NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Wednesday, September 26, 2012
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, Tim Mathern, Gerald Uglem, John Warner; Representatives Stacey Dahl, Karen Karls, Robert Kilichowski, Jon Nelson, Karen M. Rohr, Mark Sanford, Robin Weisz

Members absent: Senators Spencer D. Berry, Ralph L. Kilzer; Representatives Kathy Hogan, Mark S. Owens, Vonnie Pietsch

Others present: Senator Rich Wardner, 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 Weisz, and carried on a voice vote that the minutes of the July 24, 2012, meeting be approved as distributed.

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 bill draft [13.0165.01000] to amend North Dakota Century Code Chapter 23-35 relating to public health units. The Legislative Council staff said the bill draft defines tribal health districts and allows a public health unit to form on an Indian reservation. In addition, the bill draft provides $200,000 from the general fund to the State Department of Health to implement a tribal public health unit pilot project.

In response to a question from Representative Weisz, the Legislative Budget Analyst and Auditor said the amendment to Section 23-35-08 relating to the powers and duties of the boards of health would limit the powers of boards of health serving the reservation to activities that do not conflict with tribal code, ordinance, or policy.

Mr. Mark Fox, Tribal Administrator, Mandan, Hidatsa, and Arikara Nation, provided information (Appendix B) regarding the bill draft and the study of the feasibility of placing the Fort Berthold Reservation in a single public health unit. He said the Mandan, Hidatsa, and Arikara (MHA) Nation Health Authority Board was created to address the governing body requirements for a health care system. He said the Health Authority Board reports to the MHA Nation Tribal Business Council, who is prepared to amend the board charter to include responsibilities related to managing a public health unit. He said benefits of establishing a public health unit at Fort Berthold include:

- Improved quality and access to services for tribal members.
- Unique billing opportunities that include access to the Medicaid all-inclusive rate for billable services for tribal programs, which is federally funded and not available to nontribal public health units.
- Improved coordination of public health services with medical services that will link screening and diagnosis to primary care available through the tribe's health center.
- An opportunity to coordinate behavioral health, public health, medical services, community health workers, long-term care, and substance abuse prevention and treatment.
- Improved coordination with State Department of Health programs and services.
- An opportunity to redirect resources of the four local public health units currently serving the Fort Berthold Reservation to other areas of western North Dakota.
- Improvements in emergency response.
- An opportunity to link public health outreach with screenings and services now covered under the Affordable Care Act.
- A reduction in health disparities among tribal members.

Mr. Fox said the MHA Nation is prepared to collaborate with the state to integrate primary care and public health services. He said estimated state funding needed for a two-year pilot project is $500,000. He said this funding will provide startup costs and allow time to develop funding streams and a business plan. He said the tribe will contribute $50,000 for a consultant to complete an evaluation of the pilot project.

In response to a question from Senator Warner, Mr. Fox said the tribe has the ability to serve both tribal and nontribal members. He said there has been a significant increase in the number of nonnative residents moving to the reservation, and this has brought an increase in demand for public health services. He said it is anticipated a federally qualified

health center (FQHC) will provide the flexibility to serve everyone.

In response to a question from Representative Rohr, Mr. Fox said goals will be set, but the success of the pilot project will be measured by the ability to provide resources to meet the medical and public health needs of the reservation.

In response to a question from Senator Warner, Mr. Fox said the tribe has established a working relationship with the Coeur d'Alene Tribe in Idaho and will benefit from its experiences.

Dr. John Baird, Special Populations Section Chief, State Department of Health, provided information (Appendix C) regarding the bill draft and the study of the feasibility of placing the Fort Berthold Reservation in a single public health unit. He said the bill draft will allow the tribe to form a public health unit to provide a good assessment of health issues, assure better public health services, and examine policies to improve the health of the community. He said the State Department of Health has met with representatives of the MHA Nation, staff of the Elbowoods Memorial Health Center, and Dr. Donald Warne, Director, Master of Public Health Program, North Dakota State University, Fargo. He said that while some codes exist, updating and consolidating tribal health and safety code into one document will provide clarity and better understanding of public health authority on the reservation. He said the group reviewed details of a model tribal health and safety code, and a smaller group will further examine the model and determine what should be presented to the tribal council. He said financial issues were discussed, but a business model and more specific budget will need to be developed as planning continues. He suggested changes to the bill draft to allow the tribal public health unit to organize as either a health district or public health department.

In response to a question from Senator Warner, Dr. Baird said the department reviewed local public health programs around the state to determine funding that may be required to support a local public health unit similar to one being considered for the Fort Berthold Reservation. He said local public health units across the state rely on local funding, and he anticipates the tribe would also need to provide support for a tribal public health unit.

In response to a question from Senator Mathern, Dr. Baird said until the tribe can identify and generate additional funding, the tribal public health unit would have an annual shortfall of approximately $200,000 per year.

In response to a question from Representative Weisz, Dr. Baird said state and local ordinances do not apply on tribal land.

Mr. Keith Johnson, Administrator, Custer Health Unit, Mandan, expressed support for the changes to the bill draft suggested by Dr. Baird relating to a tribal health unit designation rather than the tribal health district designation currently in the bill draft.

In response to a question from Senator Mathern, Mr. Johnson said a tribal public health unit project would be similar to the regional public health unit pilot project, and a two-year pilot project should be enough time to determine if a tribal public health unit will work.

In response to a question from Senator Warner, Mr. Johnson said the tribe is responsible for health and safety inspections on trust land. He said the local public health units provide inspection services on the reservation only when it is located on private or fee land.

In response to a question from Representative Weisz, Mr. Fox said individuals and businesses currently regulated by local public health units will not experience significant changes in regulation under a tribal health unit.

In response to a question from Senator Mathern, Mr. Fox said the tribe agreed with Dr. Baird's suggestions for changes to the bill draft.

Ms. Kelly Nagel, Public Health Liaison, State Department of Health, expressed concern regarding the effect of the bill draft on the tribe's ability to levy taxes for public health services. Later in the meeting, the Legislative Budget Analyst and Auditor said Section 6 of the bill draft applies only to counties, and the amendment does not preclude the tribe from levying a tax.

Ms. Katrina Wilke, student, North Dakota State University, said the oil boom and other factors have had an effect on the lives of people in the western part of the state. She said everyone should have access to health care and public health services. She said she neither supported nor opposed the bill draft; but if services are lacking, changes should be made. She said coordinated services will provide more benefits to the community.

Later in the meeting, the committee further discussed the study of the feasibility of placing the Fort Berthold Reservation in a single public health unit.

In addition to the changes to the bill draft suggested by Dr. Baird, Senator Lee suggested the committee also consider adding language to the bill draft to require a report to the Legislative Management every six months.

Senator Mathern said the appropriation should be increased to meet the estimated costs needed for the pilot project.

Senator Lee said discussions regarding funding should address the possibility of a tribal match. She said the amount of state funding available for the project will be subject to review by the Appropriations Committees during the legislative session.

Representative Kilichowski expressed concern that the tribe could discontinue the program at any time.

It was moved by Senator Mathern, seconded by Senator Warner, and carried on a roll call vote to amend the bill draft to allow the tribal public health unit to organize as either a health district or public health department and to require a report to the Legislative Management every six months.

Senators Lee, Mathern, Uglem, and Warner and Representatives Karls, Kilichowski, Nelson, Rohr, and Sanford voted "aye." No negative votes were cast.

Senator Mathern expressed concern that the bill draft includes funding of only $200,000. He said additional funding is needed for the pilot project and should be included in the bill draft initially.

Representative Sanford suggested funding be provided on a matching basis up to the maximum funding appropriated for the pilot project to allow time to determine whether the project will be successful.

It was moved by Senator Mathern, seconded by Senator Uglem, and carried on a roll call vote to amend the bill draft to include an appropriation of $500,000, of which $200,000 is from the general fund and $300,000 is provided on a matching basis by the Mandan, Hidatsa, and Arikara Nation or other source, to the State Department of Health for the purpose of implementing a tribal public health unit pilot project. Senators Lee, Mathern, Uglem, and Warner and Representatives Karls, Kilichowski, Nelson, Rohr, and Sanford voted "aye." No negative votes were cast.

It was moved by Senator Mathern, seconded by Representative Karls, and carried on a voice vote that the bill draft to allow a tribal public health unit to form and to provide funding for a pilot project related to establishing the tribal public health unit be approved as amended and recommended to the Legislative Management.

OTHER COMMITTEE RESPONSIBILITIES

Ms. Rebecca Ternes, Deputy Commissioner, Insurance Department, provided information (Appendix D) regarding the Insurance Commissioner's recommendation for a private entity to contract with to perform cost-benefit analyses of health insurance mandates during the 2013 legislative session. She said the Insurance Department solicited proposals from 13 actuarial firms to provide services as identified in the statute during the period from November 2012 through April 2013. She said in the request for proposal, firms were asked to provide a complete cost-benefit analysis within two weeks of receipt of the initial request made by the Legislative Council for a given mandate and within seven days for each request thereafter related to the same mandate. She said Milliman, Inc., was the only contractor to submit a bid, and the Insurance Commissioner recommends the Legislative Council contract with Milliman, Inc., to perform the cost-benefit analyses during the 2013 legislative session.

It was moved by Senator Warner, seconded by Senator Uglem, and carried on a voice vote to accept the Insurance Commissioner's recommendation of Milliman, Inc., as the entity to contract with for cost-benefit analyses on health insurance mandates during the 2013 legislative session.

Dr. Terry Dwelle, State Health Officer, State Department of Health, provided information (Appendix E) regarding community paramedics. He said there is the potential for community paramedics to provide additional cost-effective clinical and public health services, particularly in rural areas of the state. He said the ability to receive reimbursement for these services could enhance the sustainability of our current emergency medical services (EMS) system. He said EMS systems can function with volunteer personnel by responding to up to approximately 350 emergency calls per year, while fee-for-service systems are generally not sustainable until the service responds to at least 650 emergency calls per year. He said increased demand is causing some communities with volunteer responders to increase to more than 350 emergency calls but still less than 650. He said if the role of paramedics could be expanded to that of community paramedics, fee-for-service EMS systems could likely be sustained. He said five states currently use community paramedics. He said appropriately trained community paramedics could provide billable services, including:

- Community mid-level clinical evaluation and treatment;
- Community level call-a-nurse service and advice;
- Chronic disease management support;
- Case management of complex cases,
- Worksite wellness facilitation and onsite clinical support; and
- School wellness and mid-level clinical services.

In response to a question from Senator Lee, Dr. Dwelle said to expand the role of community paramedics in the state, appropriate training would be needed, third-party payers would need to recognize the benefit and pay for the services, and incentives would be needed to encourage community EMS systems relying on volunteers to hire paramedics.

Representative Rohr suggested the committee receive information from the State Department of Health regarding published outcomes of the community paramedic programs in states that have implemented the program.

In response to a question from Representative Sanford, Dr. Dwelle said a Helmsley Foundation grant has provided four buses equipped with the latest in simulation technology to travel throughout the state providing training to EMS and emergency personnel.

In response to a question from Representative Nelson, Dr. Dwelle said community paramedics would have to be part of the existing rural health care system.

Senator Lee suggested the committee consider a study resolution to gather more information regarding the community paramedic program.

Ms. Amy Eberle, board member, North Dakota Trauma Foundation, provided information (Appendix F) regarding a report on statewide emergency medical services and trauma plans. She said the state trauma system relies heavily on the in-kind support of the six Level II trauma centers

across the state, but the system has been struggling to meet increased demands over the past two years. She said from 2010 to 2011, rural hospitals experienced a 21 percent increase in the number of trauma patients transferred to Level II Trauma Centers. She said the foundation, trauma centers, and the State Trauma Advisory Committee have been working with the State Department of Health to develop a plan to enhance and support the resources within the state trauma system. She provided a summary of initiatives to improve the state's trauma system, including increased trauma designation site visits, additional advanced trauma life support (ATLS) education for Levels IV and V trauma centers, a rural trauma team development course, increased funding for the state medical director, an associate state trauma coordinator, and state trauma registry support.

Mr. Ron Lawler, Chair of the Community Paramedic Subcommittee, EMS Advisory Council, provided information regarding a community paramedic program. He said the community paramedic subcommittee has been meeting to gather information and is considering issues related to needs, certification, regulation, and reimbursement. He said the subcommittee is asking for support for a state regulator to oversee the community paramedic program.

Mr. Jerry Jurena, board member, Health Council, provided information (Appendix G) regarding the current level of basic care beds in the state and any issues or concerns regarding the availability of basic care beds. He said in 1994 the Health Council recommended the number of health care beds in the state not exceed 15 basic care beds per 1,000 population aged 65 and above. In 2010, he said, there were 16.49 basic care beds per 1,000 population over the age of 65; however, excluding special care facilities, the average was 15.53 basic care beds per 1,000 population over the age of 65. He said the Health Council recommends the moratorium on basic care beds continue and the target for basic care facility beds in the state continue to be 15 beds per 1,000 population over the age of 65.

Senator Lee said the committee is reviewing the Health Council's recommendation because although the number of basic care beds in the state remains over the target, there are areas of the state where demand for beds exceeds supply. She said the moratorium prevents facilities in these areas from increasing the number of beds to meet demand.

Ms. Darlene Bartz, Section Chief, Health Resources Section, State Department of Health, provided information (Appendix H) regarding the need for additional basic care beds in the state and whether the committee should consider recommending an incentive plan for moving basic care beds similar to the program available for skilled care beds. She said provisions of the moratorium include several options by which beds can be added to the state's licensed basic care bed capacity, including the conversion of nursing facility beds to basic care and the transfer of beds. She said beds can also be added to the state's licensed basic care bed capacity if the entity demonstrates to the State Department of Health and the Department of Human Services that basic care services are not readily available within a designated area of the state or that existing basic care beds within a 50-mile radius have been occupied at 90 percent or more for the previous 12 months. She said the current system is working, and the department has noted several transfers of basic care beds every month. She said it seems nursing facilities are successfully working together to transfer beds consistent with the options provided by the Legislative Assembly.

In response to a question from Representative Weisz, Ms. Bartz said when the Health Council reviewed the target levels for basic care facility beds, they considered all of the additional services available to the individuals likely to need basic care. She said increases in assisted living facilities and home and community-based services reduce the need for basic care beds.

Ms. Shelly Peterson, President, North Dakota Long Term Care Association, commented on the availability of basic care beds (Appendix I). She also provided a fact sheet on basic care, a statewide map of the location of basic care facilities, and a listing of 107 nursing facility layaway beds. She said the basic care bed moratorium, including the provisions that allow for exceptions, should continue. She said there is currently minimal demand for nursing facility beds, and she anticipates facilities will sell excess beds for use as basic care beds. She said most recently a basic care bed was sold for $10,000; however, demand for beds is low, and it is anticipated future pricing will be much lower. She said legislation in 2009 allowed a nursing facility to sell beds as either nursing facility or basic care beds to allow for more basic care beds. She said in 2011 when the new nursing facility bed layaway program was approved, this flexibility was eliminated. She said the association is proposing legislation to restore this flexibility and allow the facility receiving beds--through a sale or a transfer--the option of using the beds as either nursing or basic care beds.

Ms. Peterson said the North Dakota Long Term Care Association supports the community paramedic program and views it as a resource for personnel.

In response to a question from Representative Weisz, Ms. Peterson said the moratorium was likely established as a means to limit costs.

In response to a question from Representative Nelson, Ms. Peterson said assisted living is not regulated, nor is it eligible for reimbursement for low-income individuals.

Representative Weisz said it seems counter-productive that small facilities trying to expand to become more viable must purchase beds at times, at substantial cost.

Ms. Maggie Anderson, Interim Executive Director, Department of Human Services, provided information

regarding the ratesetting process for nursing homes and basic care facilities. She said provisions relating to occupancy percentages exist for nursing homes but not for basic care facilities. She said nursing home rates related to indirect costs and property are reduced when occupancy falls below 90 percent. She said this rate reduction is an incentive for facilities to transfer unused beds in order to maintain a higher occupancy rate. She said not all basic care facilities participate in Medicaid and basic care assistance programs, but all nursing homes do participate. She said nursing homes are also subject to the equalized rate provisions that prohibit a facility from charging a private-pay resident more than the Medicaid rate. She said based on 2010 cost reports, 21 of the 82 nursing homes were under the 90 percent occupancy requirement for full reimbursement. She said the department only has information regarding basic care facilities enrolled in the Medicaid program, and for 2010, 32 of the 54 enrolled basic care facilities were under the 90 percent occupancy rate.

Ms. Mary Jo Fries, Administrator, Golden Manor, Steele, commented on the basic care bed moratorium and the availability of basic care beds (Appendix J). She said the basic care bed target of 15 beds per 1,000 population over the age of 65 is too low for the aging population in the area served by Golden Manor. She said in order to receive a certificate of need and add to the state's licensed basic care bed capacity, Golden Manor must demonstrate that existing basic care beds within a 50 mile radius have been occupied at 90 percent or more for the previous 12 months. She said this requirement has been applied using cross-country distance and therefore includes facilities whose driving distance is greater. In addition, she said, the requirement also includes facilities within the service area radius that are in startup mode, when it is unrealistic to expect the facility to be at 90 percent occupancy. She said when Golden Manor was denied additional licensed beds, the service area occupancy rate was 89.6 percent. She said the facility then purchased three beds for $10,000 each. She said Golden Manor has filled those beds and has five rooms available for licensing and a waiting list. She said the percentage of private-pay individuals on the waiting list at Golden Manor is approximately 65 to 75 percent, so an increase in beds licensed would not substantially increase costs to the state. She said licensed beds should not be a commodity to be sold to the highest bidder and funding could be better spent on improving care for residents and wages and benefits for staff. She provided information regarding long-term care facilities' plans for beds currently in the layaway program.

Senator Mathern said before the moratorium, it was possible for an individual who did not need the assistance provided in a basic care or nursing facility to enter the facility as a private-pay resident, effectively depleting their resources before needing the services. He said when the need for services arose, there were no assets and the individual became dependent on the state and Medicaid to pay for the cost of care.

In response to a question from Senator Lee, Ms. Fries said Golden Manor acts as a senior center and hosts community events. She said the facility also provides services for the developmentally disabled and for those with mental illness.

Mr. Tom Steinolfson, Board Chairman, Golden Manor, Steele, commented on the availability of basic care bed licenses. He expressed concern that a growing facility must purchase beds from other facilities at substantial cost. He said adjustments should be made to the moratorium to allow facilities with a demonstrated demand for services to increase its bed capacity using a less costly method.

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 *Financial Assistance Programs Available to University of North Dakota School of Medicine and Health Sciences Students and Graduates*. The Legislative Council staff said financial assistance programs include federal and private loan programs, scholarships and awards. Senior medical students may also apply for one of two loan programs available to provide funding for residency interview and relocation expenses. Health care professionals may also apply for the medical personnel loan repayment program or the physician loan repayment program administered by the State Department of Health.

Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, provided information (Appendix K) regarding the utilization of the physician, dental, and mid-level loan programs, including funding available. She said the Health Council establishes loan program eligibility requirements and approves awards to applicants. She said the physician and mid-level practitioner loan programs are authorized as many awards per year as can be supported by the funding. She said the department is authorized three awards per year for the dental loan repayment program and two awards per year for the dental new business grant program.

In response to a question from Senator Lee, Ms. Smith said because of the lack of requests for funds from the dental new business grant program, the department anticipates removing the program from its budget for the 2013-15 biennium.

In response to a question from Representative Nelson, Mr. Gary Garland, Primary Care Office Director, State Department of Health, said the preference at this time is to place professionals in the western part of the state, and it is given significant consideration when reviewing applicants. He said the

department also places a high priority on applicants willing to serve in rural communities. He said if additional funding becomes available and the loan repayment programs are modified to allow more awards, the programs could be a tool to address provider shortage situations.

Representative Nelson said the need for health care professionals is not limited to the western part of the state.

Mr. Dave Molmen, Chair, University of North Dakota School of Medicine and Health Sciences Advisory Council, provided information (Appendix L) regarding an update to the comprehensive workforce plan. He said the *Second Biennial Report on Health Issues for the State of North Dakota* will provide a formal update to the comprehensive workforce plan for the Legislative Assembly. He said the workforce initiative is not an education plan but rather a proactive plan to address the health care needs of the state. He said education is one of the tools available to help meet the future health care needs of the state. He said the plan is based on age demographics, disease burden, consumer habits, health care system efficiency, health care regulations, and workforce habits. He said North Dakota is anticipated to have 210 fewer physicians than needed by 2025 based on the baseline and trend. He said strategies to address this include:

- Reducing the disease burden by establishing a Master of Public Health program and a geriatrics training program,
- Training more physicians and other health care professionals, including 16 medical students, 30 health sciences students, and 17 residency slots per year, and to provide an updated health sciences building to provide the training; and
- Retaining more of the professionals trained in North Dakota.

Mr. Molmen said as the plan was finalized, it appeared that half of the anticipated shortage in health care professionals in the state could be met by increasing the number of professionals trained and the other half could be met by increasing the retention of professionals trained in the state. He said the Legislative Assembly in 2011 provided funding for the number of additional students and residents that could be accommodated with the current medical school faculty and facility resources. He said funding for 8 medical students, 15 health sciences students, and 9 residency slots was approved.

Dr. Joshua Wynne, Dean, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix L) regarding an update on the implementation of approved initiatives included in the comprehensive workforce plan. He said there are 27 students enrolled in the Master of Public Health program, and the first class will graduate in 2014. He said the School of Medicine is recruiting a neurologist and a geriatrician to help train students and community practitioners. He said programs to enhance retention of graduates include:

- Integrated longitudinal clerkship in Minot where four students are enrolled in the program for third-year medical school students. He said the program is designed to expose the students to the community, not just diseases, and to encourage them to become part of the community.
- Additional residencies needed for licensure. He said in 2012, 70 percent of graduates from North Dakota residency programs remained in the state to practice. He said the state has been successful at recruiting School of Medicine graduates that have left the state to complete their residencies. He said the Center for Rural Health found that of the School of Medicine graduates practicing in the state, 58 percent returned to the state from an out-of-state residency.
- RuralMed program which focuses on primary care in rural areas of the state. He said if the student choses to practice family medicine in a rural area of the state, the program will reimburse the student for tuition costs of all four years of medical school. He said the program has funding available for up to eight slots per year. He said there are currently 12 students in the program.

Dr. Wynne said the School of Medicine has admitted an additional 8 medical and 15 health sciences students and expanded residency slots, all with a focus on family medicine and general surgery in rural areas of the state. He said the admission policy at the School of Medicine has been updated to focus on students likely to practice primary care in rural areas of the state. He said the second phase of the health care workforce initiative will include an additional 8 medical students, 15 health sciences students, and 8 residency slots and a facility to house the more than 200 new students, faculty, and staff associated with the full implementation of the initiative. He said the space study of the medical school facility concluded:

- The current facility is being used effectively and utilization is at or above national benchmarks;
- The current facility is unable to provide space for more students, faculty, and staff; and
- Extensive renovation is inadvisable.

In response to a question from Senator Warner, Dr. Wynne said the School of Medicine is 1 of 27 community-based medical schools in the country. He said the School of Medicine works closely with all of the major hospitals in the state. He said the community-based model is ideal for training the type of practitioners needed in North Dakota.

Mr. Molmen provided information regarding the recommendation of the School of Medicine and Health Sciences Advisory Council for the proposed renovation or construction project at the School of Medicine. He said the advisory council met in early

September to review options to accommodate the student enrollment growth associated with the health care workforce initiative at the School of Medicine. He said all of the options reviewed meet the needs of the workforce initiative. He said the advisory council evaluated the options to determine economic cost and how well each option will meet the state's future needs. He said the cost estimates for each option include construction, site preparation, and technology. He provided the following summary of the three construction options:

- Option 1 - With an estimated cost of $38.5 million, includes an 80,103 gross square footage (GSF) addition with shared education space and the renovation of 42,311 GSF of faculty offices and education space. He said this option moves some instruction into the new space and uses the old space for administration and other instruction. He said advantages of this option include the lower cost and shorter completion time. He said disadvantages include logistical difficulties, ongoing maintenance of the old facility, limitations on the development of optimal collaborative and educational space to bring health-related training programs together, the need for a pedestrian bridge, and minimal site room for future growth.
- Option 2 - With an estimated cost of $68.3 million, includes a 169,390 GSF addition with shared education space and student collaboration space and the renovation of 48,332 GSF of faculty office, collaboration, and administration space. He said advantages of this option include the intermediate cost and completion time, some integration of health-related training programs, and compliance with established national standards for educational facilities. He said disadvantages include logistical difficulties, ongoing maintenance of the old facility, some limitations on the development of optimal collaborative and educational space, the need for a pedestrian bridge, and minimal site room for future growth.
- Option 3 - With an estimated cost of $124 million, creates a new 376,812 GSF building with shared education space, student and faculty collaboration space, faculty and administration offices, and research facilities. He said advantages of this option include its potential for growth and full integration of health-related training programs, minimal effect on School of Medicine operations during construction, low maintenance and operational costs, longer useful life, and a positive effect on the university's facilities and administrative (F&A) rate used to calculate research grant reimbursements. He said disadvantages include the high initial cost and long completion time. He said because the School of Medicine is a research facility, the new construction's positive effect on the F&A rate also has a positive economic impact on the university.

Mr. Molmen said based on lower maintenance and operating costs in the future and the positive economic impact to the university, the School of Medicine and Health Sciences Advisory Council recommends Option 3--the construction of a new facility.

Dr. Wynne said all but one member of the School of Medicine and Health Sciences Advisory Council favored new construction (Option 3). He said the one dissenting vote favored the larger addition and renovation (Option 2). He said no one on the advisory council favored Option 1 or maintaining the current medical school facility. He provided the following information regarding the estimated 40-year life cycle costs, of the current facility and each of the three options:

Option	40-Year Life Cycle Cost (Amounts Shown in Millions)
Current facility without changes	$102.7
Option 1	$163.8
Option 2	$214.1
Option 3	$159.9

Dr. Wynne said lower maintenance and utility costs and the additional revenue anticipated as a result of the increased F&A rate results in the lower 40-year life cycle cost of Option 3. He said because most of the university's research space was constructed with federal funds, it is not included in the F&A rate. He said the university's rate of 38 percent is the second lowest in the nation. He said because the building's research space would be constructed using state funds, the cost would be considered in the calculation of the university's F&A rate. He said the current building will be 100 years old in 40 years, and maintenance costs will increase significantly and repairs will be more costly.

In response to a question from Representative Nelson, Dr. Wynne said the F&A rate is calculated for the campus as a whole.

In response to a question from Representative Nelson, Dr. Wynne said the new building could also have a positive effect on the recruitment of professionals and on the amount of research awarded to the School of Medicine.

In response to a question from Representative Rohr, Dr. Wynne said if approved, construction or renovation planning would begin in July 2013 and take one year. He said construction is anticipated to last another two years with the students beginning to use the facility during the summer of 2016.

Senator Warner suggested the committee receive information regarding the range of F&A rates in the nation. Dr. Wynne said he will e-mail the information to the committee.

It was moved by Representative Nelson, seconded by Representative Sanford, and carried on a roll call vote that the Health Services

Committee recommend construction of a new University of North Dakota School of Medicine and Health Sciences facility (Option 3 at an estimated cost of $124 million). Senators Lee, Mathern, Uglem, and Warner and Representatives Karls, Kilichowski, Nelson, Rohr, and Sanford voted "aye." No negative votes were cast.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

It was moved by Senator Mathern, seconded by Senator Warner, and carried on a voice vote that the Legislative Council staff prepare a resolution draft to study the potential for community paramedics to provide additional clinical and public health services particularly in rural areas of the state, including the ability to receive reimbursement for these services and the effect these reimbursements would have on the sustainability of emergency medical services providers and that the resolution draft be approved and recommended to the Legislative Management.

It was moved by Senator Mathern, seconded by Representative Nelson, and carried on a voice vote that the Chairman and the staff of the Legislative Council be requested to prepare a report and the bill and resolution drafts recommended by the committee and to present the report and recommended bill and resolution drafts to the Legislative Management.

It was moved by Representative Nelson, seconded by Senator Uglem, and carried on a voice vote that the committee adjourn sine die.

Chairman Lee adjourned the committee sine die at 4:10 p.m.

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Sheila M. Sandness
Senior Fiscal Analyst

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Allen H. Knudson
Legislative Budget Analyst and Auditor

ATTACH:12