NORTH DAKOTA LEGISLATIVE COUNCIL

Minutes of the

BUDGET COMMITTEE ON HEALTH CARE

Wednesday, July 7, 1999
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Clara Sue Price, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives Clara Sue Price, Byron Clark, William R. Devlin, David Drovdal, Deb Lundgren, Todd Porter, Wanda Rose, Dale C. Severson, Ken Svedjan; Senators Judy L. DeMers, Tom Fischer, Ralph Kilzer, Randy A. Schobinger

Members absent: Representatives Audrey Cleary, Serenus Hoffner, Keith A. Kempenich, Carol A. Niemeier; Senators Marv Mutzenberger, Russell T. Thane

Others present: See attached appendix

Mr. Chester E. Nelson, Jr., Legislative Budget Analyst and Auditor, reviewed the Legislative Council's supplementary rules of operation and procedure.

Chairman Price announced that Senator Tom Fischer would serve as vice chairman for the committee. Chairman Price suggested that committee members consider possible study areas which could be combined and possible study areas which could be expanded. She said later in the interim this committee will serve as a budget tour group for the Budget Section. Chairman Price encouraged committee members to attend the public hearings held by the State Health Council when the hearing is in the committee member's area.

COMMUNITY HEALTH GRANT PROGRAM

The Legislative Council staff presented a memorandum entitled *Study of Community Health Grant Program - Background Memorandum*. Section 9 of 1999 House Bill No. 1004 provides for the State Department of Health to develop a comprehensive plan for a community health grant program. The section also provides that the plan is to be submitted to the Legislative Council during the 1999-2000 interim and that the Legislative Council is to study the plan. The memorandum included the following proposed study plan:

1. Receive the State Department of Health's comprehensive plan for a community health grant program.
2. Review the comprehensive plan for a community health grant program and receive testimony from public interest groups regarding the content of the plan.
3. Provide recommendations to the State Department of Health regarding its development of a comprehensive plan for a community health grant program.
4. Provide recommendations to the Legislative Council and the 2001 Legislative Assembly regarding the State Department of Health's comprehensive plan for a community health grant program and consider any legislation necessary to implement the plan for the community health grant program.

Mr. Murray G. Sagsveen, State Health Officer, State Department of Health, presented information on the study of the community health grant program. A copy of his presentation is on file in the Legislative Council office. Mr. Sagsveen said based on information he received from the North Dakota Tax Department, tobacco tax revenue for calendar years 1997 and 1998 was about $48 million. He said information suggests that due to tobacco settlement related price increases, cigarette and tobacco sales could decrease by 6 to 16 percent. Mr. Sagsveen said, in addition, more effective enforcement and counter smoking programs could reduce consumption by an additional five percent during the next biennium. He said it is possible that the combined impact of increased prices, better enforcement, and improved counter tobacco programs could reduce tobacco consumption and tobacco tax revenue by up to 20 percent during the next biennium which would equate to a revenue decrease of approximately $9.6 million.

Mr. Sagsveen reviewed the following five possible uses for the funds in the community health trust fund:

1. Increase grant funding provided to local public health units from $1 million to approximately $7 million per biennium.
2. To partially meet the Center for Disease Control guidelines that the state spend at least $8.9 million for a comprehensive tobacco prevention and control program.
3. Establish a community health grant program.
4. For a one-time appropriation to construct a state morgue for the medical examiner and upgrade the existing microbiology and chemistry labs within the State Department of Health.

5. Provide funding to the State Department of Health and local public health units for a statewide data system.

Mr. Sagsveen invited the committee to tour the State Department of Health's laboratory and morgue facilities in order to obtain a better understanding of the department's needs regarding these facilities.

In response to a question from Representative Price, Mr. Sagsveen said the Health Council will be holding public hearings throughout the state to complement the work of this committee. He said the first meeting will be in Grand Forks on August 17, 1999, at the University of North Dakota School of Medicine and Health Sciences.

In response to a question from Representative Price, Mr. Sagsveen said the department can have a draft proposal for a community health grant program ready for the committee's next meeting. He said he would hope this committee and the State Department of Health can have a fairly substantive plan developed by late spring or early summer of the year 2000 in order to have some type of plan to work with for the 2001-03 budget process.

Ms. Lisa Clute, First District Health Unit, Minot, presented information on the study of the community health grant program. A copy of her presentation is on file in the Legislative Council office. She said when planning for a community health grant program, she hopes that both long- and short-range planning is taken into account. She said consideration should be given to reserving a portion of the funding for unknowns or contingency items in order to allow the local district health units the ability of applying for funds to respond to one-time issues or other short-term issues.

In response to a question from Representative Svedjan, Mr. Sagsveen said he has not discussed the five options with the Governor and, therefore, is not able to comment on the priority of the five options. He said before the next meeting he will meet with the Governor so that a prioritized proposal can be presented to this committee. He said the proposal may contain more than one of the five options.

In response to a question from Representative Drovdal, Mr. Sagsveen said maintaining a portion of the funds as contingency funding or emergency funding is a very good idea and is worth considering in the development of the plan.

Representative Porter suggested the plan look at the possibility of maintaining the principal in the community health trust fund and only spend the earnings on the fund. He said that would allow for the establishment of a permanent program rather than a 25-year program which will end when the tobacco settlement moneys are no longer being received.

Mr. Nelson said the bill establishing the trust fund is vague as to whether or not the interest on the community health trust fund would remain in the fund or go to the general fund. He said the tobacco settlement trust fund maintains its interest, which is then allocated to the other funds.

Chairman Price indicated the following would be considered as additions to the proposed study plan for the community health grant program:

1. Receive information from the State Department of Health regarding the prioritization of its options for using funding in the community health trust fund, including designating a portion of the funds as contingency funds or designating a portion of the funds to be used for one-time uses.
2. Consider whether the interest earned on the community health trust fund should remain within the community health trust fund or be deposited in the general fund.

It was moved by Representative Drovdal, seconded by Representative Svedjan, and carried on a voice vote that the Budget Committee on Health Care adopt the following study plan on the community health grant program:

1. **Receive the State Department of Health's comprehensive plan for a community health grant program.**
2. **Review the comprehensive plan for a community health grant program and receive testimony from public interest groups regarding the content of the plan.**
3. **Receive information from the State Department of Health regarding the prioritization of its options for using funding in the community health trust fund, including designating a portion of the funds as contingency funds or designating a portion of the funds to be used for one-time uses.**
4. **Provide recommendations to the State Department of Health regarding its development of a comprehensive plan for a community health grant program.**
5. **Consider whether the interest earned on the community health trust fund should remain within the community health trust fund or be deposited in the general fund.**
6. **Provide recommendations to the Legislative Council and the 2001 Legislative Assembly regarding the State Department of Health's comprehensive plan for a community health grant program and consider any legislation necessary to implement the plan for the community health grant program.**

RURAL COMMUNITY INCENTIVE PACKAGE

The Legislative Council staff presented a memorandum entitled *Incentive Package to Facilitate Reducing Long-Term Care Bed Capacity and*

Providing Alternative Long-Term Care Services - Background Memorandum. Senate Concurrent Resolution No. 4004 (1999) directs the Legislative Council to study the possibility of creating an incentive package to assist rural communities and nursing facilities in closing or significantly reducing bed capacity and providing alternative long-term care services. The resolution indicates that because the closure of a facility in a rural community can have a significant impact on the entire community, similar to the loss of other local businesses, schools, or hospitals, assistance may therefore be needed for communities when a facility chooses to close or reduce bed capacity. The resolution also cited that assistance and other incentives should be made available to enable facilities to make the transition toward closing or providing alternative long-term care services. The memorandum included the following proposed study plan:

1. Receive information regarding other states' activities relating to intergovernmental transfer programs.
2. Receive information from the Department of Human Services regarding the implementation of 1999 Senate Bill No. 2168, specifically what uses the funding contained in Senate Bill No. 2168 may be used for and the amount of funding actually available through the intergovernmental transfer program.
3. Receive information from interested groups and organizations regarding potential uses for funds in the North Dakota health care trust fund and on other types of incentives, in addition to the provisions of Senate Bill No. 2168, which could be used to assist rural communities to reduce long-term care bed capacity and to provide alternative long-term care services.
4. Provide recommendations to the Department of Human Services regarding the potential uses of the North Dakota health care trust fund moneys.
5. Provide recommendations to the Legislative Council and the 2001 Legislative Assembly regarding the development of an incentive package to assist rural communities and nursing facilities in closing or significantly reducing bed capacity and providing alternative long-term care services and on the potential uses for the North Dakota health care trust fund and consider any legislation necessary to implement the recommendations.

Mr. Mike Mullen, State Department of Health, presented information on the study of a rural community incentive package. A copy of his presentation is on file in the Legislative Council office. He said the majority of nursing homes with a vacancy rate of 10 percent or more are located along the northern, southern, and western borders of the state. He said there are also two nursing homes, one in Grand Forks County and one in Cass County, that have vacancy rates of 10 percent or more.

Mr. Mullen said the more populous counties, with the exception of Grand Forks County, have gained elderly population between 1991 and 1997 while many of the rural counties have had declines in their elderly population.

Mr. Mullen said the State Department of Health's Office of Community Assistance administers a number of federal and state programs which are focused on "right sizing" rural health care services in North Dakota. He said with the cooperation and assistance of the Department of Human Services, the Office of Community Assistance is involved in a number of projects including the merger and transition of long-term care and other services in Carrington and New Rockford and the collocation of long-term care and acute care in Forman and Stanley.

Mr. David Zentner, Department of Human Services, presented information on the study of a rural community incentive package. A copy of his presentation is on file in the Legislative Council office. He said this issue was addressed in the Task Force on Long-Term Care Planning report dated June 1998 which was presented to the interim Budget Committee on Long-Term Care during the last interim. He said the task force did not develop any specific recommendations but did conclude that the issue is complicated and needs further study before final decisions could be made regarding what types of incentives would best meet the needs of rural communities.

Mr. Zentner said after the task force had completed its work the department, with the assistance of the North Dakota Long Term Care Association, learned that Nebraska was using a new funding mechanism that allowed the state to increase federal funding. He said these funds were then designated to be used to provide loans or grants to nursing facilities wishing to develop alternative long-term care services. Mr. Zentner said based on this the department introduced Senate Bill No. 2168, which was passed by the 1999 Legislative Assembly. He said Senate Bill No. 2168 creates the intergovernmental transfer program. He said the department is in the process of implementing the program. Mr. Zentner said although this bill provides an incentive to allow communities to transition to other forms of long-term care services, it likely is not the only tool that will be needed to ensure that rural communities continue to provide needed health care services.

Mr. Zentner said the Task Force on Long-Term Care Planning will again be activated to study the ongoing changes and challenges facing the state in meeting the long-term care needs of the elderly and disabled. He said the task force plans to submit a report toward the end of the interim for legislative consideration.

In response to a question from Representative Price, Mr. Zentner said approximately $4.3 million of trust fund funding was used for the service payments for the elderly and disabled program for the 1999-2001 biennium.

In response to a question from Representative Price, Ms. Carol Olson, Department of Human Services, provided the following funding comparison of the service payments for the elderly and disabled funding for the 1997-99 and 1999-2001 bienniums:

Funding Source	1997-99 Biennium	1999-2001 Biennium	Increase (Decrease)
General fund	$8,442,577	$7,911,168	($531,409)
County funds	444,346	640,712	196,366
Trust fund		4,262,410	4,262,410
Total	$8,886,923	$12,814,290	$3,927,367

In response to a question from Senator DeMers, Mr. Zentner said other states generate much more funding through the intergovernmental transfer program because they have larger numbers of people on Medicaid and a larger difference between the Medicaid and Medicare rates.

Ms. Shelly Peterson, North Dakota Long Term Care Association, Bismarck, presented information on the study of developing a rural community incentive package. A copy of her presentation is on file in the Legislative Council office. She said one year ago the average occupancy rate of nursing facilities within the state was 95.2 percent. Ms. Peterson said the intergovernmental transfer funds will be critical for transitioning the way North Dakota delivers long-term care from an institution-dominated system to more home- and community-based care. Ms. Peterson said in order to transition into a different delivery system current costs need to be recognized. She said as the industry moves toward fewer institutional beds, the department needs to adequately fund nursing facilities and basic care facilities.

Mr. Allan Metzger, Golden Acres Manor, Carrington, commented on the study of developing a rural community incentive package. He said the Golden Acres Manor nursing facility of Carrington, the Carrington Hospital, and the nursing facility in New Rockford are working together to try to stabilize the elderly population by providing an enhanced continuum of care through the addition of other levels and types of care. He said the three facilities will reduce approximately 54 skilled beds and create a dementia unit through the conversion of beds. Mr. Metzger said the facilities will also be combining transportation services and sharing staff where possible. He said currently there are 187 skilled beds within a 14-mile radius and approximately 1,000 skilled beds within a 50-mile radius.

Mr. Brian McDermott, Carrington Hospital, Carrington, commented on the study of developing a rural community incentive package. He said the undertaking of developing a continuum of care between the three facilities prevents each facility from needing to develop its own continuum of care. He said the hospital will be converting 40 skilled beds to assisted living beds, looking at expanding clinics, and looking at establishing a wellness center. Mr. McDermott said the New Rockford facility will be converting a portion of its beds to a dementia unit.

In response to a question from Representative Svedjan, Mr. McDermott said part of the reason this project may be successful is the close proximity of the three facilities. He said he is not sure how far the distance between the facilities could be stretched and still maintain a viable relationship.

Representative Svedjan suggested that the committee receive information on the location and capacity of each long-term care facility in the state, along with information on the occupancy rate and level of care provided at each facility.

Chairman Price said the following items would be included in the study plan relating to the study of the development of a rural community incentive package:

1. Receive a report from the Task Force on Long-Term Care Planning.
2. Receive periodic updates on the joint project among the three facilities in New Rockford and Carrington.
3. Receive information regarding the location, capacity, occupancy rate, and level of care provided at all long-term care facilities throughout the state.

It was moved by Senator DeMers, seconded by Representative Svedjan, and carried on a voice vote that the Budget Committee on Health Care adopt the following study plan relating to its study of the development of a rural community incentive package:

1. **Receive information regarding other states' activities relating to intergovernmental transfer programs.**
2. **Receive information from the Department of Human Services regarding the implementation of 1999 Senate Bill No. 2168, specifically what uses the funding contained in Senate Bill No. 2168 may be used for and the amount of funding actually available through the intergovernmental transfer program.**
3. **Receive information from interested groups and organizations regarding potential uses for funds in the North Dakota health care trust fund and on other types of incentives, in addition to the provisions of Senate Bill No. 2168, which could be used to assist rural communities to reduce long-term care bed capacity and to provide alternative long-term care services.**
4. **Provide recommendations to the Department of Human Services regarding the**

potential uses of the North Dakota health care trust fund moneys.

5. **Receive a report from the Task Force on Long-Term Care Planning.**
6. **Receive periodic updates on the joint project among the three facilities in New Rockford and Carrington.**
7. **Receive information regarding the location, capacity, occupancy rate, and level of care provided at all long-term care facilities throughout the state.**
8. **Provide recommendations to the Legislative Council and the 2001 Legislative Assembly regarding the development of an incentive package to assist rural communities and nursing facilities in closing or significantly reducing bed capacity and providing alternative long-term care services and on the potential uses for the North Dakota health care trust fund and consideration of any legislation necessary to implement the recommendations.**

ACCESS, QUALITY, AND COST OF HEALTH CARE WITHIN THE STATE

The Legislative Council staff presented a memorandum entitled *Access, Quality, and Cost of Health Care Within the State - Background Memorandum*. House Concurrent Resolution No. 3070 (1999) provides for a Legislative Council study of health care in this state relative to access, quality, and cost to determine essential health care services, critical providers, access sites, and geographic, demographic, and economic issues relating to health care, including health care insurance. The resolution also provides that the State Health Council is to conduct public hearings throughout the state to elicit the public's perception and needs regarding what health care the public is willing to support and report these findings to this committee. The memorandum included the following proposed study plan:

1. Receive information from interested organizations, entities, and individuals regarding the access, quality, and cost of health care within North Dakota.
2. Receive reports from the State Health Council regarding its holding of public hearings throughout the state to elicit the public's perception and needs regarding what health care the public is willing to support.
3. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding current initiatives of the School of Medicine and Health Sciences relating to access, quality, and cost of health care within the state.
4. Receive information from Blue Cross Blue Shield of North Dakota regarding current trends in health care insurance premiums, health care utilization, and health care facility reimbursements.
5. Receive information from the University of North Dakota School of Medicine and Health Sciences, the State Department of Health, and other interested organizations regarding the duplication and overlap of health care delivery systems within the state.
6. Receive information from the Health Care Data Committee on the various reimbursement rates and methodologies provided by insurance companies, Medicaid, Medicare, and other health care payers.
7. Develop recommendations to be provided to the Legislative Council and to the 2001 Legislative Assembly regarding the access, quality, and cost of health care within the state and consider any legislation needed to implement the recommendations.

Chairman Price indicated that a presentation on the Balanced Budget Act and its impact on health care services and health care funding would be included for a future meeting of this committee.

Senator DeMers suggested that the presentation also include information on the impact of the Balanced Budget Act on the funding of medical education.

Representative Svedjan suggested the committee receive information on the role of insurance companies relating to insurance company decisions regarding what will be covered and what will not be covered and information as to when these decisions begin to have an impact on the quality of care provided by health care professionals and health care facilities.

Senator Kilzer suggested the committee receive information regarding historical profit and loss trends of Blue Cross Blue Shield, fee schedule changes for Blue Cross Blue Shield, cost changes for services provided by health care facilities within the state, and cost and reimbursement changes for HMOs and Medicaid.

The committee recessed for lunch at 11:55 a.m. and reconvened at 1:05 p.m.

Mr. Mullen presented information on the study of access, quality, and cost of health care within the state. A copy of his presentation is on file in the Legislative Council office. He said over 90 percent of the state's population is within 21 miles of a hospital. Mr. Mullen said there is fairly good geographic access to health care services today. He said the problem is that the system is fragile and that many emergency medicine service programs are struggling to recruit enough volunteers as the population moves away from rural areas or aging members retire. Mr. Mullen said many rural clinics are just one retirement or one failed recruitment away from closure or a serious primary care provider shortage.

Mr. Mullen said a measure of quality is to look at the availability and utilization of preventive care. He said in North Dakota approximately 85 percent of pregnant women receive prenatal care during their first trimester as compared to a national average of 82 percent. He said, in addition, approximately 83 percent of two-year-old children in the state have been immunized as compared to the national average of 78 percent.

Mr. Mullen said the health care cost issue that receives the most attention is the increase in health insurance premiums. He said in the early 1990s health insurance premiums were increasing by more than 10 percent per year and then the increases fell sharply until 1996 when there was a negligible increase. He said more current data shows that the rate of increase in health insurance premiums has recently become significant again, reaching 13.8 percent in 1999.

Representative Svedjan suggested the committee receive information on total health care expenditures by a major diagnostic group to see where there are increases and decreases in health care costs.

Representative Svedjan said since health care insurance premiums are again increasing it may be worthwhile to look at the impact of mandated benefits on premiums. He said the committee could also receive information on the economy's impact on health care and the impact of decreased utilization on the cost of health care.

Representative Porter suggested the committee receive information regarding the cost shift occurring from Medicare and Medicaid to private insurers and private pay individuals due to the underfunding of the Medicare and Medicaid programs.

Representative Svedjan expressed an interest in receiving information on the impact of increased regulations on health care costs.

Chairman Price said the State Department of Health may want to consider looking at home health regulations and the impact on that industry in order to get an understanding and insight on how to track the impact of increased regulations on the health care industry.

Dr. Matthew D. Layman, North Dakota Medical Association, Bismarck, presented information on the study of the access, quality, and cost of health care within the state. A copy of his presentation is on file in the Legislative Council office. Dr. Layman distributed copies of the *1999 North Dakota Medical Services Directory*, a copy of which is on file in the Legislative Council office.

Dr. Layman said the unique relationship between patient and physician is being challenged by the confusing and often contradictory results of shared risk arrangements, utilization review programs, new layers of management, reformulated payment schemes, and other solutions for how medical care should be provided by physicians. He said North Dakota physicians want what is best for the patient. He said patients want their individual health care directed by their physician rather than an insurance company. Dr. Layman encouraged the committee to request appropriate and accurate data from insurance companies in order to make informed decisions about the future of health care within the state and to find effective ways to manage costs while providing adequate care for patients.

Mr. Mike Tomasko, North Dakota Medical Group Management Association, Bismarck, presented testimony regarding the study of access, quality, and cost of health care within the state. A copy of his presentation is on file in the Legislative Council office. Mr. Tomasko distributed a 1999 membership directory of the North Dakota Medical Group Management Association, a copy of which is on file in the Legislative Council office. He said he supports the study and encourages the committee to look closely at North Dakota data. Mr. Tomasko encouraged committee members to contact their local North Dakota Medical Group Management Association member. He said the members of the association would be pleased to provide local data to committee members.

Mr. Dan Ulmer, Blue Cross Blue Shield of North Dakota, Bismarck, commented on the study of access, quality, and cost of health care within the state. He said Blue Cross Blue Shield is looking forward to working with the committee on its health care-related studies and that Blue Cross Blue Shield would be pleased to arrange for presentations at a future meeting regarding utilization, costs, and reimbursement issues relating to health care within the state.

In response to a question from Representative Price, Mr. Ulmer said for every one percent increase in health insurance premiums approximately 300,000 people discontinue health insurance coverage.

Senator Kilzer said utilization will increase as the average age of the insured group increases. He suggested the committee receive information from Blue Cross Blue Shield comparing the Blue Cross Blue Shield of North Dakota statistics to the national Blue Cross Blue Shield figures regarding utilization, age of subscriber, premium cost, and reimbursement to providers.

Chairman Price said the approval of the study plan for the study of the access, quality, and cost of health care within the state would be considered along with the study plan regarding the study of the challenges facing the delivery of health care within the state, unless there was objection from committee members.

CHALLENGES FACING THE DELIVERY OF HEALTH CARE WITHIN THE STATE

The Legislative Council staff presented a memorandum entitled *Study of the Delivery of Health Care Within the State*. House Concurrent Resolution

No. 3046 (1999) provides for a Legislative Council study of the challenges facing the delivery of health care in the state, including the concerns relating to reimbursement of hospitals for medical services, technological innovation, and possible regionalization of services. The memorandum included the following proposed study plan:

1. Receive information from interested organizations, entities, and individuals identifying the perceived challenges facing the delivery of health care within North Dakota.
2. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding current initiatives of the School of Medicine and Health Sciences to maintain health care services in rural communities.
3. Receive information regarding the changes in the health care delivery system as a result of managed care.
4. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding technological innovations affecting the delivery of health care in rural areas including information on telemedicine initiatives.
5. Receive information from the Health Care Data Committee on the various reimbursement rates and methodologies provided by insurance companies, Medicaid, Medicare, and other health care payers.
6. Develop recommendations to be provided to the Legislative Council and the 2001 Legislative Assembly regarding the challenges facing the delivery of health care within the state and consider any legislation needed to implement the recommendations.

Chairman Price said the committee would be receiving reports on Tioga's critical access hospital designation at future committee meetings.

Mr. Mullen presented information on the study of the challenges facing the delivery of health care, including the reimbursement of hospitals. A copy of his presentation is on file in the Legislative Council office. He said inpatient admissions in North Dakota decreased from 137,000 in 1980 to 91,000 in 1993, a 33 percent decrease. Mr. Mullen said during approximately the same time period the average length of stay for inpatient care in the north central states fell from 7 days to 4.4 days.

Mr. Mullen said from 1976 to 1997 rural hospitals in North Dakota experienced the following decreases in inpatient hospital days:

Watford City	78 %
Tioga	66 %
Grafton	75 %
Elgin	85 %
Devils Lake	77 %
Cavalier	77 %
Rugby	68 %
Stanley	67 %

Mr. Mullen said 15 small hospitals in North Dakota experienced an average decrease in inpatient hospital days of 71 percent over a 21-year period. He said during a more recent timeframe, 1990 to 1997, Medicare inpatient days in North Dakota hospitals decreased 21 percent, from 280,000 to 221,000. He said this decrease in hospital admissions and average length of stay together with a declining population and residents bypassing the local community hospitals places substantial stress on small health care facilities.

Mr. Mullen said a new program that may assist rural hospitals in achieving a better balance between capacity and revenue and may allow small hospitals to continue to meet the needs of their communities is the Medicare rural hospital flexibility program which allows the designation of rural facilities as critical access hospitals if the hospital meets certain criteria. He said to qualify the facility must:

1. Be located a sufficient distance, generally 35 miles from other hospitals.
2. Make available 24-hour emergency care.
3. Maintain no more than 15 inpatient acute care beds and a combined total of up to 25 beds including swing beds.
4. Keep inpatients no longer than 96 hours except where weather or emergency conditions dictate or a peer review organization waives the limit.

Mr. Mullen said payment for inpatient and outpatient services at a critical access hospital is based on reasonable costs. Mr. Mullen said the Health Care Financing Administration has approved the North Dakota "state rural health care plan" and three hospitals have applied for designation as critical access hospitals. He said the hospitals are located in Garrison, Tioga, and Turtle Lake.

Representative Svedjan asked if the 96-hour stay limit for critical access hospitals will impact the way doctors provide care and if it may mandate the transfer or referral of more cases to other hospitals. Mr. Mullen said many of the cases now being treated at these hospitals are already falling within the 96-hour stay limit.

Dr. Layman said there may be a slight impact on how doctors treat certain cases and it may require the referral of certain cases to other hospitals, but when comparing that to the closing of the hospital, it may be a worthwhile tradeoff.

Mr. Arnold Thomas, North Dakota Healthcare Association, Bismarck, testified in support of the study of the challenges facing the delivery of health care within the state. He said the Healthcare Association is working on its vision of how health care will look in the future. He said the vision will cover two-thirds of the state.

In response to a question from Representative Svedjan, Mr. Thomas said the health care industry in the eastern third of the state is very fluid at this point and the vision being worked on by the Healthcare Association would mainly apply to the western two-thirds of the state.

Chairman Price requested that the Healthcare Association and State Department of Health provide the committee with information on the location of all hospitals in the state and what services are provided at each hospital. She said it would be helpful if this information could be shown on a map of the state.

Senator DeMers suggested the committee receive information on critical access hospitals including reports on quality indicators and outcomes of these types of facilities.

Senator DeMers requested that the committee receive a report from the Department of Human Services on the Medicaid policies relating to the reimbursement of nurse practitioners and physician assistants. She also requested that the committee receive information on the location of nurse practitioners throughout the state.

Representative Porter suggested the committee receive a report on licensing and reimbursement regulations relating to health care facilities in order to determine if the regulations are treating the different types of facilities in the same manner and are being fairly applied.

Chairman Price asked the Legislative Council staff to review the various requests for additions to the study plans for the study of the access, quality, and cost of health care and the study of the challenges facing the delivery of health care. The Legislative Council staff said the following items had been mentioned by committee members as additions to the study plans:

1. Receive information from the State Department of Health regarding the Balanced Budget Act and its impact on health care services, health care funding, and the funding of medical education.
2. Receive information on the role of insurance companies regarding what insurance companies will and will not pay for and when the decisions of insurance companies begin to impact the quality of care provided by health care professionals and health care facilities.
3. Receive information from Blue Cross Blue Shield regarding historical profit and loss trends, fee schedule changes, and cost changes for health care services.
4. Receive information regarding cost and reimbursement changes for HMOs and Medicaid.
5. Receive information on total health care expenditures by a major diagnostic group to see where there are increases and decreases in health care costs.
6. Receive information regarding the impact of mandated benefits on premiums, the economy's impact on health care, and the impact of decreased utilization on the cost of health care.
7. Receive information regarding the cost shift occurring from Medicare and Medicaid to private insurers and private pay individuals due to the underfunding of Medicare and Medicaid.
8. Receive information regarding the impact of the increased regulations of health care costs.
9. Receive information from Blue Cross Blue Shield regarding reasons for changes in utilization, reimbursement, and cost of services.
10. Receive information from Blue Cross Blue Shield regarding a comparison of Blue Cross Blue Shield of North Dakota to the national Blue Cross Blue Shield regarding trends in the utilization of services, age of subscribers, premium costs, and reimbursements to providers.
11. Receive reports on the status of the critical access hospital designation for rural hospitals within North Dakota and on critical access hospital quality indicators and outcomes.
12. Receive information on the location of all hospitals in the state and what services are provided at each of the hospitals.
13. Receive a report from the Department of Human Services regarding Medicaid policies relating to reimbursement of nurse practitioners and physician assistants along with information on the location of nurse practitioners throughout the state.
14. Receive reports from the Department of Human Services and the State Department of Health on the licensing and reimbursement regulations relating to health care facilities and whether or not the regulations are being applied fairly.

It was moved by Representative Svedjan, seconded by Senator Schobinger, and carried on a voice vote that the Budget Committee on Health Care combine the study of the access, quality, and cost of health care within the state (HCR 3070) and the study of the challenges facing the delivery of health care within the state (HCR 3046) into one health care study with the following study plan:

1. **Receive information from interested organizations, entities, and individuals regarding the access, quality, and cost of health care within North Dakota.**
2. **Receive reports from the State Health Council regarding its holding of public hearings throughout the state to elicit the**

public's perception and needs regarding what health care the public is willing to support.

3. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding current initiatives of the School of Medicine and Health Sciences relating to access, quality, and cost of health care within the state.
4. Receive information from Blue Cross Blue Shield of North Dakota regarding current trends in health care insurance premiums, health care utilization, and health care facility reimbursements.
5. Receive information from the University of North Dakota School of Medicine and Health Sciences, the State Department of Health, and other interested organizations regarding the duplication and overlap of health care delivery systems within the state.
6. Receive information from the Health Care Data Committee on the various reimbursement rates and methodologies provided by insurance companies, Medicaid, Medicare, and other health care payers.
7. Receive information from interested organizations, entities, and individuals identifying the perceived challenges facing the delivery of health care within North Dakota.
8. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding current initiatives of the School of Medicine and Health Sciences to maintain health care services in rural communities.
9. Receive information regarding the changes in the health care delivery system as a result of managed care.
10. Receive information from the University of North Dakota School of Medicine and Health Sciences regarding technological innovations affecting the delivery of health care in rural areas including information on telemedicine initiatives.
11. Receive information from the State Department of Health regarding the Balanced Budget Act and its impact on health care services, health care funding, and the funding of medical education.
12. Receive information on the role of insurance companies regarding what insurance companies will and will not pay for and when the decisions of insurance companies begin to impact the quality of care provided by health care professionals and health care facilities.
13. Receive information from Blue Cross Blue Shield regarding historical profit and loss trends, fee schedule changes, and cost changes for health care services.
14. Receive information regarding cost and reimbursement changes for HMOs and Medicaid.
15. Receive information on total health care expenditures by a major diagnostic group to see where there are increases and decreases in health care costs.
16. Receive information regarding the impact of mandated benefits on premiums, the economy's impact on health care, and the impact of decreased utilization on the cost of health care.
17. Receive information regarding the cost shift occurring from Medicare and Medicaid to private insurers and private pay individuals due to the underfunding of Medicare and Medicaid.
18. Receive information regarding the impact of the increased regulations on health care costs.
19. Receive information from Blue Cross Blue Shield regarding reasons for changes in utilization, reimbursement, and cost of services.
20. Receive information from Blue Cross Blue Shield regarding a comparison of Blue Cross Blue Shield of North Dakota to the national Blue Cross Blue Shield regarding trends in the utilization of services, age of subscribers, premium costs, and reimbursements to providers.
21. Receive reports on the status of the critical access hospital designation for rural hospitals within North Dakota and on critical access hospital quality indicators and outcomes.
22. Receive information on the location of all hospitals in the state and what services are provided at each of the hospitals.
23. Receive a report from the Department of Human Services regarding Medicaid policies relating to reimbursement of nurse practitioners and physician assistants along with information on the location of nurse practitioners throughout the state.
24. Receive reports from the Department of Human Services and the State Department of Health on the licensing and reimbursement regulations relating to health care facilities and whether or not the regulations are being applied fairly.
25. Develop recommendations to be provided to the Legislative Council and to the 2001 Legislative Assembly regarding the access, quality, and cost of health care

within the state and the challenges facing the delivery of health care within the state and consider any legislation needed to implement the recommendations.

OTHER COMMITTEE DUTIES AND RESPONSIBILITIES

The Legislative Council staff presented a memorandum entitled *Budget Committee on Health Care - Other Duties*.

Section 12 of 1999 Senate Bill No. 2012 requires the Department of Human Services to report annually on the enrollment statistics and costs associated with the children's health insurance program state plan. The memorandum included the following proposed action plan:

1. Receive a background report and implementation status reports from the Department of Human Services on the children's health insurance program.
2. Receive a report from the Department of Human Services on the enrollment statistics and costs associated with the children's health insurance program.
3. Receive information from interested persons regarding the children's health insurance program.
4. Consider developing recommendations to be provided to the Legislative Council and to the 2001 Legislative Assembly regarding the children's health insurance program and consider any legislation needed to implement the recommendations.

Section 3 of House Bill No. 1403 requires the Department of Human Services and the Board of Nursing to prepare a joint recommendation for consideration by the 57th Legislative Assembly regarding administration of medication. The section also requires the Department of Human Services and the Board of Nursing to report during the 1999-2000 interim regarding the progress in preparing the joint recommendation.

The memorandum included the following proposed action plan for receipt of the recommendation on the administration of medication:

1. Receive the joint recommendation from the Department of Human Services and the Board of Nursing regarding the administration of medication.
2. Receive information from interested persons regarding the joint recommendation on the administration of medication.
3. Consider developing recommendations to be provided to the Legislative Council and to the 2001 Legislative Assembly regarding the administration of medication and consider any legislation needed to implement the recommendations.

Mr. Zentner commented on the committee's receipt of the report on the enrollment statistics and costs associated with the children's health insurance program. He said the request for proposal was issued on July 7, 1999, and by the end of August the department plans on having a provider selected. He said the department's goal is to have the program implemented by October 1.

Mr. Zentner said he could provide the committee with an update on the program sometime after October 1, 1999, and by the spring of 2000 the department should have statistics available regarding the children's health insurance program.

In response to a question from Representative Svedjan, Mr. Zentner said the report regarding enrollment statistics could include information on denials and referrals.

Chairman Price said the information should also include the number of referrals or denials actually followed up with Medicaid applications.

Ms. Constance Kalanek, North Dakota Board of Nursing, Bismarck, commented on the recommendation regarding the administration of medication. A copy of her presentation is on file in the Legislative Council office. She said the Board of Nursing has and will continue to make every effort to resolve the issues that surfaced during the last legislative session. Ms. Kalanek said she has contacted several other states to obtain information on other state models that might be useful in assuring safe and effective care to North Dakota citizens and that it is the intent of the board to assure that this issue is properly taken care of and finally resolved.

It was moved by Representative Porter, seconded by Representative Severson, and carried on a voice vote that the Budget Committee on Health Care adopt the action plans included in the *Budget Committee on Health Care - Other Duties* memorandum presented by the Legislative Council staff.

The meeting was adjourned at 3:00 p.m.

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Paul R. Kramer
Senior Fiscal Analyst

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Chester E. Nelson, Jr.
Legislative Budget Analyst and Auditor

ATTACH:1