# BUDGET COMMITTEE ON HUMAN SERVICES

The Budget Committee on Human Services was assigned the following responsibilities:

1. Section 21 of Senate Bill No. 2004 (2005) directed a study of the state's public health unit infrastructure and the ability of public health units to respond to public health issues. The section also provided the study include an assessment of the efficiency of the operations and the effectiveness of services of the public health units and the efficiency of the food and lodging investigation services provided by the State Department of Health and public health units.
2. Section 5 of House Bill No. 1459 (2005) directed a study of the Medicaid medical reimbursement system, including costs of providing services, fee schedules, parity among provider groups, and access to services.
3. The Legislative Council assigned the committee responsibility to receive the following reports from the Department of Human Services relating to the medical assistance program:
   a. A five-year Medicaid analysis report, pursuant to North Dakota Century Code (NDCC) Section 50-06-25.
   b. A report on the status of the department's amendment to the North Dakota Medicaid state plan allowing the disregard of assets for individuals owning long-term care insurance policies, pursuant to Section 1 of House Bill No. 1217 (2005).
   c. Status reports of activities of the prescription drug monitoring workgroup and implementation of a prescription drug monitoring program, pursuant to House Bill No. 1459 (2005).
   d. A report on the status of development of management initiatives for the Medicaid program, pursuant to Section 4 of House Bill No. 1459 (2005).
   e. A report regarding the department's progress in developing and implementing a plan for the implementation of the Medicare prescription drug program, pursuant to Section 2 of House Bill No. 1465 (2005).
4. Section 20 of Senate Bill No. 2004 (2005) provided for a study of the costs and benefits of adopting a comprehensive Healthy North Dakota and workplace wellness program.
5. Section 15 of House Bill No. 1012 (2005) provided for a study of the services provided by residential treatment centers and residential child care facilities and the appropriateness of the payments provided by the state for the services.
6. House Concurrent Resolution No. 3054 (2005) provided for a study of state programs providing services to children with special health care needs to determine whether the programs are effective in meeting these special health care needs, whether there are gaps in the state's system for providing services to children with special health care needs, and whether there are significant unmet special health care needs of children which should be addressed.
7. The Legislative Council assigned the committee responsibility to receive reports from the Department of Human Services on the status of the Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care, the number of applications the department received for the in-home services, and the status of the program's appropriation, pursuant to Section 5 of Senate Bill No. 2395 (2005).
8. The Legislative Council also assigned the committee responsibility to receive the following reports:
   a. A report from the Department of Human Services regarding the department's review of its budget, programs, and services to determine the extent to which the department can provide additional general fund requirements resulting from changes in the federal medical assistance percentage (FMAP) for North Dakota without affecting the level of services provided by the department, pursuant to Section 11 of House Bill No. 1012 (2005).
   b. A report from the Department of Human Services on the department's plan to transfer appropriate individuals from the Developmental Center to community placements, including the anticipated number of individuals that will be transferred during the biennium as required by Section 16 of House Bill No. 1012 (2005).

Committee members were Senators Dick Dever (Chairman), Richard L. Brown, Tom Fischer, Aaron Krauter, Judy Lee, Russell T. Thane, and John M. Warner and Representatives Jeff Delzer, William R. Devlin, Lee Kaldor, James Kerzman, Gary Kreidt, Ralph Metcalf, Jon O. Nelson, Vonnie Pietsch, Chet Pollert, Todd Porter, Louise Potter, Clara Sue Price, Sally M. Sandvig, Ken Svedjan, Gerald Uglem, and Alon C. Wieland.

The committee submitted this report to the Legislative Council at the biennial meeting of the Council in November 2006. The Council accepted the report for submission to the 60th Legislative Assembly.

## PUBLIC HEALTH UNIT STUDY

Section 21 of Senate Bill No. 2004 (2005) directed a study of the state's public health unit infrastructure and the ability of the health units to respond to public health issues. The study was to include an assessment of the efficiency of operations, given the personnel and

financial resources available, and the effectiveness of services, given the lines of governmental authority of the current infrastructure. In addition, the study was to include the efficiency of the food and lodging investigation services provided by the State Department of Health and the public health units and the development of a plan maximizing efficiencies through a coordinated system and fee structure.

## Current Public Health Structure

The committee learned the state has 28 public health units--7 multicounty health districts, 10 single-county health districts, 3 city/county health departments, 1 city/county health district, and 7 single-county health departments.

North Dakota Century Code 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 into joint powers agreements with other public health units upon approval of each governing body to provide shared services. The committee learned a public health district has a separate governing board, while a public health department is an agency within a city or county government.

## Mill Levies for Public Health

North Dakota Century Code Section 23-35-07 limits public health district budgets to an amount that does not exceed the amount of revenue that can be raised by a levy of five mills of the taxable valuation of the district. The statutory provisions limiting the mill levy of a health district began in 1943. The following schedule shows a history of changes to the number of mills a health district may levy:

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

The committee received a report showing for 2004, by county, the value of one mill of property tax, the number of mills levied and the funding generated for each county's general fund, and the number of mills levied and funds generated for public health districts. In 2004, 46 counties levied mills for health districts with an average of 3.58 mills, which generated $3,255,415.

## State General Fund Support

Since 1977 each Legislative Assembly has appropriated funding from the general fund for state aid to public health units. The following schedule presents the funding appropriated for each biennium since 1977:

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

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

## Core Functions and Essential Services

North Dakota Century Code Section 23-35-02 authorizes the State Health Council to issue rules defining the core functions of a public health unit; however, state law is not specific regarding the duties and responsibilities of public health units.

The committee learned 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- and population-based health services.
10. Research new insights and innovative solutions to health problems.

The committee heard the results of a 2002 national survey of local public health units involving the assessment of the three core functions of public health. The survey results indicated local public health units serving fewer than 25,000 people do not have the capability to conduct the core functions. The committee learned that in North Dakota 20 of the state's 28 local public health units serve fewer than 25,000 people each.

## Survey of Public Health Units

The committee surveyed all public health units in the state regarding their funding, programs, demographics, and essential services. The following schedule summarizes funding of the public health units as reported on the survey:

**Total 2005 Funding Sources of North Dakota Public Health Units**

| Source | Funding | Per Capita Average |
|---|---|---|
| State (general fund, community health trust fund, and abandoned automobile fund) | $2,987,195 | $5.44 |
| Federal | 9,869,053 | 13.44 |
| County | 5,120,574 | 10.98 |
| City | 4,354,328 | 1.92 |
| Fee collections | 2,958,376 | 3.48 |
| Other | 1,257,844 | 1.44 |
| Total | $26,547,370 | $36.70 |

The health units estimated spending approximately 12.7 percent of their annual budgets on administrative responsibilities. Regarding the number of grant applications and awards submitted and received by public health units during 2005, the public health units reported spending an estimated 6,075 hours preparing 406 grant applications, 353 or 87 percent of which were approved.

The schedule below lists the 10 essential services as defined by the American Public Health Association and an administrative cost category and comparison of the public health units' estimate of the "Best Practice" or "Ideal" percentage for each category to the units' estimate of actual spending for 2005.

| | Essential Services and Administrative Costs | Average "Best Practice" or "Ideal" Percentage | Public Health Units' Percentage of 2005 Costs | Variance |
|---|---|---|---|---|
| 1 | Monitor health status to identify community health problems | 12.5% | 9.6% | 2.9% |
| 2 | Diagnose and investigate health problems and health hazards in the community | 11.9% | 9.6% | 2.3% |
| 3 | Inform, educate, and empower people about health issues | 17.0% | 21.1% | (4.1%) |
| 4 | Mobilize community partnerships to identify and solve health problems | 10.6% | 5.4% | 5.2% |
| 5 | Develop policies and plans that support individual and community health efforts | 8.2% | 4.9% | 3.3% |
| 6 | Enforce laws and regulations that protect health and ensure safety | 7.3% | 6.1% | 1.2% |
| 7 | Link people to needed personal health services and assure the provision of health care when otherwise unavailable | 14.3% | 28.5% | (14.2%) |
| 8 | Assure a competent public health and personal health care workforce | 6.5% | 6.8% | (.3%) |
| 9 | Evaluate effectiveness, accessibility, and quality of personal and population-based health issues | 4.0% | 1.7% | 2.3% |
| 10 | Research for new insights and innovative solutions to health problems | .5% | .3% | .2% |
| | Indirect or administrative costs | 7.2% | 6.0% | 1.2% |
| Total | | 100.0% | 100.0% | 0.0% |

Public health units indicated 2005 essential services percentages may differ from "Best Practice" or "Ideal" percentages because:

1. Programs provided must follow grant guidelines and funding levels.
2. Demands for direct patient care, grant reporting and requirements, and attendance at meetings make it difficult to provide other essential services.
3. Private health care providers cannot meet the demand for health services, especially in rural areas, resulting in the public health units arranging for or directly providing a wide variety of health services.
4. New methods of gathering community input to prioritize services are needed.
5. Additional funding flexibility is needed to address local priorities and needs.
6. The formula for distributing state aid to health units should consider the socio-economic conditions of each unit's residents.
7. Additional funding for state aid to health units is necessary to allow the units more discretionary funding to address the essential services currently not being adequately provided.

8. Additional funding for staff is needed, especially for environmental health, school nursing, and administration.
9. Additional funding to increase staff salaries and benefits would help recruit and retain staff.
10. Additional funding is needed for monitoring and understanding local health issues, analyzing local health data, and evaluating local public health services.
11. A credentialing process for public health employees to assure a competent workforce is not in place.

## Other States' Public Health Units

The committee received information on other states' models of public health unit administration and accreditation. The committee learned some states have developed an accreditation process for public health units in order to encourage the provision of core services.

Nebraska has a decentralized public health structure similar to North Dakota's. In 2001 the Nebraska Legislature approved legislation promoting the formation of multicounty health departments consisting of at least three contiguous counties or serving at least 30,000 people. Each health department is required to provide the 10 essential services.

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

North Carolina is in the process of developing and implementing an accreditation process for public health units. A public health task force in North Carolina identified a uniform set of activities that all local health departments are expected to meet. The activities are based on the core functions and 10 essential services of public health. The state recently piloted the accreditation process with 10 local health departments.

## North Dakota Public Health Assessment and Planning Process

The committee learned the State Department of Health conducted an assessment of the state's public health system. The state level assessment resulted in identifying the following priority areas:

1. Diagnose and investigate health problems and health hazards.
2. Monitor health status to identify health problems.
3. Enforce laws and regulations that protect health and safety.
4. Inform, educate, and empower people about health issues.

At the local level, 12 of the 28 health units completed the voluntary assessment. According to assessments completed, the following essential services and activities were identified as needing improvement:

1. Monitor health status to identify community health problems:
   a. Population-based community health profile.
   b. Access to and utilization of current technology.
2. Research for new insights and innovative solutions to health problems:
   a. Capacity for epidemiological policy and service research.
   b. Fostering innovation.
   c. Linkage with institutions of higher learning and research.
3. Develop policies and plans that support individual and community health efforts:
   a. Community health improvement process.
   b. Public health policy development.
   c. Strategic planning on alignment with the community health improvement process.
4. Evaluate effectiveness, accessibility, and quality of personal and population-based health services:
   a. Evaluation of population-based services.
   b. Evaluation of local public health systems.
5. Mobilize community partnerships to identify and solve health problems:
   a. Constituency development.
   b. Community partnerships.

The committee learned the State Department of Health held public health planning meetings across the state to determine the public health services North Dakota residents should have available to them regardless of where they live in the state. Preliminary observations and recommendations generated as a result of these meetings include:

1. The majority of public health infrastructure services should be considered minimum essential services and should be provided locally or regionally.
2. Population-based and personal health services, including those relating to communicable diseases, tobacco use prevention, maternal and child health, immunizations, prenatal and infant care, and clinical prevention screenings, should be considered minimum essential services. Services identified as not being adequately provided at the present time are violence prevention, asthma, mental health, alcohol abuse prevention, substance abuse prevention, infant care, and physical activity.

3. Infectious disease services are considered minimum essential services.
4. Promulgating rules and policies for environmental health services, enforcement, monitoring, and consultation are considered minimum essential services. A local and state partnership to deliver environmental health services should be considered. Statewide consistency of rules regarding environmental health is needed.
5. Services for disaster preparedness and response had the highest scores for being adequately provided. These services have adequate funding and regional coordination. This system could serve as a model for other service delivery systems of public health units.
6. Quality and accessibility of health services are considered a minimum essential service with both local and state responsibility.

The State Department of Health has established a public health task force to review and analyze the data gathered and to develop strategies for building local public health capabilities. Some of these strategies may involve legislative changes that will be presented to the 2007 Legislative Assembly.

## Public Health Unit Comments and Suggestions

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. Public health units reporting to the committee were Fargo Cass Public Health Department; Bismarck-Burleigh Health Department; Custer District Health Unit, Mandan; Emmons County District Health Unit; Wells County District Health Unit; First District Health Unit, Minot; Lake Region District Health Unit, Devils Lake; Central Valley Health District, Jamestown; Grand Forks Public Health Department; Walsh County Health District; and Upper Missouri District Health Unit, Williston. Comments, concerns, and suggestions of representatives of these health units included:

1. A more uniform set of services should be established for all local public health units. Currently the level of services vary widely by unit across the state.
2. Smaller health units have chosen not to combine with other health units because currently:
   a. Funds remain within the community.
   b. The board controls its own program.
   c. The units meet the health needs of their areas.
3. A more standardized system of environmental health regulations should be developed for all public health units to provide more consistency in environmental health regulations from one jurisdiction to another.
4. Counties with tribal lands are unable to generate adequate county funding because tribal lands are not subject to property taxes.
5. Federal funding sources are available to implement new programs; however, funding is not always adequate for the costs necessary to manage the new programs.
6. 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.
7. Additional flexible funding from the state could be used to meet various program needs of the health units.
8. Additional funding is needed to provide for core public health functions and to respond to health-related issues.
9. Discretionary funding provided by state aid and local mill levy revenues is important to meet the program needs of each unit.
10. The Fargo Board of Health developed an ordinance describing the Fargo Cass Public Health Department's function and role in the city. The ordinance was approved and provides for the purpose, authority, duties, and essential services of the public health department in Fargo based on the 10 essential services developed by the American Public Health Association.

## Grant Writing Assistance

The committee considered options for providing grant writing assistance to public health units. The State Department of Health does not have a central function for grant writing for the department or for public health units. Many program managers or division directors within the State Department of Health inform local health workers of grant opportunities. Many also offer assistance or training on how to prepare a grant proposal or assist by reviewing the proposal. Areas of assistance identified as being needed by public health units include planning, training, obtaining community-level data, and technical assistance for grant applications. The committee learned the department, within its current staff and resources, may be able to:

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

## Food and Lodging Investigation Services

North Dakota Century Code Section 23-09-16 requires any food or lodging establishment to be licensed either by the State Department of Health or by a local health unit. Section 23-09-11 requires each establishment to be inspected at least once every two years. The State Department of Health Food and Lodging Division is responsible for licensing and inspecting restaurants, bars, lodging facilities, mobile home parks, campgrounds, bed and breakfast facilities,

retail food stores, meat markets, bakeries, schools, salvage food establishments, small food manufacturers and processors, assisted living facilities, and jails and other correctional facilities. Under an agreement with the Department of Human Services, the division also inspects preschools and day care centers that prepare food. The division also serves as the federal Food and Drug Administration liaison in the state on issues relating to manufactured food and pesticide residues in food.

The mission of the Food and Lodging Division is to ensure safe and sanitary food and lodging establishments in North Dakota through education and inspection of licensed facilities. The division licenses facilities annually on a calendar basis. Generally one inspection per food facility is conducted each year to ensure that the facility meets both sanitation and certain life and fire safety standards before opening to the public and while in operation. Nonfood facilities, such as lodging facilities and mobile home parks, are generally inspected once every two years.

The division has six staff members--inspectors located in Dickinson, Jamestown, Fargo, and Grand Forks and two administrative positions in Bismarck.

The department may enter into agreements with local health units allowing the health units to provide some of the inspection and licensing functions within their areas of jurisdiction. The department has seven agreements in place--three with city/county health units and four with multicounty health units. The local health units establish their own license fees to provide funding for their operations. Under these agreements, the local health units must follow state laws and rules or they must have adopted local ordinances that are at least as stringent as state laws and rules. Summaries of the agreements include:

1. Fargo Cass Public Health - Responsible for all retail food, food service, and lodging facilities in Fargo and West Fargo.
2. Grand Forks Public Health - Responsible for all retail food and food service facilities within the city of Grand Forks.
3. Bismarck Fire and Inspections - Responsible for all retail food, food service, and lodging with food service within the city of Bismarck.
4. First District Health Unit, Minot - Responsible for all food and lodging facilities within its seven-county health unit, including Bottineau, Burke, McHenry, McLean, Renville, Sheridan, and Ward Counties.
5. Custer District Health Unit, Mandan - Responsible for all retail food and food service facilities within its five-county health unit, including Grant, Mercer, Oliver, Sioux, and Morton Counties.
6. Southwest District Health Unit, Dickinson - Responsible for food service facilities within its eight-county health unit, including Stark, Adams, Billings, Slope, Golden Valley, Bowman, Dunn, and Hettinger Counties.
7. Upper Missouri District Health Unit, Williston - Responsible for food service facilities within the city of Williston.

The agreement with First District Health Unit in Minot provides the unit authority over all food and lodging facilities, which results in the State Department of Health having no jurisdiction or inspection activity within that health unit. In the other six health units, the department still has some inspection responsibilities, mainly in the areas of lodging, mobile home parks, trailer parks, and campgrounds.

Prior to July 1, 2005, annual license fees for food and lodging establishments were set in statute and the collections were deposited in the state general fund. Funding for providing food and lodging inspection services in the State Department of Health was primarily from the general fund. The 2005 Legislative Assembly in Senate Bill No. 2004 changed the funding source for these services from primarily the general fund to primarily special funds from food and lodging license fee collections deposited in the department's operating fund. Statutory references to the food and lodging license fee rates were also removed. The State Department of Health was authorized to establish license fees by rule. The 2005-07 biennium budget for these services in the State Department of Health is:

| | |
|---|---|
| Salaries and wages | $600,634 |
| Operating expenses | 147,241 |
| Total | $747,875 |
| General fund | $125,000 |
| Federal funds | 79,429 |
| Other funds | 543,446 |
| Total | $747,875 |

The following schedule compares the license fees for food and lodging facilities across the state:

**North Dakota Food and Lodging License Fees**

| Department or Health Unit | Restaurant | Limited Restaurant | Mobile Food | Retail Food | Bakery |
|---|---|---|---|---|---|
| State Department of Health | | | | | |
| Statutory fee prior to July 1, 2005 | $60, $80, $85 | $50 | $40 | $50, $60 | $50, $60 |
| Fees effective July 1, 2005 | $75 flat fee $.50/seat, $150 maximum | $75 | $75 | $75, $85, $95 | $75, $85, $95 |
| Fargo Cass | $150 base $1.50/seat, $250 maximum | $100 | $125 | $75 | $75 |
| Grand Forks | $135 base $.30-$1.30/seat | | $55 | $60, $115, $130 | $90, $180, $215 |
| Bismarck | $175 | $175 | $50 | $100, $150 | $100 |
| First District, Minot | $85, $105, $110 | $75 | $25, $50, $75 (number of days) | $75, $100 | $75, $100 |

| Department or Health Unit | Restaurant | Limited Restaurant | Mobile Food | Retail Food | Bakery |
|---|---|---|---|---|---|
| Southwest District, Dickinson | $55, $65 | $55 | $45 | | $45 |
| Upper Missouri, Williston | $60, $80, $85 | | | | |
| Custer Health, Mandan | $70, $80, $90 | $60 | | $70, $80 | $50, $60 |
| **Department or Health Unit** | **Food Processors** | **Lodging** | **Mobile Home Parks** | **Bed and Breakfast** | **Schools** |
| State Department of Health | | | | | |
| Statutory fee prior to July 1, 2005 | $25 | $20-$80 | $50-$120 | $15 | N/A |
| Fees effective July 1, 2005 | $35 | $35-$150 | $75-$160 | $25 | $90 |
| Fargo Cass | | $100-$400 | | | $60, $85 |
| Grand Forks | $105, $195, $230 | $75, $145 | $115 + $2.15/lot | $75 | $70, $140 |
| Bismarck | $50, $75 | | | | $75 |
| First District, Minot* | $50 | $20-$80 | $50-$120 | $30 | $0 |
| Custer Health, Mandan | | | | | $0 |
| Southwest District, Dickinson | | | | | $0 |
| Upper Missouri, Williston | | | | | $0** |

*First District does not currently charge a license fee for schools but will be approaching its board to do so in the near future.

**Upper Missouri currently does not charge for school inspections but if reinspections are needed after several visits because of continued problems, a flat $25 fee is charged for those inspections.

The committee learned the State Department of Health is considering legislation to allow the department to immediately fine or close an establishment that does not pay its annual license renewal fee by February 1. Each year many establishments do not pay their license renewal fees by the deadline, resulting in the department's staff spending a considerable amount of time and resources trying to collect the fees.

The department suggested a statutory change to allow the department to assess a reinspection fee if a facility has a number of critical violations. In addition, a statutory change could be made to require all high-risk establishments to be inspected annually rather than biennially. High-risk food establishments are those that cook some menu items from scratch or prepare large batches of food that are cooled and reheated later for service to the public. Annual inspections would require additional resources for the department either from additional general fund support or increased fees.

## Other Reports

The committee heard other reports, including:

1. A report on action taken by the Public Employees Retirement System (PERS) affecting health insurance premium rates for public health units. Currently, health districts pay the blended single/family health insurance premium. Because the blended rate was intended only for state agencies, PERS was considering whether the health districts should be paying the separate single premium rate and family premium rate as do other political subdivisions. The Public Employees Retirement System is delaying a final decision on this issue until after the 2007 legislative session.
2. A report on the University of North Dakota School of Medicine and Health Sciences' role and involvement with local public health units. The committee learned the medical school and local public health units collaborate primarily in the following areas:
   a. Technical assistance and research.
   b. Education support.
   c. Information dissemination.
3. A report regarding the involvement of public health units in the cleanup of methamphetamine laboratories. The committee learned public health units have had very little involvement with the cleanup of methamphetamine laboratories during the past year.
4. A report on potential federal fund reductions affecting public health services. The committee learned the state may be receiving less federal funds under a number of federal grants, including the grant for chronic disease and tobacco prevention, the Environmental Protection Agency performance partnership grant, the emergency preparedness and response grants, and the preventive health block grant.
5. A report from the Indian Affairs Commission regarding the coordination of public health services on Indian reservations. Concerns in the report include:
   a. Structure - The structure of the state public health system is not organized to work with the North Dakota Indian public health system.
   b. Health disparities - The federal Indian Health Service, which provides health services on Indian reservations, does not meet the health service needs on Indian reservations.
   c. Health disparities - Tribal governments do not have adequate funding to provide quality health care for the residents of the reservations.
   d. Lack of culturally trained staff - Staff of public health units are unable to coordinate effectively with the tribal public health system.
6. A report on the nursing program at the University of North Dakota. The report indicated the need for increasing the number of students entering the nursing profession to adequately provide health services in North Dakota in the future due to the increasing number of nurses who will be retiring.

### Recommendations

The committee made no recommendation regarding its study of public health units. The public health task force, established to review and analyze data and develop strategies for building local public health capabilities, may have recommendations for the 2007 Legislative Assembly to assist in implementing these strategies.

## MEDICAID STUDY AND REPORTS

The committee was assigned a Medicaid medical reimbursement system study as well as the responsibility to receive reports from the Department of Human Services relating to a five-year Medicaid analysis, asset disregard for long-term care insurance, prescription drug monitoring program, Medicaid management initiatives, and Medicare prescription drug implementation.

### Medicaid Study

Section 5 of House Bill No. 1459 (2005) provided for a study of the Medicaid medical reimbursement system, including costs of providing services, fee schedules, parity among provider groups, and access to services.

**2005-07 Funding**

For the 2005-07 biennium, the Legislative Assembly appropriated $976.1 million for medical assistance, of which $307 million is from the general fund. Of the $976.1 million total, $385.6 million is for medical services, $343 million is for nursing home services, $211.6 million is for developmental disabilities grants, $12.1 million is for Healthy Steps, and $23.8 million is for other services, including personal care services, targeted case management, and waiver services. The 2005 Legislative Assembly provided funding for 2.65 percent annual inflationary increases for Medicaid providers for the 2005-07 biennium. In addition, the Legislative Assembly added $170,940, of which $60,000 was from the general fund for increasing ambulance services payment rates.

**Federal Medical Assistance Percentage**

Medicaid costs are shared between the federal and state governments. The federal medical assistance percentage determines the federal share of Medicaid costs with the state paying the remaining amount. The FMAP changes each October 1 and is based on the federal fiscal year (October through September). The FMAP is calculated using a three-year average of state per capita personal income compared to the national average per capita personal income. A state with an average per capita personal income has an FMAP of 55 percent. A state's FMAP may not be less than 50 percent nor more than 83 percent. Two programs have an enhanced FMAP--the children's health insurance program and breast and cervical cancer treatment services. The enhanced FMAP is calculated by reducing each state's share of the regular FMAP by 30 percent.

North Dakota's estimated and actual FMAPs for the 2005-07 biennium are:

| | Estimated | Actual |
|---|---|---|
| 2005 | 67.49% | 67.49% |
| 2006 | 65.85% | 65.85% |
| 2007 | 62.37% | 64.72% |

As a result of the increased FMAP for 2007, the department anticipates collecting an additional $8.8 million of federal Medicaid funds, which will result in an estimated $8.8 million of general fund savings for the biennium.

**Payment Methodology**

The committee learned Medicaid pays based on a fee-for-service concept. Payments for physicians and their allied providers are based on a relative value process. Each procedure is assigned a value based on the type of procedure being performed. The relative value for each procedure is multiplied by a conversion factor to arrive at the payment amount. The rate for fiscal year 2006 was $34.02 per unit, compared to the Medicare rate of $37.90 per unit.

Dentists, ambulances, and other similar providers are also paid on the basis of established procedure codes. Fees were established decades ago and generally increase only when the department receives specific direction regarding inflation or other increases from the Legislative Assembly.

Inpatient services are paid based on a diagnostic-related group (DRG) which classifies each hospital stay based on the diagnosis and procedures that are performed. Currently, there are about 540 different groups. Each group has a particular value based on its complexity. That value is multiplied by the established rate to arrive at the payment for each hospital stay.

Outpatient hospital services are based on the established cost-to-charge ratio for each facility with no cost settlements.

Pharmacies are paid on the basis of average wholesale price (AWP) minus 10 percent plus a dispensing fee of $5.60 for a generic drug and $4.60 for a brand name drug. In addition, payments for approximately 12,000 generic drugs are based on the maximum allowable cost process that estimates the actual cost of the drug. This pricing process has saved the state an estimated $3.8 million per year since it was implemented in 2002.

Nursing facilities are paid based on allowable costs that are submitted annually. Facilities that have costs below established limits will receive these costs plus inflation, operating margins, and incentives. Providers over the limits have their cost reimbursed only up to the limit recognized for the ratesetting process. The limits are currently calculated based on costs submitted by providers for the cost reporting year ending June 30, 2003, and will be "rebased" for the rate year beginning January 1, 2006.

The committee learned the Medicaid payment process is similar to systems used by other third-party payers; however, a concern expressed by providers is that the Medicaid program pays less for similar services than Medicare or other third-party payers.

**Medicaid Expenditures - Medical Services**

The committee received a report on final medical assistance-related expenditures by category for the 2003-05 biennium compared to the 2003-05 biennium budget and to appropriations provided for the 2005-07 biennium. In total, actual 2003-05 medical assistance-related expenditures for medical services totaled $407.8 million, $37.8 million more than the $370 million appropriated for the 2003-05 biennium. Compared to the 2005-07 appropriations, including Healthy Steps of $397.6 million, 2003-05 actual expenditures were $10.2 million more; however, the 2003-05 actual expenditures include $28.3 million of intergovernmental transfer payments that will not occur in the 2005-07 biennium.

For long-term care expenditures, the committee learned 2003-05 actual expenditures totaled $336.2 million, which is $21.9 million less than the 2003-05 appropriation of $358.1 million. For the 2005-07 biennium, appropriations for long-term care are $394 million, $57.8 million more than the 2003-05 actual expenditures.

The committee reviewed Medicaid prescription drug expenditures since fiscal year 2000 as follows:

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

## Medicaid Provider Testimony

The committee received testimony from providers receiving payments under the Medicaid program on the availability and accessibility of services across the state and on the appropriateness of the amounts paid by Medicaid.

Regarding pharmacy services, the committee learned the North Dakota Pharmacists Association is recommending increasing the dispensing fee for generic medication from $5.60 to $15. The committee learned this increase would cost an estimated $6.8 million for the 2007-09 biennium, of which $2.5 million would be from the general fund.

The committee learned the following concerns affect the future of community pharmacies in North Dakota:

1. Payment levels under the Medicare Part D prescription drug program.
2. Reductions in pharmacy reimbursements effective January 2006 by Blue Cross Blue Shield of North Dakota.
3. The impact of decreases affecting state Medicaid programs included in the federal Deficit Reduction Act of 2005.

The committee was provided information on a cost of dispensing study by Dr. Michael Rupp, Midwestern University, Phoenix, Arizona, involving 43 community pharmacies in North Dakota. Dispensing costs of these pharmacies ranged from $4.77 to $15.04, with the median cost being $8.59.

The State Board of Pharmacy anticipates over 50 percent of the licensed, practicing pharmacy owners in North Dakota will retire during the next 10 years and unless pharmacy payment rates are increased, it is likely that many of these pharmacies will close when the current owners retire. The committee received information on a proposed medication therapy management services initiative. Medication therapy management is a collaborative effort involving physicians and pharmacists to resolve drug therapy problems for Medicaid patients. The committee learned these initiatives have lowered health care costs in several states.

Regarding long-term care services, the committee learned North Dakota operates under a rate equalization system, meaning the amounts paid by Medicaid for long-term care services determine the amounts paid by all payers, except Medicare. The North Dakota Long Term Care Association testified that the 2.65 percent annual inflationary increases approved by the 2005 Legislative Assembly have not been adequate to meet the increasing costs incurred by nursing homes. Concerns of the long-term care industry include the ability to recruit and retain staff and facilities' actual costs exceeding payment rates. The North Dakota Long Term Care Association suggested the 2007 Legislative Assembly consider providing larger inflationary increases for long-term care service providers.

Regarding developmental disabilities services, the committee learned developmental disabilities service providers are concerned with their ability to recruit and retain staff. Providers are experiencing a turnover rate of 46 percent. The developmental disabilities service providers plan to ask the 2007 Legislative Assembly to provide inflationary increases of at least 4 percent for each year of the 2007-09 biennium to provide funding to increase wages by at least $1.15 per hour for all community provider staff and to allow a 3 percent increase in the allowable fringe benefit rate for providers.

Regarding hospital services, the committee learned North Dakota residents expect physician and hospital services to be available close to home and 24 hours a day 7 days a week. Based on a 2004 study, the committee learned that in North Dakota Medicaid pays 70 percent of the actual costs incurred by a hospital in providing services. In the past, hospitals have been able to shift this payment shortfall to commercial payers and the self-insured; however, commercial insurers are no longer willing to pay increased rates to offset the low payments paid by the Medicaid program. The North Dakota Healthcare Association suggested that adequate inflationary adjustments are needed for hospitals to cover their actual cost of services.

Regarding physician services, the committee learned the primary concern of physicians is that the Medicaid payment methodology has systematically resulted in payments being substantially less than the actual cost of service. Medicaid payments for physician services are estimated to cover only 74 percent of the actual cost of providing the services. The North Dakota Medical

Association suggested the 2007 Legislative Assembly address payment rates for physicians and hospitals to more adequately cover the cost of services.

The committee received a copy of a September 2005 resolution relating to medical assistance rates in North Dakota prepared by the North Dakota Medical Association. The resolution, approved by the 2005 House of Delegates of the North Dakota Medical Association, encouraged the Governor and legislative leaders to address the unfairness of state Medicaid rates that do not cover practice costs for physicians and hospitals in North Dakota.

## Other Reports

The committee heard other reports, including a report by Dr. Stephen Schondelmeyer, University of Minnesota, on issues and research findings relating to prescription drugs and pharmacy services. The committee learned the cost of prescription drugs as a percentage of the total United States Medicaid program expenditures increased from 5.5 percent in 1990 to 14.1 percent in 2005. The average United States Medicaid prescription drug product cost has increased from $17.72 in 1990 to $67.68 in 2004, while the average dispensing fee payment has increased from $3.81 to $4.15 for the same period. The primary factors contributing to the change in drug expenditures are increases in utilization and the drug manufacturer's prices.

The committee reviewed schedules of total billed charges by provider type, the amount of billed charges paid by Medicaid, and the percentage of the billed amount paid. For 2004 the percentage of billed amount paid by provider type varied from 30.5 percent for ambulance services to 95.5 percent for hearing aid dealers. For 2005 the total percentage of billed amount paid by provider type varied from 32.4 percent for ambulance services to 92.7 percent for hearing aid dealers.

## Five-Year Medicaid Analysis Report

North Dakota Century Code Section 50-06-25 requires the Department of Human Services to present a biennial report to the Legislative Council providing a five-year historical analysis of the number of persons receiving services under the medical assistance (Medicaid) program, the cost of the services by program appropriations, the budget requested, the budget appropriated, and actual expenditures for each of the five preceding fiscal years. The report is to include a comparison of the state's experience to surrounding states and, using actuarial tools, must project estimated usage trends and budget estimates for meeting those trends for the succeeding five-year period.

The committee received the biennial Medicaid report from the department. The committee learned the department contracted with Milliman, Inc., for actuarial services for completing the report at a cost of $100,000, $50,000 of which is from the general fund and $50,000 is from federal Medicaid administrative funding.

The report includes information on medical-related costs of the Medicaid program but does not include information on long-term care or developmental disabilities services. The report includes schedules comparing North Dakota medical assistance funding to similar funding in South Dakota, Minnesota, and Montana and information on the unduplicated number of recipients by eligibility categories. The following schedule compares selected North Dakota payment rates to South Dakota, Minnesota, and Montana:

| Service Category | Ratio of South Dakota to North Dakota | Ratio of Minnesota to North Dakota | Ratio of Montana to North Dakota |
|---|---|---|---|
| Dental* | N/A | 103.5% | 110.4% |
| Laboratory | 96.6% | 95.2% | 100.6% |
| Mental health | 53.2% | 127.0% | 98.0% |
| Outpatient hospital | 97.8% | 110.0% | 99.9% |
| Physical therapy | 77.0% | 153.6% | 146.8% |
| Physician | 85.3% | 81.8% | 103.4% |
| Radiology | 100.1% | 141.8% | 99.9% |
| Speech therapy | 82.1% | 144.3% | 141.7% |

*Minnesota figures are relative to 2005 fee-for-service experience. Dental services in South Dakota are provided through a capitated, managed care program.

The following schedule compares North Dakota payment rates to payment rates of Medicare, Workforce Safety and Insurance, and Blue Cross Blue Shield of North Dakota:

| Service Category | Ratio of Medicare to North Dakota Medicaid | Ratio of North Dakota Workforce Safety and Insurance to North Dakota Medicaid | Ratio of Blue Cross Blue Shield (BCBS) of North Dakota to North Dakota Medicaid |
|---|---|---|---|
| Dental* | N/A | 167.2% | 222.9% |
| Inpatient hospital | 107.0% | 130.6% | 134.7% |
| Laboratory | 100.0% | 203.8% | 169.8% |
| Mental health** | 106.4% | 124.0% | N/A |
| Outpatient hospital | 113.9% | 252.4% | 236.4% |
| Patient therapy** | 135.0% | 175.8% | N/A |
| Physician | 113.5% | 156.3% | 168.8% |
| Radiology | 110.6% | 185.3% | 180.6% |
| Speech therapy** | 105.6% | 162.1% | N/A |

*Medicare does not cover dental services.

**Mental health care, physical therapy, and speech therapy (BCBS) - Fee schedule not provided by BCBS.

Based on the actuary's baseline forecast for Medicaid expenditures through fiscal year 2011, projected expenditures for the 2005-07 biennium are $378 million and projections for the 2007-09 biennium are $417.7 million, an increase of 10 percent. Factoring in a 1 percent inflationary rate, 2007-09 projected expenditures would total $422 million. The following schedule presents the Milliman, Inc., baseline annual forecast for the North Dakota Medicaid program:

| State Fiscal Year | Expenditures | Percentage of Growth |
|---|---|---|
| 2005 | $184,923,700 | |
| 2006 | $193,360,600 | 4.6% |
| 2007 | $184,238,300 | (4.7%) |
| 2008 | $198,860,300 | 7.9% |
| 2009 | $218,831,300 | 10.0% |
| 2010 | $230,488,200 | 5.3% |
| 2011 | $247,337,100 | 7.3% |

**NOTES:**
The lower growth rates in state fiscal years 2006 and 2007 correspond to implementation of Medicare Part D pharmacy benefits, effective January 1, 2006.

The increased growth rate for paid state fiscal year 2009 corresponds to a 53-week payment pattern (i.e., 53 Tuesdays) for the fiscal year.

For the 2007-09 biennium, Milliman, Inc., projects that North Dakota Medicaid expenditures would total $438.3 million if it paid claims based on the Medicare fee schedule compared to the North Dakota Medicaid baseline forecast for the same period of $417.7 million. The additional cost is estimated to total $20.6 million for the 2007-09 biennium, of which $7.5 million would be from the general fund.

The committee learned the department does not anticipate using the Milliman, Inc., projections as it prepares its 2007-09 biennium budget request. The department plans to use the same methodology involving historical trend data it has used for preparing previous budget requests.

## Asset Disregard for Long-Term Care Insurance Report

Section 2 of House Bill No. 1217 (2005) required the Department of Human Services to report to the Legislative Council before November 1, 2005, regarding the status of an amendment to North Dakota's Medicaid state plan allowing the disregard of assets if an individual has received or is entitled to receive benefits under a long-term care insurance policy. House Bill No. 1217 (2005) allows individuals to own and retain assets and still be eligible for Medicaid benefits if the individuals own a long-term care insurance policy. The section becomes effective on the date the department certifies to the committee that an amendment to the Medicaid state plan has been approved by the federal government allowing these provisions.

The committee learned the department is collaborating with the Insurance Department to develop a long-term care insurance partnership program. The program will allow a person who purchases long-term care insurance to protect assets equal to the amount the insurance has paid if the person needs to apply for Medicaid. The Insurance Department's role is to ensure the insurance policies meet the criteria required by the federal Deficit Reduction Act of 2005. The program will not begin until acceptable insurance policies are available in North Dakota and a state plan amendment has been approved by the federal Centers for Medicare and Medicaid Services.

## Prescription Drug Monitoring Report

House Bill No. 1459 (2005) established a prescription drug monitoring working group and required the Department of Human Services and the working group to provide periodic status reports to the Legislative Council regarding the activities of the working group and the implementation of the prescription drug monitoring program. According to provisions of the bill, the working group was to:

1. Identify problems relating to the abuse and diversion of controlled substances and how a prescription drug monitoring program could address these problems.
2. Identify a strategy and propose a prescription drug monitoring program to address the problems.
3. Establish how the program will be implemented, the fiscal requirements of the program, and the timeline for implementation.
4. Consider possible performance measures the state could use to assess the impact of the program.
5. Provide proposed administrative rules to the department to implement the program.

The committee learned the department received a $372,315 grant from the federal Department of Justice for implementation of the prescription drug monitoring program. The working group determined the program would be administered by the State Board of Pharmacy and the working group may propose legislation for consideration by the 2007 Legislative Assembly to:

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

The department and the State Board of Pharmacy will be releasing a request for proposal to secure a vendor to develop and operate the necessary computer and data services for the program. To expedite the development and implementation of the program, the working group is considering asking the Governor to allow emergency rules for the program.

## Medicaid Management Initiatives Report

Section 4 of House Bill No. 1459 (2005) provided that the Legislative Council receive a report from and provide input to the Department of Human Services regarding the development of recommendations relating to the management of the Medicaid program. A number of recommendations resulted from the report provided to the 2005 Legislative Assembly by Muse and Associates, the consultants that conducted a review of the North Dakota Medicaid program during the 2003-04 interim. House Bill No. 1459 (2005) includes the following management initiatives for the Medicaid program:

1. Provide statewide targeted case management services focusing on the 2000 Medicaid recipients with the highest cost for treatment of chronic diseases and the families of neonates which can benefit from case management services. The case management services must focus on the recipients in these groups which will result in the most cost-savings considering available resources and may include a primary

pharmacy component for the management of Medicaid recipient medication.

2. Require Medicaid providers to use the appropriate diagnosis or reason and procedure codes when submitting claims for Medicaid reimbursement. Review and develop recommendations to identify instances that a provider of services is not properly reporting diagnosis or reason and procedure codes when submitting claims and review and recommend any specific providers from which a potential benefit might be obtained by requiring additional diagnosis or reason and procedure codes.
3. Review and develop recommendations for the improvement of mental health treatment and services, including the use of prescription drugs for Medicaid recipients.
4. Review and develop recommendations regarding whether the number of Medicaid recipients placed in out-of-state nursing homes should be reduced.
5. Review and develop recommendations regarding whether use of post-office addresses or street addresses are the appropriate mailing addresses for Medicaid recipients.
6. Review and develop recommendations regarding whether to require Medicaid providers to secure prior authorization for certain high-cost medical procedures.
7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification Medicaid cards for all Medicaid recipients should be implemented.
8. Review and develop recommendations regarding whether Medicaid providers should be required to use tamper-resistant prescription pads.
9. Develop a plan to provide information to blind and disabled Medicaid recipients who may be eligible for Medicare Part D benefits.
10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and Medicaid providers.

The 2005 Legislative Assembly provided $565,000, of which $282,500 is from the general fund, for costs associated with implementing these initiatives during the 2005-07 biennium and reduced funding for Medicaid grants by $1,530,000, of which $537,030 is from the general fund, to reflect savings from implementation of these initiatives.

Regarding the targeted case management/disease management initiative, after a review of the top 2000 high-cost Medicaid recipients and the respective disease conditions, the department chose to target disease case management efforts on those recipients with asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, and depression. The department selected Specialty Disease Management Services, Inc., of Florida, to provide health management services to Medicaid recipients with these selected chronic conditions. The department is in the process of submitting a state plan amendment and waiver application to the Centers for Medicare and Medicaid Services for authority to operate the health management program. Once the amendment and waiver are approved, the department will enter into a contract with Specialty Disease Management Services, Inc., and begin the program. Once operational, the program should avert more costly health care services, such as emergency room visits or unnecessary physician visits or hospitalizations for the recipients.

Regarding the development of risk-sharing agreements or managed care programs, the department is planning to implement a program for all-inclusive care for the elderly (PACE). The program will be for individuals age 55 and older and will provide a comprehensive package of acute and long-term care services through an interdisciplinary team of professionals. The intent of the program will be to provide necessary services to prevent these individuals from moving to a more costly level of care, such as skilled nursing care. However, if an individual requires care in a skilled nursing facility, the private PACE agency will be responsible for those costs within its capitated payments. The department is considering two agencies to provide the PACE program.

Regarding diagnosis and reason codes, the committee learned the following providers are not required to submit diagnosis and reason codes:

- Dental providers.
- Pharmacy providers.
- Developmental disabilities service providers.
- Qualified service providers.
- Basic care providers.
- Nursing homes.
- Intermediate care facilities.
- Nonemergency transportation providers.

Regarding out-of-state nursing home usage, the committee learned during the 2005-06 interim, 55 North Dakota Medicaid-eligible residents were in Minnesota nursing facilities and 35 Minnesota Medicaid-eligible residents were residing in North Dakota nursing facilities. Since 1993 North Dakota has had a reciprocity agreement with Minnesota for determining the state of residence for individuals entering nursing facilities in both states. The 2005 average cost to North Dakota Medicaid for all nursing facility residents was $130 per day. The average cost to North Dakota Medicaid for residents in Minnesota facilities is $126 per day. On an annual basis, the total funds North Dakota Medicaid pays Minnesota facilities is approximately $800,000 more than the amount Minnesota Medicaid pays North Dakota facilities.

Regarding post-office box or street addresses, the committee learned addresses reported by Medicaid clients, whether a street location or post-office box, are entered into the eligibility system by staff at the time of enrollment. The department is not aware of any problems encountered in the current system and recommends no action be taken to require certain types of addresses to be used.

Regarding prior authorization for high-cost medical procedures, the committee learned the department has reviewed procedures to consider for prior authorization, including magnetic resonance imaging (MRI), positron emission tomography (PET) scans, and computed tomography (CT) scans.

Regarding photo identification on Medicaid identification cards, the department estimates the cost of adding a photo identification to the card would be $80,000.

Regarding tamper-resistant prescription pads, the department recommended the Legislative Assembly pursue the use of tamper-resistant prescription pads and consider assigning the responsibility to an entity with statewide all-prescriber responsibilities, such as the State Board of Pharmacy or the State Board of Medical Examiners.

Regarding the development of a plan to provide information to blind and disabled Medicaid recipients who may be eligible for Medicare Part D benefits, the committee learned the Department of Human Services collaborated with the State Library to inform visually impaired persons of the changes through distribution of a newsletter and through public service announcements on the Dakota Radio Information Service for visually impaired persons. In addition, the Medical Services Division and the Vocational Rehabilitation Division cross-referenced eligibility information to develop a list of visually impaired Medicaid/Medicare recipients.

## Medicare Prescription Drug Implementation Plan Report

Section 2 of House Bill No. 1465 (2005) required the Department of Human Services to report to the Legislative Council regarding the department's progress in developing and implementing a plan for the Medicare prescription drug program effective January 1, 2006. House Bill No. 1465 included an appropriation of $50,000 from the general fund to the department for costs associated with developing and implementing a plan.

Prior to implementation of the Medicare prescription drug program, individuals eligible for both the state Medicaid program and the federal Medicare program received their prescription drug coverage under the state Medicaid program. Effective January 1, 2006, under the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, these individuals began receiving coverage for their prescription drugs under the federal Medicare program. The Act, however, requires states to pay a portion of the Medicaid "savings" to the federal government each year. This "clawback" provision requires states to pay 90 percent of the estimated state "savings" during the first year. The percentage gradually decreases to 75 percent by 2014.

The committee learned the department contracted with Muse and Associates, Washington, D.C., to develop the department's implementation plan for the transition to the Medicare Part D prescription drug benefit.

The committee learned approximately 10,500 North Dakota residents are eligible for both Medicare and Medicaid (dual-eligibles) and that under provisions of House Bill No. 1465, the department had authority to provide prescription drug coverage in an emergency to dual-eligible individuals during the first 45 days of 2006. Under this provision, the department paid approximately $303,000 in Part D claims for approximately 1,900 recipients due to problems with these recipients accessing their new prescription drug plan. The department submitted a federal demonstration project application, which was approved, authorizing the department to make these payments and to be reimbursed by the federal government for any state costs incurred.

For the final 18 months of the 2005-07 biennium, the department estimated North Dakota's "clawback" payment would total $15.8 million, all of which would be from the general fund. Based on revised federal "clawback" calculations, the committee learned North Dakota's "clawback" payment was reduced to an estimated $14,135,727 for the remainder of the 2005-07 biennium, $1,715,982 less than the department's original estimate.

The committee received information from Muse and Associates, based on trend data from North Dakota prescription drug expenditures for dual-eligibles from calendar years 1999 through 2005, estimating North Dakota would spend $110 million in prescription drugs for dual-eligible beneficiaries between calendar years 2006 and 2015 under the program prior to Medicare Part D. Under Medicare Part D, Muse and Associates estimates North Dakota's drug payments plus the "clawback" payments will total $123 million. As a result, the cost of the Medicare Part D program to North Dakota will be an estimated $13 million over this 10-year period.

The committee also received information from the Insurance Department regarding its plans for educating and assisting the public in understanding the Medicare prescription drug benefit program.

## Medicaid Management Information System Replacement Project

The 2005 Legislative Assembly appropriated $29.2 million of federal and special funds to the Department of Human Services to design, develop, and implement a replacement Medicaid computer system, which includes Medicaid management information system (MMIS), decision support system, and pharmacy point-of-sale system. The committee learned the department received one proposal for the MMIS portion of the project, two proposals for decision support, and three proposals for a point-of-sale system. Based on the best and final offers received, the department revised the total project cost to $56.8 million.

The Budget Section approved a motion expressing the Budget Section's support for the department proceeding with preliminary work on the project with final direction decision to be made by the 2007 Legislative Assembly. The motion encouraged the department to begin preliminary work on the project which would be required for all of the following options:

1. Acceptance of the current Affiliated Computer Services, Inc., bid.
2. Rebidding of the MMIS project.

3. Joint development with another state.
4. Use of a fiscal agent.
5. Outsourcing the billing and payment components.

In addition, the motion encouraged the Department of Human Services to contract for an independent analysis of the above options, including a cost-benefit analysis, and to arrange for the information to be available to the Legislative Assembly by January 8, 2007.

The committee learned the department has submitted and received approval from the Centers for Medicare and Medicaid Services of the proposed MMIS contract and the department entered into an agreement with Affiliated Computer Services, Inc., in June 2006. The department selected a vendor to complete an independent analysis of the various options to be considered by the 2007 Legislative Assembly, began Phase 1 of the project, and established a stakeholder committee to gather input regarding the development of a new system and to provide communications regarding the design and operations of the new system.

### Other Medicaid-Related Reports

The committee received a report regarding the activities associated with the Real Choice Rebalancing Grant. The grant funds will be used to assist the state in complying with provisions of the Olmstead decision and the President's New Freedom Initiative, both of which are intended to improve access and choice of continuum of care services for the elderly and people with disabilities. The committee learned the goal of the grant is to:

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

### Recommendations

The committee recommends the 2007 Legislative Assembly consider the value of the biennial medical assistance report and the importance of continuing funding for the report for the actuarial analysis and other information that may be useful for the Legislative Assembly and its Appropriations Committees in the development of the Department of Human Services' appropriation.

## HEALTHY NORTH DAKOTA STUDY

Section 20 of Senate Bill No. 2004 (2005) provided for a Legislative Council study of the costs and benefits of adopting a comprehensive Healthy North Dakota and workplace wellness program in collaboration with the State Department of Health, health insurers, other third-party payers, Workforce Safety and Insurance, interested nonprofit health-related agencies, and others who have an interest in establishing accident and disease prevention programs.

### Background

The committee learned Governor John Hoeven initiated the Healthy North Dakota program in January 2002. The mission of the initiative is to inspire and support North Dakotans to improve physical, mental, and emotional health for all by building innovative statewide partnerships. The Healthy North Dakota Advisory Committee was formed in March 2002. Priority areas of Healthy North Dakota include:

1. Tobacco use.
2. Substance abuse - Mental health.
3. Healthy weight - Nutrition.
4. Healthy weight - Physical activity.
5. Health disparities.
6. Worksite wellness.
7. Community engagement.
8. Third-party payers - Insurance.

Committees have been formed to focus on each of these areas across the state.

### Funding

For the 2005-07 biennium, the Legislative Assembly appropriated $485,746 of federal and other funds for the State Department of Health's Healthy North Dakota and worksite wellness program. Federal funds of $350,746 are from the federal preventive health block grant and are used, in part, for funding 1.5 full-time equivalent (FTE) positions within the department. The $135,000 of other funds was to be raised by the department for the worksite wellness program. For the 2007-09 biennium, the State Department of Health is requesting $200,000 to $300,000 from the community health trust fund to provide a more consistent source of funding for the program.

### Status of Focus Areas

The committee received a report on the status of the focus areas of Healthy North Dakota, including:

1. Healthy weight - Healthy North Dakota has involved more than 500 state, local, and county government employees in the "five-a-day challenge" program designed to increase the amount of fruits and vegetables eaten daily. In addition, 17 community coalitions promote healthy eating and physical activity with the potential to reach more than 70 percent of the state's population.
2. Health disparities - The Health Disparities Committee received a grant to establish an office of special populations within the State Department of Health. The Tribal/State Health Task Force was formed at the request of the Indian Affairs Commission to identify the common health needs of North Dakota's American Indian population. Key issues identified include:
   a. Little public health infrastructure exists on the reservations.
   b. State/tribal communications are problematic.
   c. Access to health care is poor.

3. Tobacco use - The Tobacco Quitline began in September 2004 and is demonstrating high rates of success in assisting people to quit smoking. The 6-month quit rate is 36 percent and the 12-month quit rate is 27 percent.
4. Cancer - The cancer coalition is developing a cancer control plan for the state. The plan provides a starting point to improve cancer care.
5. Early childhood - The Early Childhood Alliance completed its early childhood comprehensive systems state plan. Key areas of the plan include access to health insurance and medical home, mental health and social/emotional development, early care and education/child care, parent education, and family support.
6. Oral health - The oral health coalition completed its state plan. The plan is important for establishing the vision to improve the oral health and well-being of North Dakota citizens. An oral health conference is scheduled for September 2006.
7. Injury - Healthy North Dakota assisted in the formation of the North Dakota injury prevention coalition. The coalition works to address prevention or intervention of intentional injuries, such as domestic violence, sexual assault, and suicide, and unintentional injuries, such as motor vehicle accidents and playground injuries.
8. Environmental quality - Environmental health partners provided expertise needed to develop objectives in the prevention section of North Dakota's cancer control plan and further collaboration opportunities have been identified.

## Strategic Assessment

The committee learned Healthy North Dakota completed a strategic assessment process and identified the following recommendations:

1. Designate focus areas for Healthy North Dakota and prioritize Healthy North Dakota resources accordingly.
2. Develop written rule and function descriptions for coordinating, advisory, and executive committees.
3. Develop legislative priorities for the 2007-09 biennium.
4. Determine the appropriate legal identity for Healthy North Dakota.

## Worksite Wellness

The committee learned the goal of worksite wellness programs is to create an environment that meets the health improvement needs of both the employee and the employer. A 2001 study by Winkleman Consulting indicated that more than 80 percent of North Dakota businesses believe that healthier employees have lower insurance costs, better morale, fewer sick days, and better productivity. At the time, fewer than 10 percent of the businesses had conducted a worksite needs assessment or prepared a worksite wellness plan. The committee learned a similar survey was conducted and preliminary results would be available in October 2006.

The Healthy North Dakota Worksite Wellness Committee developed a state-level framework to provide technical assistance and resources to businesses interested in implementing worksite wellness programs. Healthy North Dakota has provided two worksite training programs to expand the pool of trained consultants who have expertise to assist businesses in development of worksite wellness programs.

Healthy North Dakota contracted with North Dakota State University to evaluate current worksite wellness programs being piloted in the state. Pilot programs being evaluated include three programs funded by the Dakota Medical Foundation as well as programs implemented by schools in the Hettinger area, Farmers Union, Public Employees Retirement System, and North Dakota Vision Services - School for the Blind.

The committee received information on the worksite wellness program operated by Hedahl's, Inc., Bismarck. The committee learned the Hedahl's worksite wellness program began in 1992 and provides cash incentives to employees for maintaining weight within standard guidelines, limiting alcohol use, and refraining from tobacco usage. Each employee and spouse is eligible for up to $75 per month in additional compensation for maintaining these health standards. In addition, employees can receive up to $25 for each of the following tests completed annually:

1. Cancer screening.
2. Cholesterol check.
3. Blood pressure check.
4. Blood sugar check.

The committee learned health insurance premiums for Hedahl's, Inc., decreased each year for the first six years following implementation of the program.

The 2003 Legislative Assembly authorized PERS to develop an employer-based wellness program for state employees (NDCC Section 54-52.1-14). The program must encourage employers to adopt a board-developed wellness program by either charging extra health insurance premiums to nonparticipating employers or reducing premiums for participating employers. For the 2005-07 biennium, PERS charged an additional health insurance premium of 1 percent for employers that do not participate in the wellness program.

In order to qualify for the wellness program, each agency's representative must sign a commitment agreement, appoint a wellness coordinator, develop an annual wellness program, distribute educational materials on a monthly basis, and promote the smoking cessation program. For the 2005-07 biennium, 102 of the 104 state agencies participated in the program.

The committee learned PERS is implementing a pilot program for an integrated worksite wellness program in four agencies. Two of the agencies--the Tax Department and the Department of Commerce--are participating in a high-level program that involves conducting a personal behavioral health profile and providing health coaching, onsite screening, and additional services related to stopping smoking, healthy weight, and stress reduction. The other two agencies--the Office of Management and Budget and the State Historical Society--are participating in a medium-level

program that involves a personal behavioral health profile.

### Other Reports

The committee heard reports from other interested persons regarding the value of the Healthy North Dakota initiative and worksite wellness programs. The committee learned worksite wellness programs:

1. Improve performance and productivity of employees.
2. Improve worker morale.
3. Decrease absenteeism.
4. Help attract and retain key personnel.
5. Achieve greater employee allegiance.
6. Lower health and insurance premiums.
7. Improve the public image of the company.

The committee received a report on tobacco cessation efforts across the state and the outcomes of those programs. The committee learned the North Dakota Tobacco Quitline began in September 2004 and served 2,342 individuals for the 2003-05 biennium at a cost of $529,869. The average cost per individual served was $226. The Tobacco Quitline provides counseling, nicotine replacement therapy (a 28-day supply of the patch or gum) to individuals whose income is less than 200 percent of the federal poverty level, relapse prevention, and followup services. The committee learned the 6-month quit rate was 39 percent for individuals under the program and the 12-month quit rate was 33 percent. The committee also learned local public health units have established cessation programs in 69 locations in 42 counties. For the 2003-05 biennium, these programs served 1,662 tobacco users. The department is still working on collecting statistical data from the local programs.

For the 2003-05 biennium, the committee learned five counties provided cessation programs and served 85 clients at a cost of $29,205 with an average cost per client of $344 and the six-month quit rate ranges from 36 to 46 percent.

For the 2003-05 biennium, the committee learned the state employee cessation program served 169 clients at a cost of $35,301 or an average cost per client of $209. Under these programs, the 6-month quit rate was 24 percent and the 12-month quit rate was 10 percent.

### Recommendations

The committee made no recommendations regarding its Healthy North Dakota study.

## FOSTER CARE FACILITY PAYMENT SYSTEM STUDY

Section 15 of House Bill No. 1012 (2005) provided for a Legislative Council study of the services provided by residential treatment centers and residential child care facilities and the appropriateness of the payments provided by the state for these services.

### Facilities and Funding

The committee learned 10 licensed group homes and residential child care facilities operate in the state providing 281 beds. The daily rate for room and board (maintenance) ranges from $94 to $218 per day. Although the service and treatment costs at these facilities range from 28 cents per day to $32.73 per day, the Department of Human Services' reimbursement for service costs could not exceed $11.51 per day during the 2003-05 biennium.

The committee learned there are six licensed residential treatment centers operating in the state providing 84 licensed beds. The room and board (maintenance) rate for these facilities ranges from $45.95 to $110.11 per day. The treatment or service rate for these facilities ranges from $179.60 to $364.15 per day.

The committee learned the 2005 Legislative Assembly added $475,944, of which $71,630 was from the general fund, to the Department of Human Services' appropriation for increasing the maximum treatment services payment rate for residential child care facilities by $3.49 per day from $11.51 to $15 per day. The following schedule presents the Department of Human Services' estimate of foster care payments made to residential child care facilities and group homes and residential treatment centers for the 2003-05 and 2005-07 bienniums:

| | General | Federal | Other | Total |
|---|---|---|---|---|
| **2003-05 Biennium** | | | | |
| Residential child care facilities/group homes | | | | |
| Room and board | $3,122,288 | $14,594,140 | $3,768,676 | $21,485,104 |
| Treatment/services | 477,094 | 1,273,964 | 71,989 | 1,823,047 |
| Total | $3,599,382 | $15,868,104 | $3,840,665 | $23,308,151 |
| Residential treatment centers | | | | |
| Room and board | $932,632 | $4,359,289 | $1,125,709 | $6,417,630 |
| Treatment/services | 3,140,857 | 7,191,998 | | 10,332,855 |
| Total | $4,073,489 | $11,551,287 | $1,125,709 | $16,750,485 |
| **2005-07 Biennium** | | | | |
| Residential child care facilities/group homes | | | | |
| Room and board | $2,993,360 | $16,611,999 | $4,676,382 | $24,281,741 |
| Treatment/services | 910,982 | 1,719,872 | 139,982 | 2,770,836 |
| Total | $3,904,342 | $18,331,871 | $4,816,364 | $27,052,577 |
| Residential treatment centers | | | | |
| Room and board | $894,120 | $4,962,026 | $1,396,841 | $7,252,987 |
| Treatment/services | 3,817,404 | 6,945,700 | | 10,763,104 |
| Total | $4,711,524 | $11,907,726 | $1,396,841 | $18,016,091 |

## Children in Foster Care

The committee received information on the number of children in foster care. The following schedule presents the number of children in foster care by placement type since federal fiscal year (FFY) 2000:

| Placement Type | FFY 2000 | FFY 2001 | FFY 2002 | FFY 2003 | FFY 2004 | FFY 2005 |
|---|---|---|---|---|---|---|
| Preadoptive home | 154 | 166 | 157 | 160 | 207 | 228 |
| Relative placement | 237 | 240 | 276 | 328 | 383 | 507 |
| Family foster care | 875 | 835 | 824 | 932 | 912 | 896 |
| Group home | 125 | 109 | 127 | 125 | 120 | 96 |
| Facility (RTC and RCCF) | 577 | 540 | 619 | 604 | 555 | 552 |
| Total | 1,968 | 1,890 | 2,003 | 2,149 | 2,177 | 2,279 |
| Children aging out of foster care | 43 | 45 | 56 | 66 | 60 | 65 |

The following schedule presents the number of out-of-state residential foster care placements on selected dates:

| Date | Number of Out-of-State Placements |
|---|---|
| January 2003 | 33 |
| July 2003 | 43 |
| January 2004 | 50 |
| July 2004 | 56 |
| January 2005 | 62 |
| July 2005 | 53 |
| September 2006 | 72 |

Of the 72 children placed in out-of-state facilities in September 2006, the committee learned that 58 were in residential care and 14 were in family foster homes or relative care. Of the 58 children placed in residential care out of state, 39 were in these facilities for treatment services, 9 because of a lack of bed space in an in-state facility, and 10 due to the close proximity to family members.

## Change in Federal Payment Procedures

The committee learned the federal Centers for Medicare and Medicaid Services changed the regulations affecting the method of paying foster care providers for rehabilitation and treatment services. The federal changes require the state to use a 15-minute, fee-for-service billable unit for services, rather than the daily rate method previously used by the department.

To make this change, the department and providers developed the following strategies to comply with the federal regulation changes:

1. Residential treatment centers will seek accreditation status allowing them to become accredited residential treatment centers enabling them to continue to bill using the daily rate.
2. Residential child care facilities will begin billing Medicaid for the rehabilitation services on a 15-minute unit basis.

The committee learned beginning July 1, 2006, residential child care facilities and therapeutic foster care homes began billing Medicaid under the new federally required methodology for dates and services. The department will monitor payments each quarter to ensure the providers are receiving no more than the maximum $15 per child per day for rehabilitation costs authorized by the 2005 Legislative Assembly. For residential treatment centers, five of the six centers have been accredited allowing them to bill Medicaid for both rehabilitation and maintenance. The remaining center--the Ruth Meier's facility in Grand Forks--has not yet been accredited to receive payment by the federal Centers for Medicare and Medicaid Services; however, the department anticipates the facility to be accredited in December 2006.

## Other States' Payment Systems

The committee received information on the Kansas system of reimbursing its foster care providers. Kansas contracts with a foster care provider for a capitated rate and the provider is required to provide the full range of foster care services in the provider's designated area and to:

1. Place each child in the least restricted environment and close to family.
2. Develop a wraparound plan for the family, foster family, and other persons important to the life of the child within two weeks.
3. Place the child in a home that enables the child to continue in the child's current education placement which enables a child to maintain friendships, continue extracurricular activities, and be close for reunification efforts with the family.

The committee learned that Kansas reduced its number of children in residential services to 5 percent by implementing this model. North Dakota has 25 percent of its children in residential services while Wyoming has over 60 percent of its foster care children in residential facilities. The committee learned that while residential facilities continue to serve a critical function in Kansas, their focus has changed to providing crisis stabilization and reconnecting children with the community and as a result has reduced lengths of stay in foster care.

## Residential Treatment Center Tour

The committee conducted a tour of Pride Manchester House in Bismarck and learned that the residential treatment center serves eight children ages 5 through 13 with an average length of stay for each child of five to six months. The committee learned during the last two years the facility has had 100 percent occupancy and always has a waiting list. The center has begun providing outreach services to children referred to the facility and of the 74 referrals in 2005, 36 were diverted because of the center's outreach program. The committee learned of the importance of providing transition services in each child's home upon discharge from the facility. Concerns expressed by the center related to financial reimbursement not being available from the state for providing outreach services or for transition services provided outside of the facility.

## Provider Testimony

The committee received testimony from foster care providers regarding the study. Comments included:

1. Consider increasing the rehabilitation rate to more accurately reflect the actual cost of services provided to these children.
2. Children placed in residential child care facilities are requiring increasingly intensive services to meet their needs.
3. Concern that the current system for providing payments to residential child care facilities is based on costs incurred in previous years; therefore, the payment amount is not representative of current costs.
4. Concern that the Kansas system, which requires services to children close to home, may be difficult to achieve in a rural state.
5. Consider allowing facilities to develop creative ways to use funding received from the state more efficiently and effectively.

### Recommendations

The committee made no recommendations regarding its foster care facility payment system study.

## CHILDREN WITH SPECIAL HEALTH CARE NEEDS STUDY

House Concurrent Resolution No. 3054 (2005) provided for a study of state programs providing services to children with special health care needs to determine whether the programs are effective in meeting these special health care needs, whether there are gaps in the state system for providing services for children with special health care needs, and whether there are significant unmet special health care needs of children which should be addressed. In addition, Section 5 of Senate Bill No. 2395 (2005) required the Department of Human Services to report to the Legislative Council regarding the status of the Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care, the number of applications the department received for the in-home services, and the status of the program's appropriation.

### 2005 Legislative Action

The 2005 Legislative Assembly approved Senate Bill No. 2395, which authorized the Department of Human Services to provide services to children with Russell-Silver Syndrome. The bill authorized the department to pay up to $50,000 per child per biennium for medical food and growth hormone treatment at no cost to the children who have been diagnosed with Russell-Silver Syndrome, regardless of the family's income. The bill appropriated $150,000 from the general fund for providing these services for the 2005-07 biennium.

Section 3 of the bill required the department to apply for a Medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care which, if approved, will allow the services to be provided under the Medicaid program. The department may limit the waiver to 15 participants and may prioritize the applicants by degree of need.

### Children's Special Health Services Program

North Dakota Century Code Chapter 50-10 provides for aid to crippled children in North Dakota, which is the basis for the Department of Human Services' children's special health services program. The program is administered by the Medical Services Division and assists in the cost of medical services for eligible North Dakota residents up to 21 years of age who require health-related services beyond those needed by most children. The program provides assistance for diagnostic and treatment services for over 100 eligible medical conditions.

The annual budget for North Dakota's children's special health services program is approximately $960,000. Of this amount, $396,000 is from the general fund and $564,000 is from federal and other funds. The federal and other funds consist of approximately $500,000 of federal maternal and child health block grant funds. In addition, the 2005 Legislative Assembly in Senate Bill No. 2395 appropriated $150,000 from the general fund for providing medical food and growth hormone treatment services to children with Russell-Silver Syndrome.

The program is administered by the Department of Human Services and employs eight FTE positions, including a director, nurse, program administrator, two eligibility and claims staff members, and two administrative support positions. The program has a Medical Advisory Council consisting of a nine-member group of health care providers that meets annually.

The program serves approximately 1,400 children per year. Financial eligibility is not required for diagnostic services; however, for treatment services, families at or below 185 percent of the federal poverty level receive services at no cost. If a family's income exceeds 185 percent of the federal poverty level, the child may still be eligible but the family shares in the cost of the services. Approximately 300 to 325 families receive financial assistance from the program. The maximum financial assistance a family may receive each year on behalf of a child is $20,000. The department spends approximately $160,000 per year providing financial assistance to families for diagnostic and treatment services.

The primary responsibilities of the program are to:

1. Plan, organize, and manage specialty clinics for children with special health care needs by bringing in specialists to provide services for the children. The state provides for the cost of the services.
2. Provide financial assistance to families. Families with incomes up to 185 percent of the federal poverty level receive specialty care services at no cost.
3. Coordinate with county and public health staff to assist families in accessing services and resources for their child with special health care needs.
4. Provide information and resources to assist families, including offering a toll-free telephone line for families to use to obtain information.

5. Distribute food and formula for children with phenylketonuria and maple syrup urine disease.
6. Provide payment for services relating to children with Russell-Silver Syndrome.

The following schedule shows the unduplicated number of children served since federal fiscal year 2000:

| Federal Fiscal Year | Unduplicated Number of Children |
|---|---|
| 2000 | 1,604 |
| 2001 | 1,570 |
| 2002 | 1,514 |
| 2003 | 1,403 |
| 2004 | 1,371 |

The following schedule shows the number of children receiving treatment or diagnostic services since federal fiscal year 2000:

| Federal Fiscal Year | Children Receiving Treatment Services | Children Receiving Diagnostic Services |
|---|---|---|
| 2000 | 235 | 174 |
| 2001 | 228 | 162 |
| 2002 | 238 | 127 |
| 2003 | 220 | 92 |
| 2004 | 210 | 107 |

The numbers reported do not include individuals served through the metabolic food program, the Russell-Silver program, or the information resource center.

Children with the following five conditions were served most frequently in federal fiscal year 2004--asthma, cleft lip/palate, diabetes, heart conditions, and handicapping malocclusion.

The Department of Human Services provided the following comments and concerns:

1. Use of the condition list for determining medical eligibility is of concern. The list identifies the population to be served; however, the list is arbitrary and not all-inclusive when using a broad definition of children with special health care needs.
2. Out-of-pocket costs for children's medical expenses can be a burden for families.
3. The pilot study recommended by the program's Medical Advisory Council to determine if it is viable to address currently noncovered conditions should be continued. Other areas that could be considered include genetic syndromes, mental health conditions, mitochondrial disorders, and conditions leading to blindness; however, financial constraints of the program may be an issue.
4. Additional services could be covered, including respite care and transportation; however, financial constraints within the program may be an issue.
5. The Medical Advisory Council at times has difficulty agreeing on what constitutes a "special health care need" but typically the conditions chosen have been chronic and complex.
6. Many children are excluded from coverage simply because the condition which affects them has never been discussed by the Medical Advisory Council.
7. Because the Medical Advisory Council only meets annually, rapid advances in medical care can make it difficult to keep the list current.
8. Few health care providers have any knowledge of the list or the program as a possible resource for children under their care.
9. Some members of the Medical Advisory Council believe the medical director should be given broader authority to determine medical eligibility.
10. The Medical Advisory Council has developed a grid which may be used to evaluate potential eligible conditions.

## Waiver Request

The committee received status reports at each of its meetings regarding the Department of Human Services' Medicaid waiver request that if approved would allow the state to provide in-home services to children with extraordinary medical needs. The committee learned the department convened a medical needs task force to assist in gathering information to better understand the unmet special health care needs of children and to provide recommendations regarding the Medicaid waiver.

The committee learned the department anticipates the draft of the waiver application to be available for public comment during the fall of 2006 and the waiver application to be submitted with a July 1, 2007, effective date contingent upon legislative appropriations to operate the waiver during the 2007-09 biennium.

The committee received the following information on the various options under federal law for states to provide Medicaid services to children with special health care needs:

| | Waiver | Medicaid Buy-In | Katie Beckett Eligibility Option |
|---|---|---|---|
| **Description** | A home and community-based waiver is designed to reduce extended hospitalizations and prevent skilled nursing facility placements for children who are medically fragile by providing assistance for families who require long-term support and services to maintain their child at home while meeting the child's medical needs. | The Family Opportunity Act, authorized by Congress in 2006 as part of the Deficit Reduction Act, allows states to create Medicaid buy-in programs for children who meet the Social Security standard for disability, but whose family income is above standard Medicaid eligibility limits. States need legislative approval and Centers for Medicare and Medicaid Services approval. | The Katie Beckett eligibility option is an optional eligibility category that allows children with long-term disabilities or complex medical needs, living at home, to access Medicaid services. |

| | Waiver | Medicaid Buy-In | Katie Beckett Eligibility Option |
|---|---|---|---|
| **Covered population** | Medically fragile children aged 2 to 18. Medically fragile children are at times medically stable but still may require skilled nursing care, specialized therapy, and specialized medical equipment and supplies to enhance or sustain their lives. | Disabled children aged 18 and under whose family income does not exceed 300 percent of poverty (could be lower at state option). In 2006 for a family of four, this amount would be $6,668 per month (**net income**). Assets are not considered. Eligibility will be phased in starting in October 2007 for children aged 6 and under, in October 2008 for children aged 7 to 13, and October 2009 for children aged 12 to 18. | Children aged 18 and under who do not have income or assets in their name in excess of the current standards for a child living in an institution. Without the Katie Beckett eligibility option, the income of legally liable relatives is counted when the individual is cared for at home. |
| **Medical conditions of group** | Children must meet institutional (hospital or nursing facility) level-of-care criteria in order to qualify for waiver services. If not for the waiver, the child would require services in a hospital or nursing facility. Initial enrollment will be based on the greatest need. | Children must be determined to be disabled under Social Security Act guidelines. | Children must be determined to be disabled under Social Security Act guidelines and require a level of care at home that is typically provided in an institution. |
| **Number of children covered** | Limited to 15 | Estimated 778 (includes about 31 that would switch from medically needy) | Not available |
| **Estimated cost per year** | The estimated cost per year would be $44,769 per child ($671,535 total for 15 children). This includes both the Medicaid state plan and waiver services. | $2,066,245 per biennium. This includes an offset of premiums estimated to be $800,000. | Not available |
| **Services offered** | All Medicaid services<br>Proposed waiver services include:<br>• In-home support<br>• Respite care<br>• Excess medical-related expenses not covered by the state plan<br>• Case management<br>(Medicaid waivers are required to be cost-neutral. The overall cost of the waiver services may not exceed the cost of institutionalization.) | All Medicaid services | The cost to Medicaid cannot exceed the cost Medicaid would pay if the child were in an institution. |
| **Cost to family** | The family will not incur a Medicaid recipient liability because family income and assets will not be an eligibility consideration. | Premium equal to 5 percent of the family's gross income. The law requires participating families to first take advantage of available employer-sponsored health insurance options. These premiums would be offset by the family's private insurance premiums. Recipient liability would not apply. | Premiums and/or recipient liability would not apply. |
| **Program caps/limits** | Waivers allow a cap on enrollment. States may also determine the individual cost limit at less than institutional costs or have no individual cost limit. The Department of Human Services is proposing a waiver that caps the number of individuals enrolled and the amount of waiver services each individual may obtain per year. | All who meet program requirements would be allowed to buy in. Limits within the Medicaid program would apply. | All who meet eligibility requirements would access Medicaid. Limits within the Medicaid program would apply. |

## Other States' Programs

The committee reviewed information on surrounding states' programs for children with special health care needs and selected results from a 2004 United States Department of Health and Human Services report of a 50-state national survey of parents of children with special health care needs. The committee learned South Dakota and Montana provide financial assistance to families with children with special health care needs, while Minnesota discontinued providing financial assistance in 2003. The committee learned that Montana has an advisory board for its program, but Minnesota and South Dakota do not.

The committee learned that Montana does not have a waiver for providing in-home services to children with special health care needs, South Dakota has a family support waiver that provides in-home services for children with mental retardation, and Minnesota has a community alternatives waiver for disabled individuals that provides in-home services for disabled individuals under age 65.

## Anne Carlsen Center Tour

The committee conducted a tour of the Anne Carlsen Center for Children in Jamestown which provides services to the state's most vulnerable and fragile children. The committee learned a concern of the facility

is that actual costs for caring for children with serious medical fragility are increasing faster than state reimbursement for the services.

### Other Comments and Suggestions

The committee received information from families with children with special health care needs and other interested persons. Comments and suggestions include:

1. It is important to define which children will be considered to be those with special health care needs.
2. Public assistance is generally available for children with special health care needs up to age 3; however, for older children much of the assistance is no longer available.
3. The waiver being developed by the Department of Human Services will benefit only a limited number of families.
4. The state should consider developing a Medicaid buy-in program to allow more families to access Medicaid services for their children with special health care needs.
5. The Legislative Assembly should continue to review information on all programs and services available for these children and how to better coordinate and inform families of children with special health care needs.
6. Based on a survey of families raising children with special health care needs, the following suggestions were made:
   a. Coordination of care and communication among providers are essential and must be improved to ensure quality of care for children with special needs and to reduce health care costs.
   b. Families with children with special health care needs require access to more information and assistance to ensure a health system that works for their children and families.
   c. Additional opportunities should be made available for family involvement at the state policy level.
7. The state should identify children who are not accessing the state's current system of services and identify services that are lacking to assist families of children with special health care needs.
8. Change the eligibility criteria for the program to allow additional families to access the program.
9. Because obtaining services for children with special health care needs is difficult and services are inadequate and inadequately coordinated, the following changes should be made to the system:
   a. Develop a simpler system of accessing quality services.
   b. Provide care coordination.
   c. Provide transition services.
   d. Improve screening services.
   e. Address the shortage of specialty providers and expand interdisciplinary clinics.

### Recommendations

The committee made no recommendations regarding the children with special health care needs study.

## OTHER RESPONSIBILITIES

### Department of Human Services' Budget Review Report

Section 11 of House Bill No. 1012 (2005) required the Department of Human Services to report to the Legislative Council by July 1, 2006, regarding the department's review of its budget, programs, and services to determine the extent to which the department can provide for additional general fund requirements resulting from changes in the federal medical assistance percentage for North Dakota without affecting the level of services provided by the department.

The committee learned the actual FMAP for North Dakota for federal fiscal year 2007 is 64.72 percent, a decrease of 1.13 percent from the 2006 FMAP of 65.85 percent but an increase of 2.35 percent compared to the 62.37 percent estimate used by the 2005 Legislative Assembly in developing the Department of Human Services' 2005-07 biennium budget. The 2007 FMAP will affect the final 10 months of the 2005-07 appropriation and will result in an estimated $8.8 million of reduced general fund matching requirements for the Medicaid program for state fiscal year 2007.

The department reported FMAP changes anticipated for the 2007-09 biennium will require an additional $11.9 million of general fund appropriations for the 2007-09 biennium. Other estimated budget increases reported by the department include:

1. The North Dakota Medicare Part D "clawback" payment will increase by $3.8 million during the 2007-09 biennium as a result of the payment being made for 24 months rather than 18 months.
2. Information received from Blue Cross Blue Shield of North Dakota indicates the monthly premium payment for the children's health insurance program will increase by 20.3 percent or $36.94 per month per contract over the current monthly premium of $181.71.
3. Additional funding of $1.4 million, $615,000 of which is from the general fund, will be needed to provide for the Information Technology Department rate increases for the 2007-09 biennium.

The department provided information relating to the Medicaid program, including eligibility categories and expenditures, mandatory and optional services, current service limits and copayments, and input received from Medicaid providers.

The committee received a report from the Department of Human Services regarding its organizational restructuring and learned that effective January 1, 2006, the department implemented a six-member cabinet under the executive director.

### Department of Human Services' Plan to Transfer Individuals From the Developmental Center to Community Placements

Section 16 of House Bill No. 1012 (2005) required the Department of Human Services to report to the Legislative Council during the 2005-06 interim on the department's plan, developed with input from developmental disabilities service providers, to transfer appropriate individuals from the Developmental Center to community placements and to begin the transfers during the 2005-07 biennium.

The committee received the report from the Department of Human Services and learned the department was serving 139 individuals with developmental disabilities--134 at the Developmental Center and 5 at the State Hospital. Because community capacity needs to be expanded and resources need to be in place to meet the current and projected needs of the individuals to be transferred into the community from the Developmental Center, the following action steps were reported by the department in order to allow for these transfers:

1. Ensure that every person with developmental disabilities at the Developmental Center and State Hospital has a placement plan in order to place the person in an appropriate community setting;
2. Expand community capacity by having:
   a. A statewide crisis prevention response system that is based on a zero-reject model;
   b. Crisis intervention services, including crisis beds, out-of-home crisis residential services, in-home technical assistance, followup services after a crisis residential services placement, and training for staff;
   c. Increased capability and capacity to serve young adults with developmental disabilities; and
   d. Increased consultation services available.
3. Make changes to funding and staffing by:
   a. Changing administrative rules that are a disincentive for independent supported living arrangement placements;
   b. Increasing funding for independent supported living arrangement placements; and
   c. Improving recruitment and retention of staff.
4. Reduce the number of residents at the Developmental Center to 127 by July 1, 2007, to 97 by July 1, 2009, and to 67 by July 1, 2011.
5. Develop a transition budget as part of the Department of Human Services' 2007-09 budget request.
6. Determine the long-term future of the Developmental Center services system, including clinical, health care, residential, and vocational components.

## BUDGET TOURS

During the interim, the Budget Committee on Human Services functioned as a budget tour group of the Budget Section and visited the South Central Human Service Center, Northeast Human Service Center, West Central Human Service Center, North Central Human Service Center, State Hospital, Veterans Home, and Developmental Center. The committee heard budget reports from the Lake Region Human Service Center, Southeast Human Service Center, Badlands Human Service Center, and Northwest Human Service Center.

During the budget tours, the committee also learned about facility programs, major improvement needs, and problems the institutions' facilities may be encountering during the interim. The tour group minutes are available in the Legislative Council office and will be submitted in report form to the Appropriations Committees during the 2007 legislative session.

The committee received comparative funding and statistical data from each human service center. The committee learned the human service centers were having difficulty recruiting and retaining clinical specialists at the human service centers, particularly licensed addiction counselors, nurses, psychologists, psychiatrists, and social workers. In addition, the committee learned the human service centers were experiencing an increasing number of individuals being referred by the Department of Corrections and Rehabilitation for treatment services. As a result of these concerns, the committee received:

1. Information on selected clinical specialty programs of the University System.
2. Information on the number of psychiatrists, psychologists, licensed addiction counselors, and social workers in the state.
3. A report on the effect on human service center services of addiction counselor vacancies. The committee learned the Board of Addiction Counseling Examiners may request statutory changes during the 2007 Legislative Assembly to allow more flexibility in administrative rules regarding licensing of addiction counselors which may result in more addiction counselors being available in the state.
4. Information from the Department of Human Services and the Department of Corrections and Rehabilitation on the process involved in providing treatment for inmates during incarceration and as a condition of parole and probation and on the cost of providing these treatment services by the Department of Corrections and Rehabilitation and at the human service centers.

## OTHER REPORTS

The committee received a report on federal changes affecting the temporary assistance for needy families program and reviewed activities of the department to comply with the federal changes. The committee learned that with the plans in place, the department anticipates that North Dakota will avoid penalties for failure to comply with the work participation rate changes.