NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Thursday, July 28, 2011
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Spencer D. Berry, Ralph L. Kilzer, Tim Mathern, Gerald Uglem, John Warner; Representatives Kathy Hogan, Karen Karls, Robert Kilichowski, Jon Nelson, Mark S. Owens, Vonnie Pietsch, Karen M. Rohr, Mark Sanford

Members absent: Representatives Stacey Dahl, Robin Weisz

Others present: See Appendix A

Mr. Allen H. Knudson, Legislative Budget Analyst and Auditor, reviewed the *Supplementary Rules of Operation and Procedure of the North Dakota Legislative Management*.

COMMENTS BY COMMITTEE CHAIRMAN

Chairman Lee welcomed the committee and encouraged the members to fully participate in study discussions.

REGIONAL PUBLIC HEALTH NETWORK PILOT PROJECT STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Regional Public Health Network Pilot Project Study - Background Memorandum* relating to the committee's assigned responsibility to study the regional public health network pilot project conducted during the 2009-11 biennium.

The Legislative Council staff said the Legislative Assembly approved 2011 House Bill No. 1004. Section 8 of the bill provides the Legislative Management study the regional public health network pilot project conducted during the 2009-11 biennium, including services provided, effects of the project on participating local public health units, efficiencies achieved in providing services, cost-savings to state and local governments, and possible improvements to the program.

The Legislative Council staff said North Dakota Century Code Chapter 23-35 contains public health law. The Legislative Assembly in 1999 required that all land in the state must be in a public health unit by January 1, 2001. As a result of that requirement, 28 public health units have been established. The public health units take a variety of forms, including:

- 7 multicounty health districts;
- 11 single county health districts;
- 3 city/county health departments;
- 1 city/county health district; and
- 6 single county health departments.

Chapter 23-35 includes provisions relating to establishing public health units, including the establishment of multicounty or city/county health districts and authority for health districts to merge into a single health district. Chapter 54-40.3 allows public health units to enter joint powers agreements with other public health units upon approval of each governing body to provide shared services. A public health district has a separate governing board, while a public health department is an agency within a city or county government.

The Legislative Council staff said although all areas of the state are required to be included within a public health unit, state law does not mandate any minimum requirements or establish any expectations of services for public health units. A county may allocate funding not exceeding the amount raised by levying up to five mills to support public health units. In addition to the local tax funding, public health units receive state and federal grants and fees collected for services. Because funding levels and service areas vary for the 28 public health units, the services provided also vary.

The Legislative Council staff said the American Public Health Association Committee on Administrative Practice has adopted core functions and 10 essential services to guide public health decisionmaking and operations. The core functions are:

1. Assessment - Activities to evaluate the current health level and current threats to health in the community.
2. Policy development - Developing policies to address the identified health threats and problems.
3. Assurance - Implementation of policies to improve public health.

Each of the core functions includes essential services that provide the framework for measuring and improving public health practice. According to the American Public Health Association, the following 10 essential public health services should be provided to citizens by the public health system:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal-based and population-based health services.
10. Research new insights and innovative solutions to health problems.

The Legislative Council staff said results of a 2002 national survey of local public health units involving the assessment of the three core functions of public health indicated local public health units serving fewer than 25,000 individuals do not have the capability to conduct the core functions. In North Dakota 20 of the state's 28 local public health units serve fewer than 25,000 individuals each.

The Legislative Council staff said the Legislative Assembly approved 2009 Senate Bill No. 2333, which created regional public health networks. Section 1 of Senate Bill No. 2333 established regional public health networks that correspond to the emergency preparedness and response regions established by the State Department of Health. The regional public health networks must share a minimum of three administrative functions and a minimum of three public health services. Participation by local public health units is voluntary. The bill provided $275,000 from the general fund to the State Department of Health for a regional public health network pilot project during the 2009-11 biennium.

The Legislative Council staff said pursuant to Section 2 of Senate Bill No. 2333, the State Health Officer was to appoint a regional public health network task force to establish protocol for the regional public health network. A regional public health network is defined as a group of local public health units that have entered a joint powers agreement or an existing lead multidistrict health unit identified in the emergency preparedness and response region that has been reviewed by the State Health Officer and verified as in compliance with the following criteria:

- The geographical region corresponds to one of the emergency preparedness and response regions.
- The regional network shares emergency preparedness and response and environmental health services and shares a regional public health network health officer.
- The joint powers agreement:

  Includes sharing at least three administrative functions and at least three public health services identified in Section 23-35.1-02(3)(b).

  Provides for the future participation of public health units that were not parties to the original joint powers agreement and an appeal process for any application denials.

  Provides the structure of the governing body of the network.
- The regional network complies with other requirements adopted by the Health Council by rule.
- The regional network meets maintenance of effort funding requirements.

The Legislative Council staff said each regional public health network was to prepare an annual plan regarding the provision of required and optional public health services that must be approved by the State Health Officer and may receive and expend money for the provision of services.

The Legislative Council staff said Southeast Central in the Jamestown region was selected as the regional public health network pilot site and was approved by the Health Council to receive the $275,000 public health network pilot grant. Participating health units were:

- Central Valley Health District - Jamestown;
- City-County Health District - Valley City;
- LaMoure County Public Health Department - LaMoure; and
- Wells County District Health Unit - Fessenden.

The Legislative Council staff said the pilot network established a joint powers agreement in July 2010 to share family planning, sexual assault response, and chronic disease management services. The shared administrative functions provided in the agreement include billing, accounts receivable, policy standardization for public health services, and implementation of community health assessment data. A baseline evaluation revealed participants were supportive of the regional project but also expressed concern that mandates may result from the project without adequate input from all participants. The State Department of Health reported to the 2011 Legislative Assembly that overall benefits of the shared functions have been access to and shared staff expertise, especially for system training and writing policies and procedures, as well as access to the electronic systems which were purchased at a reduced group cost. The department reported the pilot project allowed health units that did not have the means or capacity to recoup revenue for services to now have the capability to do so, and as a result, staff has reduced the time necessary to process insurance claims by as much as five times and reduced the

number of steps involved by 50 percent. The department reported other accomplishments of the pilot project include:

- Completion of a draft community health assessment for all network members.
- Website development for all local public health units.
- Completion of a family planning client survey and scheduling of evening clinic hours for network clients.
- Coordination with community partners of network members to provide education about the sexual assault response program.

The Legislative Council staff said in August 2010 a joint powers agreement formed the North Dakota State Association of City and County Health Officials--a state association for North Dakota local public health units. Similar associations have been formed in other states to streamline communications between state and local public health agencies and to receive current information on national public health initiatives, including quality improvement and public health accreditation. The purpose of the association is to improve coordination of local public health department efforts across the state, enhance consistent messaging and education, improve training and advocacy, and share best practices. The association is governed by a 10-member executive committee with representatives from local public health units, the State Department of Health, and the North Dakota Association of Counties.

The Legislative Council staff said the 2011-13 executive recommendation for the State Department of Health in House Bill No. 1004 included $275,000 of one-time funding from the general fund to establish joint powers agreements to form another regional public health unit during the 2011-13 biennium. In addition, the executive recommendation included $2.4 million from the general fund for grants to local public health units. The Legislative Assembly increased funding from the general fund for grants to local public health units by $600,000 to provide a total of $3 million from the general fund, removed the one-time funding included in the executive budget to establish another regional public health network, and provided for a study of the regional public health unit pilot program conducted during the 2009-11 biennium.

The Legislative Council staff said the state grants to local public health units are distributed to each unit pursuant to a formula developed by the State Department of Health. The department currently provides $400,000--$50,000 per unit--to the eight lead health units to provide regional environmental health services during the biennium. The remaining funds are distributed through a formula that provides each public health unit with 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 the following proposed study plan for the committee's consideration:

1. Gather and review information regarding services provided and administrative functions shared by the regional public health unit established pursuant to the regional public health network pilot project conducted during the 2009-11 biennium.
2. Gather and review information regarding the effects of the regional public health network pilot project on participating local public health units.
3. Gather and review information regarding efficiencies achieved in providing services through a regional public health unit.
4. Gather and review information regarding cost-savings to local governments participating in the regional public health unit pilot program and to the state.
5. Receive information from the State Department of Health and the local public health units regarding possible improvements to the regional public health network program and whether any local public health units are interested in establishing additional regional public health networks.
6. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
7. Prepare a final report for submission to the Legislative Management.

Chairman Lee said statewide flooding has been a challenge for public health units due to increased demands on resources available. She said the pilot project was intended to be flexible and was modeled after the regional education associations formed by joint powers agreements of public schools.

Representative Hogan suggested the committee receive information regarding collaborations of other public health units that are not part of the pilot project.

Ms. Kelly Nagel, Public Health Liaison, State Department of Health, provided information regarding the regional public health network conducted during the 2009-11 biennium (Appendix B). She said the western part of the state consists primarily of multicounty health districts, while the eastern part of the state consists mostly of single county health districts and departments. She said there are three city health departments in the state--Bismarck, Fargo, and Grand Forks. She said a regional infrastructure was established for emergency preparedness and response with a lead local public health unit in each of the eight regions. She said the state health officer appointed the regional public health network task force to develop criteria and prepare a grant document for the regional public health network pilot project. She said the regional public health network must consist of newly formed relationships within the emergency preparedness region in order to be eligible for the grant. She said a multicounty health district comprising an entire emergency preparedness region was not eligible. She said proposals were received from two regions--Southeast Central with Central

Valley Health District in Jamestown being the lead health unit and Southwest Central with Bismarck/Burleigh Health Department being the lead health unit. She said Southeast Central in the Jamestown region was selected as the pilot site, and the network entered a joint powers agreement in July 2010. She said the entire $275,000 appropriated for the regional public health network pilot project was spent during the 2009-11 biennium with 76 percent of the funding spent on personnel.

Ms. Tami Dillman, Finance Manager, Central Valley Health District, Jamestown, appeared on behalf of the Southeast Central Regional Public Health Network to provide information regarding the local public health units involved in the pilot project (Appendix C). She said Central Valley Health District is the lead public health unit in its emergency preparedness region and provides environmental health services to the counties in the region. She said that Central Valley Health District also collaborates with counties outside its emergency preparedness region to provide services, such as tobacco prevention and control. She said shared administrative functions included billing, accounts receivable, policy standardization for public health services, and implementation of community health assessment data. She said administrative functions were selected to build capacity and strong policies, and community health assessments are key to public health accreditation. She said shared services included family planning, sexual assault response, chronic disease management, and immunization. She said services were chosen to support existing programs based on the potential for expansion to outlying areas and supported by data from county health profiles (Appendix D). Chairman Lee suggested that electronic copies of the county health profiles be provided to the committee members.

In response to a question from Senator Mathern, Ms. Dillman said, where possible, collaboration is continuing through partnerships that existed previously. She said changes made to processes will be ongoing. She said there will be a cost to continue, but most of the cost of the pilot project was labor costs to set up the network.

Representative Nelson suggested the committee receive a list of services added and improved by the regional public health network pilot project, including the locations benefiting by the service improvements.

In response to a question from Representative Nelson, Ms. Dillman said while emergency preparedness and environmental health could not be considered one of the three shared services for purposes of the pilot project, public health units in their emergency preparedness region have agreed to contribute to the cost of environmental health services provided by the lead public health unit.

Representative Nelson suggested the committee receive information regarding the level to which public health units are participating in the cost of environmental health services provided by the lead public health unit.

In response to a question from Representative Nelson, Ms. Dillman said the transition from the University of North Dakota (UND) School of Medicine and Health Sciences billing system required local public health units to determine how they would continue to bill for immunizations. She said because of the network relationship, pilot project partners already had a billing system in place.

Ms. Theresa Will, Administrator, City-County Health District, Valley City, said the pilot project was a collaborative effort. She said each participant was provided equal representation and participated in the decisions of the network. She said positive, trusting relationships were formed, and the pilot project was an opportunity to make necessary changes in administration, including changes in registration, billing, charting, and filing.

In response to a question from Senator Lee, Ms. Will said the pilot project was a positive experience, and she was not aware of negative outcomes.

Ms. Karen Volk, Administrator, Wells County District Health Unit, said the health unit updated its time and billing systems and are pleased with the efficiencies and time savings realized as a result of the pilot project. She said policies and procedures have been made available online, and the website established for the project has been helpful. She said these improvements would not have been possible without the pilot project. She said environmental health services did not exist in Wells County prior to the project. She said with the assistance of Central Valley Health District, the Wells County District Health Unit has established public health ordinances. She said Central Valley Health District assisted with training and answering questions.

In response to a question from Representative Nelson, Ms. Volk said Wells County District Health Unit contracts with Central Valley Health District for septic inspections.

At the request of Representative Hogan, Ms. Dillman provided a copy of the pilot project joint powers agreement (Appendix E).

Ms. Sophia Prezler, Bismarck, distributed information regarding the committee's agenda (Appendix F).

It was moved by Senator Warner, seconded by Representative Sanford, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding services provided and administrative functions shared by the regional public health unit established pursuant to the regional public health network pilot project conducted during the 2009-11 biennium.**
2. **Gather and review information regarding the effects of the regional public health**

network pilot project on participating local public health units.

3. **Gather and review information regarding efficiencies achieved in providing services through a regional public health unit.**
4. **Gather and review information regarding cost-savings to local governments participating in the regional public health unit pilot program and to the state.**
5. **Receive information from the State Department of Health and the local public health units regarding possible improvements to the regional public health network program and whether any local public health units are interested in establishing additional regional public health networks.**
6. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
7. **Prepare a final report for submission to the Legislative Management.**

STUDY OF THE FEASIBILITY OF PLACING THE FORT BERTHOLD RESERVATION IN A SINGLE PUBLIC HEALTH UNIT

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Study of the Feasibility and Desirability of Placing the Fort Berthold Reservation in a Single Public Health Unit - Background Memorandum* relating to the committee's assigned responsibility to study the feasibility and desirability of placing the entire Fort Berthold Reservation in a single public health unit. The Legislative Council staff said the Legislative Assembly approved 2011 Senate Concurrent Resolution No. 4012 which provides the Legislative Management study the feasibility and desirability of placing the entire Fort Berthold Reservation in a single public health unit. She said the 2005-06 interim Budget Committee on Human Services studied the state's public health unit infrastructure and the ability of the health units to respond to public health issues. The committee heard reports from a number of public health units across the state regarding the services and funding of each unit and suggestions for improving public health services in the state. Concern was expressed by representatives of certain health units that counties with tribal lands are unable to generate adequate county funding because tribal lands are not subject to property taxes and the statutory mill levy for public health is limited to five mills, which does not allow additional funding to be raised at the local level for meeting program needs.

The Legislative Council staff said during the 2011 legislative session, the State Department of Health provided the following information to the Legislative Assembly regarding Senate Concurrent Resolution No. 4012:

- Local public health funding is approximately 30 percent federal funds, 35 percent local funds, 5 percent state aid, and the remainder comes from third-party reimbursement and fee collections.
- Local public health units provide or contract for services on the reservation but challenges include culture, capacity, geographic boundaries, and statutory authority.
- Previously the Fort Berthold Reservation was chosen for a performance improvement plan pilot program. The Fort Berthold Reservation is served by four health units--First District Health (Minot), Upper Missouri District Health (Williston), Custer Health (Mandan), and Southwestern District Health (Dickinson). The department sought input from the four health units and tribal health and determined improved coordination and planning at state and local levels could improve service. The department indicated a tribal local public health unit was explored. The State Department of Health testified challenges of placing the entire Fort Berthold Reservation in a single public health unit include financial impact on local public health units, funding of a tribal public health unit, structure of the tribal public health unit, and geographic access.

The Legislative Council staff said the Legislative Assembly in 2011 provided $3 million from the general fund for state aid to public health units during the 2011-13 biennium, an increase of $600,000 from the 2009-11 biennium. The state aid funds are distributed to each health unit pursuant to a formula developed by the State Department of Health that provides each public health unit a base allotment per biennium with the remainder of the funding being distributed on a per capita basis, including reservation populations.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Receive information from representatives of the following regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit:

   Fort Berthold Reservation.

   State Department of Health.

   Local public health units serving the Fort Berthold Reservation.
2. Receive information from representatives of the Tax Commissioner regarding the property tax revenue generated for local public health on the Fort Berthold Reservation.
3. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
4. Prepare a final report for submission to the Legislative Management.

Senator Warner suggested the committee receive information regarding the availability of federal Bureau of Indian Affairs (BIA) funding for placing the Fort Berthold Reservation in a single public health unit.

Representative Hogan suggested the committee receive information regarding the delivery of public health services on the other reservations in the state.

Dr. Thomas Walker, Chief Medical Officer, Three Affiliated Tribes of the Fort Berthold Reservation, provided information regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit (Appendix G). He said the Fort Berthold Indian Reservation is part of the Aberdeen, South Dakota, Service Area of the Indian Health Service (IHS). He said the 2010 census indicated 6,341 people live on the Fort Berthold Reservation, of which 4,556 are Native American. He said the number of nontribal members continues to increase as the oil and gas industry expands in the area.

Dr. Walker said placing the entire Fort Berthold Reservation in a single public health unit would improve communication and coordination of public health services, such as immunizations. He said challenges include jurisdiction, staffing, and funding. He said the funding issue is complicated by a mixture of trust land and nontrust land (fee land) on the reservation. He said the tribe and tribal members pay property taxes on fee land, and although reservation trust land is exempt from property taxes, the federal government makes payments in lieu of property taxes on federal and reservation trust lands. He suggested funding from these federal payments or from revenues collected by the state for oil and gas production on reservation trust land could be used to provide funding for a reservation public health unit.

In response to a question from Senator Mathern, Dr. Walker said health services are currently being paid by federal funds available from IHS, tribal funds, and service billings. He said the level of participation by the four public health units serving the reservation varies.

In response to a question from Senator Mathern, Dr. Walker said ideally, a Fort Berthold public health unit would be operated separately from the tribe. He said a large portion of the population increase is nonnative, and because federal funding (IHS) is intended for the native population, it may not be used for costs relating to the nonnative population.

Senator Lee said collaboration and possibly a regional public health network agreement could benefit a Fort Berthold public health unit.

In response to a question from Senator Lee, Dr. Walker said in addition to IHS funding restrictions, other issues include culture and access. He said area roads have deteriorated due to heavy traffic, and travel by emergency personnel is dangerous.

Senator Lee suggested the committee receive information from the State Department of Health regarding whether any reservations in other states have been placed in a single public health unit and the challenges and benefits of the change.

In response to a question from Senator Mathern, Ms. Phyllis Howard, Past President, Fort Berthold Community College, said the Fort Berthold Community College serves both tribal and nontribal members and has a governing board separate from the tribe. She said the tribal chairman and communities have representation on the community college board.

In response to a question from Representative Nelson, Dr. Walker suggested oil and gas tax revenue collected by the state for oil and gas production on the reservation be returned to the reservation to pay for services and infrastructure.

In response to a question from Representative Nelson, Ms. Nagel said public health governing boards are typically determined by county commissioners. She said tribes have no representation on county commissions.

Senator Mathern suggested Dr. Walker develop a proposed governance model for a local public health unit that includes the entire Fort Berthold Reservation and present it to the committee at a future meeting. Dr. Walker said it is in the best interest of the community that all of its residents are healthy, and with tribal input, a model could be developed that served the whole community, including native and nonnative residents.

Representative Karls suggested the committee receive information regarding the use of casino tax revenue for public health services in Wisconsin. Chairman Lee asked the Legislative Council staff to provide this information to the committee at a future meeting.

Representative Nelson suggested the committee receive information regarding property taxes generated for local public health by nontrust land on the reservation and the estimated property taxes that would be generated for local public health if all reservation trust lands were taxed.

Senator Lee suggested the committee receive information regarding the mills assessed by each county for local public health, the amount of revenue generated by the assessments, and the population served.

Dr. John Baird, Special Populations Section Chief, State Department of Health, provided information regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit (Appendix H). He said the mission of public health is to protect and enhance the health and safety of all North Dakotans and the environment in which we live. He said curative medical care focuses on evaluation and treatment of individuals, while public health takes a broader view, understanding the specific health issues confronting the community and working to address physical, behavioral, environmental, social, and economic conditions affecting them.

Dr. Baird said challenges include:

- Finding agreement among the number of interested parties, including IHS, tribal, county, and local public health units. He said the Three Affiliated Tribes has contracted with IHS under the provisions of Public Law 93-638, so management of medical services is locally controlled by the tribe;
- Staffing of a new public health unit;
- Proper training of the public health unit staff; and
- Funding. Changes in the distribution of funding may result in the loss of funding for current local public health units, and tribal funding may not be adequate to provide for a local health department.

Dr. Baird said benefits include improved cultural awareness, coordination of services, and access to services. He said a tribal health unit may have access to special grants not available to other local public health units.

Dr. Baird said he is aware of tribal health boards in Arizona and Coeur d'Alene, Idaho.

In response to a question from Representative Rohr, Dr. Baird said he is not aware of any federal prohibition to a tribal public health system on the Fort Berthold Reservation. He said IHS is responsible for public health on the reservation, but it lacks adequate funding, and resources available are needed to provide curative medical care.

In response to a question from Representative Nelson, Dr. Baird said the Fort Berthold Reservation would benefit from becoming a separate health district, but the district should be independent of the tribal government.

Representative Owens suggested the committee review liaisons established with reservations by the state of Maine in its health districts.

Mr. Scott J. Davis, Executive Director, Indian Affairs Commission, provided information regarding the committee's study of the feasibility and desirability of placing the entire Fort Berthold Reservation in a single public health unit. He said consistent medical care on the reservations is important. He said federal barriers, including credentialing, can impede doctors willing to serve on reservations. He said memorandums of understanding may provide a solution to some of the barriers. He said it is important for the study to identify and engage all of the partners. He offered his assistance to the committee for the study.

In response to a question from Senator Lee, Mr. Tom Nehring, Director, Division of Emergency Medical Services and Trauma, State Department of Health, provided information regarding 2011 legislation related to ambulance services. Mr. Nehring said 2011 House Bill No. 1044 increased the base funding for state assistance grants to emergency medical services operations by $3 million to provide a total of $4.25 million. In the past, he said, funding has been used to provide staffing grants, and because IHS typically provides funding for ambulance services on the reservation, those ambulance services have not been considered for the grants. He said a newly appointed Emergency Medical Services Advisory Council will provide recommendations regarding the use of future funding. He said one reservation operates its own ambulance service, another contracts for the service, and a third is a combination involving IHS which owns the equipment and the tribe which employs the technicians.

Chairman Lee asked the State Department of Health to provide information to the committee at its next meeting on the various methods of funding emergency medical services operations on the reservations in the state.

Mr. Howard C. Anderson Jr., Executive Director, State Board of Pharmacy, provided information regarding the committee's study of the feasibility and desirability of placing the entire Fort Berthold Reservation in a single public health unit. He said the Three Affiliated Tribes contracts for health care from the BIA. He said the State Board of Pharmacy licenses four tribal telepharmacies on the Fort Berthold Reservation and the central pharmacy in New Town. He said the pharmacies, because of their relationship to the BIA, purchase vaccines through the government contract at a discount. He said the discounted medications may not be sold to nonnatives. He said this has led to a telepharmacy in New Town to serve the nonnative residents who are not served by the IHS facility.

It was moved by Senator Mathern, seconded by Senator Uglem, and carried on a voice vote that the committee proceed with this study as follows:

1. **Receive information from representatives of the following regarding the benefits and challenges of placing the entire Fort Berthold Reservation in a single public health unit:**

   Fort Berthold Reservation.

   State Department of Health.

   Local public health units serving the Fort Berthold Reservation.
2. **Receive information from representatives of the Tax Commissioner regarding the property tax revenue generated for local public health on the Fort Berthold Reservation, including information regarding property taxes that would be generated for local public health if all reservation trust lands were taxed, and information regarding the mills assessed by each county for local public health, the amount of revenue generated by the assessments, and the population served.**
3. **Review public health services on other reservations in the state served by a single health unit.**
4. **Receive information regarding the availability of federal BIA funding for**

placing the Fort Berthold Reservation in a single public health unit.

5. **Receive information from the State Department of Health regarding the delivery of public health services on the other reservations in the state and whether any reservations in other states have been placed in a single public health unit and the challenges and benefits of the arrangement.**
6. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
7. **Prepare a final report for submission to the Legislative Management.**

STUDY OF THE FUTURE OF HEALTH CARE DELIVERY IN THE STATE AND THE ABILITY OF THE UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES TO MEET THE HEALTH CARE NEEDS OF THE STATE

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled *Study of the Future of Health Care Delivery in the State and the Ability of the University of North Dakota School of Medicine and Health Sciences to Meet the Health Care Needs of the State - Background Memorandum* relating to the committee's assigned responsibility to study the future of health care delivery in the state and the ability of the School of Medicine to meet the health care needs of the state.

The Legislative Council staff said the Legislative Assembly approved 2011 House Bill No. 1152. Section 3 of the bill provides that the Legislative Management study the future of health care delivery in the state. The study must focus on the delivery of health care in rural areas of the state and include input from the UND School of Medicine and Health Sciences Center for Rural Health, hospitals, and the medical community. In addition, the Legislative Assembly approved 2011 House Bill No. 1003. Section 23 of the bill provides the chairman of the Legislative Management consider appointing a separate committee to study the ability of the School of Medicine to meet the health care needs of the state. The study must include a review of the health care needs of the state, options to address the health care needs of the state, and the feasibility and desirability of expanding the School of Medicine to meet the health care needs of the state.

The Legislative Council staff said the 2005-06 interim Budget Committee on Health Care studied the need for a comprehensive long-range study of the state's current and future health care needs in order to address issues, such as the aging population of the state, the phenomenon of health care cost-shifting to the private sector, the trend of uncompensated health care services, shortages in the number of health care professionals, duplication of technology and facilities, and any other factors that might affect the health care system in North Dakota in the year 2020. It is expected that the state's current population over age 65 will increase from 97,800 to approximately 149,600 by 2020. The state's population over age 85 is expected to increase from 15,300 to approximately 24,300 by 2020. The committee learned approximately 58 percent of North Dakotans travel 5 miles or less to receive health care services, approximately 9 percent travel 21 miles to 50 miles, and approximately 20 percent travel more than 50 miles. The committee learned studies have shown that greater distances people must travel to receive health care services result in underutilization of health care services.

The Legislative Council staff said the 2005-06 interim Budget Committee on Health Care received information regarding the status of the School of Medicine. The committee learned approximately 68 percent of the state's practicing family medicine physicians graduated from UND with a medical degree, residency training, or both. Family medicine physicians provide the majority of patient care in rural areas. However, in North Dakota and throughout the country, the number of medical student graduates choosing a residency in family medicine is decreasing. The decrease in the number of family medicine physicians is primarily due to lower salaries and more "on call" hours as compared to specialty practice physicians. For the period 1990 through 2000, approximately 37 percent of the medical school graduates remain in North Dakota, while 39 percent of those completing their residency training in the state remain in North Dakota, and 38 percent of those receiving combined medical school and residency training in North Dakota remain in the state. In comparison, approximately 25 percent of all UND graduates (all majors) continue to reside in the state after graduation. The committee learned approximately six to eight third-year students are chosen to participate in the rural opportunities in medical education (ROME) program. The ROME program allows third-year medical students to live and train in a nonmetropolitan community under the supervision of physician preceptors. A goal of the ROME program is to expose students to practicing medicine in rural areas throughout North Dakota.

The Legislative Council staff said the 2009-10 interim Health and Human Services Committee studied unmet health care needs in the state. The study included an assessment of the needs of underinsured and uninsured individuals and families, considered federal health care initiatives, and included consultation with the State Department of Health, the Insurance Commissioner, and the Department of Human Services. She said the committee learned the state has:

- Six tertiary hospitals in the four major cities of Bismarck, Fargo, Grand Forks, and Minot.
- Thirty-six critical access hospitals in rural communities.

- Seven specialty hospitals, including two long-term care acute hospitals, the State Hospital in Jamestown, a psychiatric care hospital in Fargo, and a Department of Veterans' Affairs hospital in Fargo.
- Two IHS hospitals.

The Legislative Council staff said the 2009-10 interim Health and Human Services Committee learned there is concern regarding the future viability of a number of hospitals in the state. Low profits and operating deficits make it difficult for North Dakota health care providers to offer competitive salaries and maintain current technology. The committee learned Medicare and Medicaid are the major payers of health care in North Dakota, especially in the rural areas of the state. Medicare payments generate approximately 50 percent of hospital revenue and Medicaid payments generate from 12 percent to 20 percent.

School of Medicine Health Care Workforce Initiative

The Legislative Council staff said during the 2009-10 interim, the Higher Education Committee received information regarding issues affecting the School of Medicine, including medical student residencies and future health care needs. The committee learned the medical school class of 2014 includes 66 students, and the average student age is 24.8 years. The following schedule details the state of residence for the students, including students enrolled through an agreement with the Western Interstate Commission for Higher Education:

Residency Type	Number	Percentage of Total Students
North Dakota resident	46	78%
Minnesota resident	6	10%
Enrolled through the Western Interstate Commission for Higher Education exchange program	7	12%
Total	59[1]	100%

[1]Does not include seven students enrolled in the Indians into Medicine Program.

The 2009-10 interim Higher Education Committee received the following information comparing medical student residencies in North Dakota to national averages:

	North Dakota	National Average
Number of residencies per 100,000 residents	17.8	35.7
Ratio of medical residents to medical students	0.42	1.11
Percentage change in the number of medical residents from 1999 to 2008	(3.4%)	12.6%

The number of first-year residencies available in North Dakota was 44 in 2010. Of this number, 17 were related to family medicine. The following schedule details the number of physicians that remain in the state after attending medical school in North Dakota or completing a residency in the state:

	North Dakota	National Average
Retention of students that attend medical school in the state	31%	37%
Retention of students that complete a medical residency in the state	43%	45%
Retention of students that attend medical school in the state and complete a medical residency in the state	63%	66%

The Legislative Council staff said the 2009-10 interim Higher Education Committee learned 1,489 physicians are actively practicing in the state. Of these physicians, 51 percent are aged 50 or younger, and 17 percent have their primary office in a rural area. Of the total number of actively practicing physicians in the state, 461 are graduates of the UND School of Medicine and Health Sciences.

The Legislative Council staff said the 2009-10 interim Higher Education Committee learned the School of Medicine RuralMed program provides eight new freshman medical students per year with a full tuition waiver for all four years of medical school if the student agrees to complete a family medicine residency and then practice family medicine in a rural area of the state for five years. Guidelines for the RuralMed program define a rural area of the state as being anywhere in the state except Bismarck, Fargo, Grand Forks, and Minot. The School of Medicine RuralMed program is modeled after the School of Medicine Indians into Medicine Program. The Indians into Medicine Program was established as a means of providing American Indian health professionals to meet American Indian health needs. The School of Medicine reserves places in its medical school freshman class, and physical therapy and occupational therapy programs, for fully qualified American Indian students.

The Legislative Council staff said the UND School of Medicine and Health Sciences Advisory Council provided information during the 2011 legislative session regarding strategies to meet the state's health care workforce needs. Strategies outlined include training more physicians and other health professionals, retaining more trained health professionals, and aggressively recruiting from outside the state to fill health care workforce needs. Original proposals included cooperating with North Dakota State University (NDSU) to provide a new master of public health degree, expanding training in geriatrics, increasing the number of medical students by 16 per year for four years beginning in July 2012, increasing the number of resident positions by 17 per year for three years beginning in July 2012, increasing

the number of health sciences students by 30 per year for three years beginning in July 2012, and constructing a new health sciences facility addition for program expansion. The estimated 2011-13 biennium base budget increase required to provide for the original proposals totaled $5.9 million, and the one-time cost of the health sciences facility addition was estimated at $28.9 million. The cost of the initiatives was estimated to total $20.6 million during the 2013-15 biennium and $27.7 million during the 2015-17 biennium.

The Legislative Council staff said the School of Medicine submitted modified proposals for consideration by the Legislative Assembly. The modified health care workforce initiative proposals did not require construction of a new health sciences facility addition and included cooperating with NDSU to provide a new master of public health degree--expanding training in geriatrics, increasing the number of medical students by 8 per year for four years beginning in July 2012, increasing the number of resident positions by 9 per year for three years beginning in July 2012, and increasing the number of health sciences students by 15 per year for three years beginning in July 2012. The Legislative Assembly in 2011 appropriated $46.8 million from the general fund to the School of Medicine for the 2011-13 biennium. Included in the funding is $4.3 million of initiatives relating to:

- A new master of public health degree for $1.2 million (included in the executive budget).
- Expansion of geriatric training for $1.2 million (included in the executive budget).
- Increasing the number of medical and health sciences students and residencies for $1.8 million.
- One-time funding for a space utilization study of the School of Medicine for $100,000.

The cost to continue the $4.3 million of initiatives approved by the Legislative Assembly in 2011 are estimated to total $12 million during the 2013-15 biennium and $15.8 million during the 2015-17 biennium.

Loan Repayment Programs

The Legislative Council staff said Chapter 43-17.2 provides for the state community matching physician loan repayment program. A qualifying physician may receive up to $22,500 per year for up to two years for a total of $45,000. Section 43-12.2-01 provides for qualifying mid-level practitioners to receive loan repayments totaling up to $30,000 over two years. Communities must contribute an amount at least equal to the amount of the state contribution for the physicians and mid-level practitioners. The Legislative Assembly in 2009 appropriated $75,000 from the general fund and $272,500 from the community health trust fund for the program, including $67,500 provided in 2009 Senate Bill No. 2227 which removed the limit on the number of recipients and increased the limit on the maximum loan repayment from $10,000 to $30,000 for the medical personnel loan repayment program relating to mid-level practitioners. The 2011-13 executive budget recommended and the Legislative Assembly in 2011 approved $420,000, of which $345,000 is from the general fund and $75,000 is from the community health trust fund, for the medical personnel loan repayment program, $72,500 more than the 2009-11 biennium. During the last two bienniums a total of 11 physicians and 5 mid-level practitioners have been accepted into the program.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding health care needs in the state, options to address the health care needs in the state, the future of the delivery of health care services in the state--especially in rural areas, and the role of technological innovations and telemedicine in providing health care services in the state from interested persons, including AARP, the North Dakota Hospital Association, the North Dakota Medical Association, the North Dakota Health Information Technology Office and advisory committee, and the UND Center for Rural Health.
2. Receive information from the School of Medicine relating to:
   a. Students/resident experiences and rotations in community health (SEARCH) program, including information regarding the program and opportunities for health profession students to work in interdisciplinary teams in rural North Dakota communities.
   b. Rural opportunities in medical education program, including information regarding the program, the number of third-year medical students placed in rural communities, and the number of ROME students choosing to practice in rural communities after graduation.
   c. RuralMed scholar program, including information regarding the program and its success at recruiting, educating, and retaining physicians who will practice family medicine in rural North Dakota.
3. Receive information from the School of Medicine regarding shortages of health care professionals in the state, how expanding programs at the university would address health care needs in the state, and the cost of program expansion.
4. Gather and review information on federal health care initiatives, including how they will affect access to health care in the state.
5. Receive information from the Department of Human Services and the State Department of Health regarding programs and services

available to provide health care in rural areas of the state.

6. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
7. Prepare a final report for submission to the Legislative Management.

Senator Kilzer suggested the study review the effects of Medicaid reimbursement on the retention of physicians in the state.

Mr. Tim Sauter, Regional Director, West Central Human Service Center, Bismarck, provided information regarding programs and services provided through the eight regional human service centers (Appendix I). He said each of the eight regional human service centers provides direct outreach services on a regular basis. He said core services include:

- Work with high-risk families referred because of abuse or neglect;
- Direct case management services for individuals with developmental disabilities or serious mental illness;
- Mental health evaluations and therapy;
- Addiction evaluations and treatment;
- Partnership care coordination for children with serious emotional disturbance and their families;
- Care coordination and skills training for transition-aged youth; and
- Services to vulnerable adults.

Mr. Sauter said, depending on the needs of the region, other services may include tribal agency consultation, transition services for youth leaving residential psychiatric care, psychiatrist consultations in nursing homes or jails, and crisis response in a natural disaster or suicide. He said emphasis has been made on the provision of telemedicine services for areas lacking adequate onsite psychiatric services. He said the State Hospital has been exploring the possibility of providing telepsychiatric services to rural hospitals.

Representative Hogan suggested the committee receive information regarding the ability of the program of all-inclusive care for the elderly (PACE) to provide care for the elderly in rural communities.

Senator Lee suggested representatives of the State Hospital be invited to a future meeting to provide information regarding the telepsychiatry program.

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, provided information regarding programs and services available to provide health care in rural areas of the state (Appendix J). She said the Medicaid program provides funding for eligible clients to receive services approved in the North Dakota state Medicaid plan. She said Health Tracks is a preventative health program available for children to age 21 who are eligible for Medicaid. She said the six regional Health Tracks coordinators work with local county social services offices generating referrals for local public health units and primary care providers, providing assistance with screenings, educating nurses on screening tools, and reviewing program changes. In addition, she said, Healthy Steps--the state's children's health insurance program (CHIP)--provides eligible children with health insurance coverage. She said other health care programs include:

- Experience Health North Dakota which serves individuals diagnosed with asthma, diabetes, congestive heart failure, or chronic obstructive pulmonary disease. As of June 2011, 3,382 eligible recipients were receiving care coordination services, education materials, and access to a 24/7 telephone health information line. Of this total, 1,192 individuals resided in rural counties.
- The program of all-inclusive care for the elderly which is currently operational in two sites in the state--Bismarck serving 39 clients in June 2011 and Dickinson serving 21 clients in June 2011. The program of all-inclusive care for the elderly serves individuals that meet nursing home level of care in order to allow the individual to remain at home. The program of all-inclusive care for the elderly is all inclusive and provides health care, personal care, nutritional counseling, recreational therapy, and meals.
- Home and community-based services which include homemaker and personal care services, transportation assistance, and home-delivered meals. The services are provided by qualified service providers (QSPs) through several different programs with varying levels of service and financial eligibility.

Ms. Anderson said 2009 Senate Bill No. 2158 allows Medicaid recipients to choose an advanced registered nurse practitioner as their primary care provider within the primary care case management program. She said 110 nurse practitioners are serving as primary care providers for Medicaid recipients in the state.

Ms. Anderson said 2011 House Bill No. 1152 authorized a Medicaid supplemental payment to critical access hospitals and the Department of Human Services is awaiting Centers for Medicare and Medicaid Services approval to make the supplemental payments.

Ms. Anderson said an adequate workforce is essential to providing services. She said the department has contracted to develop a video to educate potential QSPs. In addition, she said, 2009 House Bill No. 1307 and 2011 House Bill No. 1169 allows nursing homes to claim an education expense in their nursing home rate for staff pursuing an education in a shortage area.

In response to a question from Senator Mathern, Ms. Anderson said the Medicaid fee schedule is set based on legislative increases provided. She said nurse practitioners are reimbursed at 75 percent of the fee schedule, while doctors receive 100 percent of

the rate established. Regarding home and community-based services, she said, there are different rates for individual QSPs and agency QSPs, but each is reimbursed based on 15-minute units of time.

In response to a question from Senator Warner, Ms. Anderson said physicians are reimbursed differently through Medicaid and CHIP. She said CHIP payments are based on the Blue Cross Blue Shield fee schedule.

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, provided information regarding programs and services available to provide health care in rural areas of the state (Appendix K). Generally, she said, the State Department of Health provides for population health--preventative systems and services to improve the health of the entire population--as opposed to direct health care provided personally to a patient. She said the only exceptions are the oral health program where employees provide fluoride varnish and sealants; emergencies where emergency medical shelters are established; and support services, such as laboratory analysis and coordination of care for children's special health services.

Ms. Smith said the State Department of Health provides funding and supportive services for the:

- Ambulance services staffing and training programs;
- Medical and dental loan repayment programs;
- Dental new practice grant program;
- Administration, recruitment, and placement activities for physicians, nurses, dentists, nurse practitioners, physician assistants, and mental health professionals through the National Health Service Corps;
- UND School of Medicine and Health Sciences Center for Rural Health to identify and designate health professional shortage areas;
- J-1 visa waiver program which allows foreign medical school graduates to serve in designated workforce shortage areas;
- Vaccines supplied by the federal government;
- Maternal and child health contracts with local public health units, nonprofits, and Indian reservations to provide direct health care services, including maternal care, well child checkups, newborn home visits, immunizations, oral health services, school health, and genetic services;
- Family planning program contracts to provide reproductive health care services for men and women;
- Donated dental services grant program;
- Women, infants, and children (WIC) program;
- Local public health state aid grant program which provides funding to local public health units who are required to provide various services to North Dakota citizens regardless of ability to pay;
- Hospital preparedness grant program which provides funding to hospitals to purchase certain emergency room equipment to prepare them to respond to disasters; and
- Diabetes disease management program.

Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information regarding shortages of health care professionals in the state, how expanding programs at the university would address health care needs in the state, and the estimated cost of program expansion (Appendix L). He discussed the *First Biennial Report on Health Issues for the State of North Dakota 2011* prepared by the School of Medicine and Health Sciences Advisory Council to outline health care and health care needs in the state. He said the largest driver of the cost of health care and need for health care providers in North Dakota is the age of our population. He said North Dakota currently has approximately 1,500 physicians and estimates indicate a need for an additional 200 to 300 more physicians over the next 10 years to 15 years, not including the physicians needed to replace those who retire or leave their practice. He said the current medical school class is 62 students, including 7 students participating in the federally funded Indians into Medicine Program. He said the expansion approved by the Legislative Assembly in 2011 will add eight students starting in 2012. He said these additional students will not enter the provider workforce until 2019. He said the demand is not just for physicians, but also for other health sciences students. He said the expansion approved will also add 9 residency slots and 15 health sciences students.

Dr. Wynne said the advisory council proposed the following four core approaches to solving the health care supply and demand imbalance in the state:

1. Reduce the disease burden.
2. Retain more health care providers.
3. Train more health care providers.
4. Improve the efficiency of the health care delivery system in the state.

Dr. Wynne said the School of Medicine leads the nation in the percentage of physicians choosing family medicine but is slightly below average in the percentage of graduates that remain in the state following training. He said efforts at the School of Medicine to retain physicians include selecting more students from rural areas, an awareness of spousal issues, providing exposure to rural practice, and removing financial barriers. He said improvements to the efficiency of the health care delivery system include the regionalization of services, expanded use of mid-level providers, enhanced use of telemedicine, and improved coordination of services by the six largest health care systems. He asked the committee to support the full expansion of the class sizes included in the recommendations of the advisory council to provide for 16 medical students (8 more than the 2011-13 biennium), 30 health sciences

students (15 more than the 2011-13 biennium), 17 residency slots (8 more than the 2011-13 biennium), and a new health sciences building on the Grand Forks campus.

In response to a question from Senator Lee, Dr. Wynne said the new Bismarck Center for Family Medicine will open during the fourth quarter of 2011.

In response to a question from Representative Nelson, Dr. Wynne said accreditation of the School of Medicine is not compromised by the increase in the class size.

In response to a question from Representative Nelson, Dr. Wynne said the residency portion of a physician's education is critical to retention. He said attending medical school and residency in the same state increases the likelihood a physician will stay in the state to over 60 percent. He said residency is also the most expensive portion of a physician's education, and North Dakota has one of the lowest ratios of residency slots to medical students in the country. He said when the medical school reviews applications for the additional residency slots approved by the Legislative Assembly, criteria for approval will include whether the residency will meet the health care needs of the state and the educational needs of the students. He said those residencies that increase the likelihood of rural placement will also be attractive.

In response to a question from Senator Warner, Dr. Wynne said students that enroll in the RuralMed program are required to pay tuition if they leave the rural area. He said no one has left the program yet, but the program is new with little historical data.

In response to a question from Senator Warner, Dr. Wynne said physicians that train residents must be board-certified in the area in which they are teaching. He said the medical school will provide training modules to help physicians develop their teaching skills. He said physicians are under increasing pressure to see patients and, therefore, have less time to teach medical students or residents. He said of the 1,500 physicians in the state, over 900 physicians are on the faculty of the medical school. He said compensation for teaching is lower than what the physicians could make in their practice. He said the availability of physicians willing to teach is a concern when the class sizes and residencies are expanded.

In response to a question from Senator Mathern, Dr. Wynne said the current medical school facility can accommodate all of the students added by the Legislative Assembly in 2011.

In response to a question from Senator Lee, Dr. Wynne said medical students need an appropriate blend of urban and rural experiences. He said students in the ROME program are given extended rural experience but have experience in one of the urban centers. He said changes to the program will allow the medical school to accommodate additional students. He said the medical school anticipates making clerkships available at the Minot campus for third-year students. He said a proposed longitudinal integrated clerkship for third-year students would allow students to follow families in the community and learn from each experience.

In response to a question from Senator Berry, Dr. Wynne said a survey of providers in the state was conducted by Altru Hospital and the School of Medicine. He said the survey responses have not yet been summarized. In many cases, he said, physicians that leave the state to complete their residencies do not return to practice here. He said if residencies were added in the state, he anticipates more residents will remain in the state.

In response to a question from Senator Lee, Dr. Wynne said the number of residencies filled by students from other medical schools varies widely by program and from year to year. He said nationally approximately 40 percent of the family medicine residencies are occupied by United States medical school graduates.

Senator Lee suggested the committee receive information regarding the citizenship of those occupying North Dakota residency positions.

Senator Warner suggested the committee receive information regarding compensation and licensure issues related to innovative delivery methods, such as telemedicine.

In response to a question from Senator Mathern, Mr. William G. Goetz, Chancellor, North Dakota University System, said the State Board of Higher Education works with the advisory council in the budget development process.

In response to a question from Senator Kilzer, Dr. Wynne said nationally the ratio of medical school applicants to those accepted is 3-to-1, and in North Dakota the ratio is about 5-to-1. He expressed confidence that the medical school could admit another eight students without compromising the quality of the class. He said the goal is to promote health care careers in the state; so, if an additional class expansion is approved in the future, there will be enough quality student applicants.

In response to a question from Senator Kilzer, Dr. Wynne said the medical school's board certification pass rate is well within the national average. Senator Kilzer suggested the committee receive information regarding the national board certification pass rate of recent medical school classes and how the rates compare to the national average.

In response to a question from Senator Kilzer, Dr. Wynne said the new public health program offered with NDSU will offer not only a master's degree, but also a certificate. He said it is anticipated the degree and certificate programs will attract current local public health workers, physicians, physicians in training, and hospital and clinic administrators.

It was moved by Representative Hogan, seconded by Senator Berry, and carried on a voice vote that the committee proceed with this study as follows:

1. **Gather and review information regarding health care needs in the state, options to address the health care needs in the state, the future of the delivery of health care services in the state--especially in rural areas, and the role of technological innovations and telemedicine in providing health care services in the state from interested persons, including AARP, the North Dakota Hospital Association, the North Dakota Medical Association, the North Dakota Health Information Technology Office and advisory committee, and the UND Center for Rural Health.**
2. **Receive information from the School of Medicine relating to:**
   a. **Students/resident experiences and rotations in community health program, including information regarding the program and opportunities for health profession students to work in interdisciplinary teams in rural North Dakota communities.**
   b. **Rural opportunities in medical education program, including information regarding the program, the number of third-year medical students placed in rural communities, and the number of ROME students choosing to practice in rural communities after graduation.**
   c. **RuralMed scholar program, including information regarding the program and its success at recruiting, educating, and retaining physicians who will practice family medicine in rural North Dakota.**
3. **Receive information from the School of Medicine regarding shortages of health care professionals in the state, how expanding programs at the university would address health care needs in the state, and the cost of program expansion.**
4. **Gather and review information on federal health care initiatives, including how they will affect access to health care in the state.**
5. **Receive information from the Department of Human Services and the State Department of Health regarding programs and services available to provide health care in rural areas of the state, including information regarding the ability of PACE to provide care for the elderly in rural communities.**
6. **Review the effects of Medicaid reimbursement on the retention of physicians in the state.**
7. **Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
8. **Prepare a final report for submission to the Legislative Management.**

OTHER COMMITTEE RESPONSIBILITIES

The Legislative Council staff presented a background memorandum entitled *Other Duties of the Health Services Committee - Background Memorandum*. She said in addition to the study responsibilities assigned to the Health Services Committee for the 2011-12 interim, the committee has also been assigned to:

- Receive from the State Fire Marshal a report regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes;
- Recommend a private entity to contract with for preparing cost-benefit analyses of health insurance mandate legislation;
- Receive reports from the State Department of Health before January 1, 2012, April 1, 2012, and July 1, 2012, regarding the department's inventory of material relating to abortions and outlining the department's practice of gathering the inventory items; and
- Receive a report from the Health Council by July 1, 2012, regarding the findings of its review of current health care bed recommendations and whether changes should be made to better serve the population of North Dakota.

Effectiveness of Legislation Related to Reduced Ignition Propensity Standards for Cigarettes

The Legislative Council staff said the Legislative Assembly in 2009 House Bill No. 1368 created Chapter 18-13 relating to reduced ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. The bill provides for enforcement of the standards by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. No funds were deposited into the fire prevention and public safety fund during the 2009-11 biennium. In addition, fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial $250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. Deposits into the fund totaled $228,250 during the 2009-11 biennium and contract expenditures totaled $9,438. Section 18-13-02(6) requires the State Fire Marshal review the effectiveness of test methods and performance standards and report each interim to the Legislative Council the State Fire Marshal's findings and any

recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes. The Health Services Committee has been assigned the responsibility to receive this report.

Health Insurance Coverage Mandates

The Legislative Council staff said Section 54-03-28 provides that a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Health Services Committee has been assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2013 legislative session. The Insurance Commissioner is to pay the costs of the contracted services, and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

The section also provides that a legislative measure mandating the health insurance coverage must provide that:

1. The measure is effective only for the next biennium.
2. The application of the mandate is limited to the public employees health insurance program and the public employees retiree health insurance program.
3. For the next Legislative Assembly, the Public Employees Retirement System (PERS) prepare and request introduction of a bill to repeal the expiration date and extend the mandated coverage to apply to all accident and health insurance policies.

The Legislative Council staff said the PERS Board is also required to prepare a report, which is attached to the bill, regarding the effect of the mandated coverage or payment on the system's health insurance program. The board must include information on the utilization and costs relating to the mandated coverage and a recommendation on whether the coverage should continue. The 2009-10 interim Health and Human Services Committee learned PERS is not required the use of a consultant when evaluating legislative measures mandating health insurance coverage. However, if a future analysis does require additional resources, Section 54-52.1-06.1 provides a continuing appropriation to PERS for consulting services related to the uniform group insurance program.

A majority of the members of the standing committee to which the legislative measure is referred during a legislative session, acting through the chairman, determines whether a legislative measure mandates coverage of services. Any amendment to the legislative measure that mandates health insurance coverage may not be acted on by a committee of the Legislative Assembly unless the amendment has had a cost-benefit analysis prepared and attached.

The Insurance Department has categorized and defined mandated health insurance benefits as follows:

1. Service mandates - Benefit or treatment mandates that require insurers to cover certain treatments, illnesses, services, or procedures. Examples include child immunization, well-child visits, and mammography.
2. Beneficiary mandates - Mandates or defines the categories of individuals to receive benefits. Examples include newborns from birth, adopted children from the time of adoption, and handicapped dependents.
3. Provider mandates - Mandates that require insurers to pay for services provided by specific providers. Examples include nurse practitioners, optometrists, and psychologists.
4. Administrative mandates - Mandates that relate to certain insurance reform efforts that increase the administrative expenses of a specific health care plan. Examples include information disclosures, precluding companies from basing policy rates on gender, and precluding insurers from denying coverage for preauthorized services.

The Legislative Council staff said the 2003-04 and 2005-06 interim Budget Committees on Health Care, the 2007-08 interim Human Services Committee, and the 2009-10 interim Health and Human Services Committee recommended that the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, 2009, and 2011 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of $8,323. In addition, the Insurance Department paid $5,606 to Milliman USA for general project work during the 2005 legislative session for total payments during the 2005 legislative session of $13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The Insurance Department paid a total of $28,070 to Milliman USA for analyses conducted on three bills during the 2009 legislative session and $14,982 to Milliman USA for analysis conducted on one bill during the 2011 legislative session.

The Legislative Council staff said the 2009-10 interim Health and Human Services Committee

received information regarding the length of time necessary to complete cost-benefit analyses for health insurance mandates proposed during each of the last four legislative sessions. The committee learned the number of days required to perform the analyses ranged from 6 days to 19 days during the 2003 legislative session and 20 days for one bill proposed during the 2005 legislative session. There were no mandates proposed during the 2007 legislative session. The number of days required to perform the analyses ranged from 23 days to 24 days for the three bills introduced during the 2009 legislative session. Analysis performed on the one bill introduced during the 2011 legislative session took 14 days. The committee reviewed legislative rules relating to health insurance mandate legislation. The committee learned in September 2008 the 2007-08 interim Legislative Management Committee recommended proposed amendments to House and Senate Rules 402 relating to bill introduction deadlines for measures subject to cost-benefit analysis under Section 54-03-28. The proposed rules amendment provided that a current legislator may submit a mandated health insurance bill to the Employee Benefits Programs Committee no later than April 1 of the year before a regular legislative session. Any new legislator taking office after November 30 of the year preceding the legislative session may submit a mandated health insurance bill for consideration by the Employee Benefits Programs Committee no later than the first Wednesday following adjournment of the organizational session. During the December 2008 organizational session, the House adopted the proposed amendment to House Rule 402, but the Senate has not yet adopted the amendment.

Report on Inventory of Abortion Data and State Department of Health Practices Regarding Inventory Development

The Legislative Council staff said the Legislative Assembly approved 2011 House Bill No. 1297 which expands information related to abortions and alternatives to abortion that must be included in the printed materials that are provided by the State Department of Health. The bill also provides for additional reporting requirements for the State Department of Health. Section 15 of the bill requires the State Department of Health to:

- Create an inventory of the data, reports, records, and other material the department is required to gather, receive, create, or maintain relating to abortions as required under Chapter 14-02.1. The inventory must include information regarding the frequency with which the items in the inventory must be gathered, received, or created;
- Create a report that outlines the department's practices in gathering, receiving, and creating the items in the inventory; and
- Make three reports to the Legislative Management on the status and outcome of the creation of the inventory and the practices report. The first report must be made before January 1, 2012; the second before April 1, 2012; and the third before September 1, 2012. The Health Services Committee has been assigned the responsibility to receive these reports.

Section 16 of the bill limited the cost to the State Department of Health of producing printed information related to abortion data to $50,000.

State Health Council Review of Health Care Beds in the State

The Legislative Council staff said the Legislative Assembly approved 2011 House Bill No. 1040 which extends the moratorium on expansion of basic care bed capacity and the moratorium on expansion of long-term care bed capacity from July 31, 2011, to July 31, 2013. As of March 1, 2011, there were 6,363 licensed long-term care beds and 1,786 basic care beds in the state. Section 3 of the bill requires the Health Council review current health care bed recommendations to determine if changes should be made to better serve the population of North Dakota and report its findings to the Legislative Management by July 1, 2012. The Health Services Committee has been assigned the responsibility to receive this report.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Representative Nelson suggested the committee receive a copy of the *First Biennial Report on Health Issues for the State of North Dakota 2011* prepared by the advisory council and referenced by Dr. Wynne. Chairman Lee asked that the report be provided to committee members.

Chairman Lee said the committee will be notified of the next meeting date.

No further business appearing, Chairman Lee adjourned the meeting at 3:47 p.m.

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Sheila M. Sandness
Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:12