human Services, through the human service centers, provides services to the Standing Rock Reservation, including seriously emotional disturbed and developmental disabilities case management. He said the regional representative for social services participates in Standing Rock Sioux Tribe children and family team meetings for Title IV-E children. He said Sioux County Social Services interacts daily with Standing Rock child protection workers regarding payment, placement, jurisdiction, and Medicaid issues. He said although the county interacts with the tribe, there is not much collaboration between the county, state, tribes, and BIA. He said each governmental entity has varying degrees of responsibility for the same services, which leads to the duplication of most services by the tribes and other government agencies.

Mr. Gillette said the federal BIA is responsible for providing services on the reservations. He said in 1975 the federal government, through the Indian Self-Determination and Education Assistance Act (Public Law 93-638), allowed tribal governments to contract with the BIA to provide certain services or programs. He said this can result in four social service agencies serving one reservation, including BIA Social Services, the Standing Rock Sioux Tribe Child Protective Services, the IHS, and the Sioux County Social Services. He said determining which agency has jurisdiction in child welfare cases is often a

challenge. He said Sioux County Social Services, Standing Rock Child Protective Services, the Federal Bureau of Investigation, Bureau of Criminal Investigation, and Sioux County Sheriff's Department may need to investigate a case exclusively or in conjunction with one another. He said if the child is Native American, a memorandum of understanding with the tribe signed in 1983 prohibits the state from being involved in the assessment and placement of a Native American child.

Ms. Beverly J. Mathiason, Director, Rolette County Social Services, provided information regarding the involvement of the tribes in the budget development process of county social services offices, collaboration with the tribes and the Department of Human Services in providing services on reservations, and the child abuse and neglect referral process in Rolette County (Appendix S). She said Rolette County administers SNAP and the TANF program. She said approximately 90 percent of the TANF caseload and 80 percent of the SNAP caseload is Native American. She said the Department of Human Services has contracted with the Tribal Employment and Training program to provide job opportunities and basic skills program services. She said the department also has a memorandum of understanding for another tribal program, the Tribal New program. She said the contract and the memorandum of understanding require communication and coordination with the county and the tribal programs to ensure clients are properly referred and are compliant. She said both the county and the tribe operate child care and fuel assistance (LIHEAP) programs. She said the budget is published each year, and a public hearing is held to gather comments.

Mr. Bryan A. Quigley, Director, Mountrail County Social Services, provided information regarding the involvement of the tribes in the budget development process of county social services offices, collaboration with the tribes and the Department of Human Services in providing services on reservations, and the child abuse and neglect referral process in Mountrail County (Appendix T). He provided examples of collaboration between Mountrail County Social Services and the Three Affiliated Tribes of the Fort Berthold Reservation, including:

- Outreach by eligibility workers.
- Assessments.
- The use of Mountrail County Social Services licensed foster homes for Three Affiliated Tribes Social Services placements.
- The Dreamcatchers Servant Camp, a volunteer renovation and repair of homes for families in need.

Mr. Quigley said more collaboration is needed regarding the funding of foster care and child abuse and neglect. He said direct involvement of the tribe in the budgeting process is minimal. He said the budget is published and public hearings are held each year before the budget is finalized. He said approximately 75 percent to 80 percent of economic assistance clients are Native American, and approximately 50 percent to 60 percent of the home and community-based service clients are Native American.

Mr. Edward D. Forde, Director, Benson County Social Services, provided information regarding the involvement of the tribes in the budget development process of county social services offices, collaboration with the tribes and the Department of Human Services in providing services on reservations, and the child abuse and neglect referral process in Benson County (Appendix U). He said Benson County provides outreach to Fort Totten 4.5 days per week in space provided by Spirit Lake Tribal Social Services. He said Benson County administers SNAP and the TANF program. He said approximately 87.5 percent of the TANF caseload and 68.8 percent of the SNAP caseload is Native American. He said both the county and the tribe operate child care and fuel assistance LIHEAP programs. He said child abuse and neglect reports relating to Native American children residing on the reservation are referred to tribal social services. He said tribal social services is typically understaffed, and work is often limited to crisis resolution and referral to other service agencies. He said Benson County has three licensed child foster care homes. He said 92.1 percent of the foster care caseload is Native American. He said tribal social services certifies its own foster care homes. He said certain counties explored sharing child welfare staff with tribal social services offices that were understaffed, but were unable to agree on funding issues. He said 60.6 percent of the home and community-based service program clients are Native American. He said the budget is developed based on history and service trends and published at least two weeks before final approval.

Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, provided information regarding tribal social services programs. He said it is necessary to develop a spirit of collaboration between the state and the tribes. He said recent memorandums of understanding are evidence that collaboration can be achieved.

Mr. Kevin Dauphinais, Director, Spirit Lake Social Services, provided information regarding tribal social services programs (Appendix V). He expressed concern regarding the understaffing of child protective services staff. He said in 2007 there were approximately 202 reports of child abuse and neglect to Spirit Lake Social Services, of which 26 cases of sexual abuse, 48 physical abuse, and 78 neglect cases were substantiated. He said Spirit Lake Social Services has one child protective services investigator. He said as of October 1, 2009, Spirit Lake Social Services has received approximately 127 reports of child abuse and neglect. He said a state grant providing two parent aides has had a positive impact on families. He provided a BIA funding schedule for 2010-11 indicating the Spirit Lake Tribe would receive $311,508 in 638 funds for tribal social services. He said the funding was

intended for foster care, but must also be used for child protective services.

Senator Mathern suggested representatives of agencies involved in providing the services on reservations meet and develop and outline a solution to service barriers. He requested the group provide specific proposals regarding staffing, jurisdiction, and funding that could lead to the development of a memorandum of understanding. He suggested an update of this group's progress be provided to the committee at its next meeting.

Representative Conrad suggested the North Dakota Association of Counties be involved in facilitating the meeting that could involve Indian reservations and counties across the state.

Mr. Davis said the 2009 Legislative Assembly provided funding for a North Dakota Indian education advisory council to address education issues on the reservation. He suggested a tribal and county social service advisory council could be formed with tribal, county, and state representatives to develop solutions to the current issues faced by county and tribal social services.

Ms. Tara Lea Muhlhauser, Director, Children and Family Services, Department of Human Services, provided information regarding changes in Department of Human Services memorandums of understanding with the tribes for child protective services and foster care, including examples of current memorandums of understanding (Appendix W). She said Title IV-E funding is federal funding used to provide payment for maintaining children in a foster care placement. She said memorandums of understanding allow tribes to claim these federal funds for payment of foster care-related expenses for children that meet Title IV-E eligibility. She said claims are made through the state and reimbursement is made to the tribe. She said Children and Family Services currently has foster care-related memorandums of understanding with every tribe in the state. She provided copies of a memorandum of understanding with Three Affiliated Tribes and an addendum to the memorandum of understanding with Standing Rock Sioux Tribe. She said the Standing Rock Sioux Tribe memorandum of understanding addendum is unique because it involves the State of South Dakota and allows for a claim across state lines. She said there are currently no memorandums of understanding in place for child protective services.

In response to a question from Chairman Weisz, Ms. Muhlhauser said Title IV-E funding cannot be used for child protective services assessments because it is not available until the child is placed in foster care.

In response to a question from Senator Mathern, Mr. Craig Poitra, Western Workforce Project Coordinator, Native American Training Institute, said the institute has a contract with the Department of Human Services and will be meeting with it quarterly on the reservations to address several topics, including training to enhance collaboration between the tribes and the counties. He said the issue of child protective services could also be addressed by the group. He said the institute receives funding from various sources, including grants and contracts. He said the institute could assist in organizing a stakeholders meeting.

IMMUNIZATION PROGRAM STUDY

Mr. Randy Eken, Associate Dean, Administration and Finance, University of North Dakota School of Medicine and Health Sciences, provided information via teleconference regarding its involvement in the state's immunization program, including billing, billing services, fee collections, and uncollectible accounts (Appendix X). He said the State Department of Health asked the School of Medicine to assist with the insurance company billing process for local public health units' immunization programs. He provided a list of the services currently provided to local public health units by the School of Medicine, including billing services, fee collections, and uncollectible accounts. He said the School of Medicine receives claims through electronic transfer from Blue Cross Blue Shield of North Dakota on a weekly basis, processes the claims, works with the insurance companies, and receives insurance remittance. He said School of Medicine withholds $2 per administration fee billed by the local public health units for processing. He said payment, as adjusted for the processing fee, credit card fees, and insurance adjustments, is sent to the local public health units on a monthly basis. He said it was not unexpected, but this process has resulted in the School of Medicine providing payment to the local public health units prior to collecting the revenue. He said currently the School of Medicine is carrying a negative balance of approximately $91,000 in accounts with local public health units. He said the School of Medicine has assisted local public health units in reconciling the monthly payments.

Representative Frantsvog suggested the committee receive an update regarding the delay in the processing of the electronic member claims at its next meeting.

Ms. Laura Olson, Business Manager, PROtect ND Kids, State Department of Health, provided information regarding the status of the public health units' immunization programs and the status of the independent quality improvement evaluation of the state's immunization program (Appendix Y). She said the local public health units enter immunizations and insurance and billing information into the North Dakota Immunization Information System triggering the billing process. She said HL7 bi-directional transfer allows for the sharing of data electronically in two directions and eliminates the need for dual entry of immunization information. She said the department is partnering with Altru Health Systems to pilot the HL7 bi-directional transfer.

Ms. Olson said Dr. William Riley, Associate Dean, University of Minnesota School of Public Health, has been retained for the independent quality improvement evaluation of the state's immunization program. She said a steering committee has been established to work with Dr. Riley to make project decisions. She said the four local public health unit pilot sites include First District Health Unit in Minot, Walsh County Health District in Grafton, Central Valley Health District in Jamestown, and City-County Health District in Valley City.

In response to a question from Representative Delzer, Ms. Olson said the department did an alternate procurement request based on the capacity of this contractor to work with both local public health units and private providers. She said the study will cost up to $90,000. She said the department has applied for a $10,000 grant from the Dakota Medical Foundation and will use $35,000 from the department's state general fund appropriation. In addition, she said, $45,000 of the funding provided in 2009 Senate Bill No. 2333 was approved by the PROtect ND Kids Task Force and the Health Council for use on this study.

Ms. Lisa Clute, Executive Officer, First District Health Unit, Minot, provided information regarding the status of the immunization program (Appendix Z). She provided a summary of cashflow status for local public health units identifying whether the local public health unit is in deficit, surplus, or at breakeven. She said administrators noted that funding provided in Senate Bill No. 2333 and the high volume of flu vaccinations administered in 2009 assisted them financially. She said local public health unit administrators support the study and are looking forward to identifying efficiencies.

In response to a question from Senator Mathern, Ms. Clute said the local public health units were involved in the selection and the procurement of the study contractor.

In response to a question from Representative Delzer, Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, said the department received American Recovery and Reinvestment Act of 2009 funding, but it could not be used for immunization losses at the local public health units as provided in Senate Bill No. 2333.

Representative Delzer suggested the State Department of Health provide information regarding the use of American Recovery and Reinvestment Act of 2009 funding appropriated in Senate Bill No. 2333 and, if applicable, the use of contingent general funds appropriated in Senate Bill No. 2333. In addition, Representative Delzer suggested the department provide a summary of all general funding provided for the immunization system.

In response to a question from Representative Pollert, Ms. Smith said the local public health units are planning for their immunization programs to be self-sustaining. She said the local public health units have identified other programming needs for billing systems in home health services and family planning.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Weisz anticipates the next committee meeting will be in June 2010.

It was moved by Senator Mathern, seconded by Representative Pollert, and carried on a voice vote that the Health and Human Services Committee meeting be adjourned subject to the call of the chair.

Chairman Weisz adjourned the meeting at 4:21 p.m.

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Sheila M. Sandness
Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:26