2011 SENATE APPROPRIATIONS

SB 2012

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 17, 2011
Job #12941

☐ Conference Committee

Committee Clerk Signature Alice Dulzer

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony #1 - 6

Chairman Holmberg called the committee to order on SB2012, Department of Human Services (DHS) at 8:30 am on January 17, 2011. All committee members were present except Senator Fischer. Lori Laschkewitsch, OMB and Roxanne Woeste, Legislative Council were present.

Senator Kilzer asked Roxanne to assist the members of the committee to access the website for the Executive Summary as he found this very helpful in his own research

Chairman Holmberg: announced the subcommittee members are Senator Kilzer, Senator Fischer, Senator Erbele and Senator Warner, and they will have time to meet this Thursday. He now opened the hearing on SB 2012.

Carol Olson, Executive Director DHS testified in favor of SB 2012 and provided written Testimony attached # 1. She gave an overview of the budget request for the 2011-2013 biennium for the Department of Human Services. (Meter 11. 22)

Senator Robinson: had questions concerning the FMAP.

Carol Olson: I think there are a number of reasons why our Medicaid rolls are increasing. I know we have continuing eligibility for children now which has pushed up the numbers on Medicaid, I do believe the elderly, the frail elderly, and those with disabilities probably are increasing our rolls, I am not sure if the economy at that level has made an impact, but I know that Maggie Anderson will testify concerning that matter. Yes, that is true our Medicaid numbers are on the increase.

Senator Warner had questions regarding global mental health issues.

Carol Olson: It is different; it has the same type of impact in our community. But it is different in relation to the work we did with our private providers and our hospitals that we did during the interim. We met with the hospitals and we concentrated on relieving some of

the pressure they had with their inpatient psychiatric, and that's why we chose to continue our contracts but also raise the Medicaid clients, The Human Services clients that weren't Medicaid eligible and so now they are all going to be at that level, up to 4900 of them. We will also be able to have the flexibility to move them throughout regions as opposed to before, we are going to have the same contracts in all 8 regions and so we will have the ability to be flexible as far as what hospitals are going to be moved into.

Chairman Holmberg: When I visited with people about your budget, they are intrigued by the large increase in Medicaid, but I constantly remind them that number was outside of the control of the Legislature when we spent the stimulus money last time we knew that next session we were going to have to take it back to the general fund and then the change in the FMAP, which we can wring our hands over, but the bottom line, would you rather have more money coming from the federal government or would you rather have increases in personal income in North Dakota and we chose as a state to have increase in personal income. The cost is there but there are a lot of things in this budget that are outside of the control of the Department as you present the budget to OMB and to us.

Brenda Weisz, Chief Financial Officer for DHS (Meter 16.53) testified in favor of SB 2012 and provided written Testimony attached # 2. (Meter 31.18)

Chairman Holmberg had questions regarding the dollar amount for medical assistance grants and what shows up in the general fund or doesn't show up at all.

Brenda Weisz: it does not show up at all and actually when I walk you through our changes to our general fund, it will be the second to the last bullet on page 6. Where there is actually a reduction. The budget we turned into OMB then was reduced by that dollar amount of general fund.

Chairman Holmberg: But the money does exist and will be spent, but it is off the books. It seems to have disappeared.

Lori Laschkewitsch: Since the money was appropriated in this 09-11 biennium, it's the continuation of that 09-11 appropriations so it will be carry over and they actually will have appropriation authority from the carry over committee to use that money in the 11-13 biennium.

Chairman Holmberg: But in the past we have turned the money back in to general fund and then redone it. What you are doing is just allowing them to keep the money that they didn't spend this last biennium to spend on the same program next biennium.

Lori Laschkewitsch: That is correct, however with some of the federal money that they have gotten with the stimulus money, that money isn't allowed to be put into a rainy day fund and since some of the money is a result of stimulus money that they received in this 09-11 it insures that that money doesn't get transferred into a rainy day fund and gets used for medical services programs.

Senator Wanzek: So what you are saying is if we will allow for the continuing appropriation the budget request would have been higher. The answer was yes.

Chairman Holmberg: Committee members you have the handout from Legislative Council; they have the chart which charts the FMAP changes going down. So you have that also in Brenda's presentation and also visually.

Brenda Weisz continued on page 4 of testimony. (36.46)

Chairman Holmberg: Is that a number that you all put forth, or was it a number that was in response to the governor's budgetary increases for state employees at 3%?

Brenda Weisz: The Department put an OAR (optional adjustment request) of 3%. She continued with written testimony. There was a change last legislative session with House Bill 1540, in the Indian county allocation payment to counties. She continued on with reading her written testimony. (Meter 46.35)

Chairman Holmberg: There are those that have suggested, because we have had a number of FTE requests in the Insurance Department too dealing with implementing health care reform that is still in it's jelling stage that the legislature might consider just delaying that until next fall before they make that decision, because the resolution that is in that deals with redistricting also mentions health care changes that need to be made. Would that present a major problem if that's the direction the legislature went in these additional FTE's that are here because of health care? There might be practical implications but I think it is something that the legislature certainly will have that on the table because it is in the resolution on redistricting.

Brenda Weisz: There is only a couple of them that we have scheduled to go into effect July 1of 2011 and I think what we do is it would be the wishes of the policy makers as to how you want to implement heath care reform. She continued her testimony. (Meter 52.34)

Chairman Holmberg: I was looking at the FTEs, the 400 FTEs at the Developmental Center that is, and then last time we had 440 and the secured services at State Hospital; how are those differentiated between State Hospital and Secured Services?

Brenda Weisz: In our budget bill we have those combined as one. For our presentation we track them separately so I guess we do a separate line item for that but they are all State Hospital FTE.

Brenda Weisz testified in support of SB 2012 and presented written testimony attached #3: Overview of the Administration/Support

Chairman Holmberg had questions regarding the underfunding in the FTE portion of the budget

Brenda Weisz: This budget did include salary underfunding for the institutions and for the human service centers. We did submit it that way knowing that we had direct care staff and we do have turnover there so we did propose our budget that way. It's a little more difficult than the central office to do that. A lot of our positions are more static and we don't have the turnover that we see with direct care staff.

V. Chair Bowman also had more questions regarding underfunding and salary issues.

Brenda, Weisz: When we look at underfunding we don't so much look at what the individual makes as a salary and what we think they should make as a salary. We look more at what it costs to fund a pay plan of 400 FTE in a direct care facility, to take the Developmental Center, for example, we might look at the turnover ratio and how often or what we think the frequency of a position being open, we'll look at what our general fund target in building that budget and how long we think it will be vacant, and then, what our general fund need would be and how much of that we can tolerate of not requesting that portion of the salary. We don't analyze someone if we feel they are making too much or not, that becomes a personnel action. (Meter 59.27)

Senator Warner: With regard to sick leave, persons leaving and collecting sick leave, is it a 10 year period before they are vested and they can get paid for unpaid sick leave? He was told they are vested after 3 years. He also had questions concerning the high level of turnovers.

Brenda Weisz: In developing our budget we will look at that division by division. If a division has employees that have been there for a long period of time, and you will see it in some of the testimony where we've actually built in for retirements, pay out of retirements and that would be because in that particular division we have retirements that it will be quite costly to pay for that, and we would have built that in our budget request. There may be other division where they may have retirements but the length of stay for that employee might not be as long or the magnitude of, or the number might not be as high as other divisions or also depends on how many staff you have? If you have a staff of 9 and 3 are expected to retire the cost of that and the ability to pay for that with turnover dollars is allowed 74.6 FTE in this area of the budget. She continued testimony on page 2 and 3. (Meter 62.16)

Senator Robinson: Just a question, I understand inflation, increase of salaries, one proposal for an increase in the Attorney General's Office and we go to Administrative Hearings at 33%, what is the rational for that type of percent over a two year period?

Brenda Weisz: Those are the budget guidelines that are developed by those central service agencies that they post and put out for divisions that utilize their service they tell us to build in our budget. They will do their rate setting and it would be based on, perhaps FTE's they needed to add based on the work load that we're demanding of them. She continued testimony.

Chairman Holmberg had a question for Lori concerning fuel prices going up. Lori, do you anticipate if gas prices continue to increase, that will be enough in these budgets for travel?

Lori Laschkewitsch: We don't put additional money in to the budget for fuel increases; they have to cut back in their budget to accommodate that if the fleet charges would change.

Chairman Holmberg: We have made some accommodations for the Highway Patrol. They have a huge fuel budget. That was confirmed by Senator Wardner.

Brenda Weisz continued and concluded her testimony at this time

V. Chair Grindberg asked if we have begun to use SKYP technology or internet phone. He was told they use Webcam and also use a Polycom to reduce some of the travel.

Senator Warner had questions concerning security and if they use security regarding child support or juvenile privacy issues. He was told they have proper security in place because we are using those polycom for telemedicine. She doesn't know about child support.

Jenny Witham, Director of Information Technology Services of the DHS: testified in favor of SB 2012. I am here today to provide you an overview of Information Technology Services. Written Testimony attached # 4.

Senator Warner had questions for Lori regarding salary differentials between the FTEs which you are releasing from the Development Center and those you are adding in Administration.

Lori Laschkewitsch: I don't know if there is an easy way to track that as far as how much money would have been associated with that FTE when it's Developmental Center versus what it is. We could see if the department has some history of what that FTE might have had assocated with it at the time. Maybe Brenda can better answer that for you.

Brenda Weisz: It is true the direct care staff is paid at a different level. The other thing is that the Developmental Center, the amount of money in there is salary underfunding there, that's different that doesn't exist at the Central Office like we talked earlier, so there might not be any funds tied to that position. It might be a position that had the underfunding tied to the position and wasn't used.

Senator Warner: The Developmental Center would have quite a bit of Medicaid component to those salaries, is that correct? He had more questions concerning salaries.

Brenda Weisz: Yes as far as general fund equivalent from the amount of general funds available for a position at the Developmental Center and to use those general funds in another division, it is minimal, because of the funding like the FMAP, especially during the current biennium, 69.95% of that would have been federal funds and very little of it would have been general funds. When you come into a central office division, for some of the positions it's 50% would be general funds, so substantially more would be funded with general funds. So it will cost quite a bit more, general funds, state fund wise. .

Senator Wanzek had questions regarding IT and efficiency.

Jenny Witham: When we do large IT projects, we do have measurements that we set out for performance measurements in terms of what we expect the outcomes to be and we report that to the Legislative IT Committee of which Senator Robinson is the chair, and at the close out of those committees we also speak to talk about the performance and whether or not we met those measurements and we would continue to measure those if they were a

performance measure that we expected to see over time. Quite often in the DHS it is increasing efficiencies but It is also enhancing services for the most part.

Senator Robinson asked about hearing about MMIS and was told it will be heard in a couple of days. (Meter 84.13)

Chairman Holmberg explained to the new committee members information regarding budget requests.

Tove Mandigo, Economic Assistance Policy Division Director in DHS: testified in favor of SB 2012. I am here today to provide you an overview of the Economic Assistance Division. Written Testimony attached # 5.

V. Chair Grindberg: Over the weekend I heard a news report out of Minnesota that the increase in the support for heating assistance is significant. Is that comparable to what you plan for a budget for North Dakota or is just a Minnesota issue?

Tove Mandigo: I haven't heard here directly that we've had a big impact in heating assistance. However, we may have but we feel like we have a budget that is going to be good enough to project and be able to cover the needs even if there is a slight increase. Last biennium, we can carry over funds for two years and we can obligate LIHEAP(Low Income Heating and Energy Assistance Program) funds which we have been doing which insures us a little protection if that happens. As you know we can't predict what the weather will be around here, it would be nice if we could but last year we had kind of a nicer season so even though we had maybe a slightly larger increase we still were able to have more money to carry over or to obligate into future years. She was told by V. Chair Grindberg that the report was like a 25% increase in Minnesota. She replied I hope it doesn't increase that much here.

Senator Christmann: Does that adjust based on fuel costs? What happens if fuel prices double for heating their homes; do they get more assistance or do they just get a set amount?

Tove Mandigo: There is a matrix, that is determined that covers the whole state and it's based on the heating season, the costs, three kinds of heat that are included in that - fuel oil, propane and electric, and that determines the eligibility of that household member, we have kept that level for the last two bienniums. We haven't seen an increase or decrease in the way we project that matrix. She continued with her testimony. (Meter 101.42)

Senator Warner requested a hard copy of acronyms for DHS. Carol Olson stated she will provide that information to the committee.

Chairman Holmberg asked for an organizational chart of their Department and was told it will be provided to the committee.

James Fleming, Director of Child Support Enforcement Division of the DHS: testified in favor of SB 2012. I am here today to provide an overview of the Child Support Enforcement (SCE) Program for the DHS. In reply to Chairman Holmberg's question, I report to Tove

Mandigo who is the cabinet lead for Child Support. See written Testimony attached # 6. Many members of the committee will recall that in 2007 the eight field offices were transferred from county administration to Department administration, so this is the second complete budget that has been submitted since that transfer has occurred, first in 09 and now for 2011. (Meter 106.28)

Chairman Holmberg: For the committee members on chart #21 that we received from the Legislative Council it has that FTE change, and the fact that there were 132 people added to Human Services in 2007 because they took over, we mandated they take over state administration of child support, so you have that particular item also visually for you all.

James Fleming: And I'll add later in my testimony we identify what the current FTE complement is in the proposed budget. If I talk about IV-D (Four D) cases that's what we are talking about is those for which federal funding is permitted under Title IV-D of the Social Security Act. (Meter 113.29)

Chairman Holmberg had questions regarding the use of electronic transfers to pay child support.

James Fleming: The support is paid from a lot of folks, over half comes from income withholding, so it is not actually the payor that's making the payment, it's the employer on their behalf. We do have a program where a customer can set up an automatic withdrawal instead of having income withholding go to their employer. Especially if they change jobs a lot it can be hard to match the payroll cycle of the employer with how much is due each month. There is room for improvement on the electronic payments that we receive but on the disbursements we disburse 95% of our money electronically, either through direct deposit or debit card or to other states.

Senator Christmann had questions regarding the establishment of paternity and what can we do if they don't provide that information. Could it be, sadly, for the father to threaten someone and try to keep them from telling who the paternal parent is?

James Fleming: If the custodial parent can come in and ask for our help and not be a referral from another public assistance program, if they don't cooperate with the information that we need we would close the case and say we can't help you until you work with us. If you had a referral from a public assistance program from a parent who is not cooperating in the identification of the dad in a paternity case those programs have different types and sanctions that can be placed on the custodial parent to prompt their cooperation. I think in the TANF program, if they are not cooperating, the TANF benefits can actually be suspended until they cooperate. On your second question, I haven't heard that is a concern.

Senator O'Connell had questions on how this Department works with other states.

James Fleming: Every state is required to have the same Uniform Interstate Family Support Act that establishes foundational requirements for how each program in each state and tribe work with each other. There is a standard set of federal documents to open a case across state lines that are now on the web and can be electronically transmitted so that is how we work back and forth. In the situation you describe where they are trying to work for

cash under the table an employer in ND who does that is risking statutory penalties for failing to report new hires. There are set consequences for that. By and large our employer community in ND are very supportive of child support and new hiring and so we haven't seen a lot of that. He completed his testimony. (Meter 125.10)

Senator Kilzer had questions concerning the arrears piling up for years and what happens when there is a death of the responsible party.

James Fleming told the committee that they close cases when our program allows us like if there is a request to close because of dying, incarcerated or disabled and cannot continue child support payments. The obligation will not survive the death of the obligor. We will look around for the last assets of the obligor to pay the arrearage, but once they die we are able to close our case and cease collecting. There is no federal regulation for a case to be closed for un-collectability. (Meter 128.22)

Senator Warner had questions regarding special and federal funds.

James Fleming: if you compare page 5 and 6 on page 5 it shows the difference between general, fund and other funds. The difference is for our budget purposes, that is where we have the incentives are placed in that box. He was asked if that is an ongoing expectation and he was told yes and was told it is a performance bonus.

Chairman Holmberg closed the hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 17, 2011
12981

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony #7 - 11

Chairman Holmberg called the committee hearing back to order on SB 2012.
Roxanne Woeste – Legislative Council; Lori Laschkewitsch – OMB.

Chairman Holmberg asked **Carol Olson** to comment on the organizational chart that had been requested in the morning and it was explained. Testimony attached - # 7.

Public Testimony – Economic Assistance & Child Support – **none.**

Maggie Anderson, Department of Human Services, Medical Services
Traditional Medicaid Grants & Healthy Steps - Testimony attached - # 8.

Reading from testimony.

(meter 10:30)

Senator Wardner (on Attachment C of testimony #7 - discussing the eligibles and those who didn't elect to receive assistance): Of those not used. Did some of those people use them the month before and they didn't use them this month. Are they people are eligible and just don't use the services.
Maggie Anderson It's both. It could be someone going off & on eligibility. Children, for example, have 12 month continuous eligibility on Medicaid. Any child who is enrolled this month will be eligible for 12 months. Maybe they need preventative dental service this month and a flu shot, and then for a couple months, they have no medical needs. They have no reason to access care. Unlike somebody who's perhaps in need of long term care services where they need services every month.

Senator Wanzek asked if there could be potential eligibles that we don't know about and **Maggie Anderson** said yes. There are outreach programs and the counties help contact eligible people.

Continuing page 1 – (13:09)

Senator Grindberg asked for the definition of the terms QMBs, SLMBs, and QIs and **Maggie Anderson** informed him that they were Qualified Medicare Beneficiary – those are individuals whose income is below 100% of the federal poverty level; Special Low-income Medicare Beneficiary – those are individuals who are between 100 and up to 120% of the federal poverty level; and Qualifying Individuals who income is between 120-135% of the federal poverty level.

Senator Warner inquired of the current poverty levels?

Maggie Anderson said for a family of one, 100% of the federal poverty level is $903/month and for a family of four, it is $1,838/month.

(continuing with Medicare Savings Programs – page 3)

Chairman Holmberg In the budget and overview, we had information that 40 FTEs were taken out of developmental center. At the end of the day, there was a net of about 20. Could the subcommittee get information on the salaries for those 40 people compared to new positions once they all come on board? These new employees are going to be somewhat more expensive. If the subcommittee could get that from the department?

Senator Warner asked if they could also have the relative proportion of federal too.

(continuing on page 6)

Senator Warner said he's assuming you're not underpaying these people because of the decreasing amounts of money allocated. Does that indicate that they are roughly all the same salary but coming on line later in the biennium.

Maggie Anderson replied that some is related to classification differences. There will be a higher classification for a nurse than you would for the SURS analyst, but the other piece is that they're tiered in terms of how they are coming on. Some of the salaries are needed for a shorter period of time.

Maggie Anderson: (continuing page 9)

Senator Robinson asked if she could explain the Medicare Part D Clawback payments.

Maggie Anderson When Medicare part D was implemented in January of 2006, prior to that time, Medicaid was providing the prescription drug coverage for the group known as the dual eligibles – those who were eligible for both Medicare and Medicaid. When Medicare part D came into being, those individuals would then receive their prescription drugs through Medicare part D, however the Clawback or phase down contribution was included as part of the legislation where the states would still contribute towards the cost of the dual eligibles, so the Clawback payment is coming from the state of ND, going back to the federal government and if being used for the expenditures on the Medicare part D program.

Senator Warner about a ruling at the federal level between two different regions where they wouldn't have needed it in one region, but because they were in the wrong region, they did. Was there any thought of trying to recoup some of the money from the federal level and
Maggie Anderson explained the situation between supplemental payments and the federal statute language.

(Continuing on attachment E of Testimony #8)

Senator Christmann asked about the electronic health records – Was there a previous effort to do that? Someone goes into hospital and still walking around with a file folder full of charts. Has that effort failed?

Maggie Anderson said she would be uncomfortable discussing that because the electronic health records piece is so much larger than Medicaid. Others in the audience could answer that.

Healthy Steps -
Senator Robinson: Looking at these figures, do we have information that provide anything in terms of projections with our aging population? What's going to happen in the next 5-10 years?

Maggie Anderson: We have a departmental report called Aging 20/20 and we will touch on that later. With regard to the uncompensated care, we don't specifically have anything in the division on what the hospitals uncompensated or ER use type care is.

Senator O'Connell – Asterik on attachment E referring to the bank loan and tobacco money.

Brenda Weisz – For the Bank of ND loan, we had discussions about the case load and what number was right, the number that the department had or the number the House Appropriation's felt was more accurate. We met in the middle, and said if your case load ends up being higher than anticipated, how about we give you authority to go to the Bank of ND to obtain a bank loan. The tobacco money is not available – it's gone. We used that for the program as match.

Maggie Anderson – continuing Attachment F in Testimony #8.

Senator Christmann – Why would physician services costs go down?

Maggie Anderson said it's based on the services that individuals are receiving? There is not one reimbursement for physician services. There's a whole host of codes that could be used for services. If someone who goes in with a cold it's different than a broken arm. It just happens to be different costs.

Healthy Steps had many more dental costs, but didn't have orthidonture care. Mental Health parity is part of the ARRA.

Senator Grindberg asked about the changes in mandates of new coverage. She mentioned $38.00, what percent does that represent increase over the current CHIP? When you cite the $45 – is that for the biennium?

Maggie Anderson said the $45.32 is the per member/month increase and we pay the same premium the entire biennium. The $45.32 is the per member/month increase and we pay the same premium the entire biennium. It's 18.08% increase without the orthidonture and mental health parity and with them it's 19.82%.

Senator Warner asked if we cover vaccinations in Healthy Steps and the answer was Yes. He also wondered about asthma or disease management? But they don't handle specific counseling services.

Maggie Anderson said another piece of the re-authorization act for CHIP is that they have to establish additional quality measures and on annual basis have an external quality review.

(continuing attachment G – testimony #8)

Senator Bowman said they see these increases all the time, do they ever have a chart to show the increase of the economy versus the increase in cost to programs like this because if this is way over the economy's growth, where will we get money to fund any someday to fund any of it? Do they ever discuss that when you're talking about these things as how much can we actually afford versus what would be nice to be able to afford?

Maggie Anderson said not specifically in the context of your question, but certainly there are discussions and papers written nationally about the cost increases of healthcare compared to the increase to the gross domestic product or to the consumer price index or various economic indexes. How that relates to our budget, I don't know. We haven't prepared anything that specific.

Maggie Anderson concluded her testimony.

Tim Blasl (Lobbyist # 027) giving testimony for Jerry Jurena, President, ND Hospital Association (NDHA)
Testimony attached - # 9. Testified in favor of SB 2012.

Senator Kilzer said they haven't heard long term care testimony, but there was rebasing that was done, and long term care facilities ended up at 100%. Does your anticipated 3% per year fit in line with the rebasing at 100%.

Tim Blasl said they would like to discuss is reimbursement at actual cost. With the rebasing and the 3% inflator, everytime a Medicaid or Medicare, we're still under actual cost. Visiting with a lot of providers, they are ranging anywhere from on the Medicaid reimbursement side for both in and outpatient services anywhere from 85-92% of actual cost to provide services to that patient.

Senator Warner said that his organization was instrumental to getting $400,000 to the critical access hospital in the last session. He asked him to address the problem of under reimbursement in a hospital which relies so heavily on Medicaid.

Tim Blasel said they continue to work on that and are reviewing the amendment that was part of HB 1012. We do still review the anesthesia and lab reimbursement payment and fee schedule. They are researching being paid less than cost and checking federal guidelines. Just to give you an idea, to get the hospitals in the state up to cost, it would take an additional $30 million to get us up to actual cost.

Senator Robinson asked if that includes charity care and Tim Blasl said it's based on today's cost and it will be both hospital and physician if the physician is employed by the hospital.

Senator Grindberg asked for further testimony

Bruce Levi – Executive Director, North Dakota Medical Association
Testimony attached - # 10. Testified in favor of SB 2012.

Bruce Levi concluded his testimony.

Sheldon Wolf, Health Information Technology Director, State of North Dakota

He had information in reference to Senator Christmann's question in regard to electronic health records. It started in 2006. There was a process put in place with Senator Conrad. In 2007 there was a bill to provide some funding and set up a steering committee. In 2009, another bill came in place with Senate Bill 2030-32 which changed the steering committee to an advisory committee. There was money put in there for pending legislation that was coming through with the ARRA funding that came through. There was $8M in match, $80M in federal funding and $350,000 to establish a Health Information Technology office. There has been work that has been ongoing regarding the electronic health records since that time. The Center for Medicare and Medicaid Services has come about through the ARRA funding and provided additional incentives through Medicare and Medicaid to be able to have providers put those systems in place. In addition to that, there was money to build health information exchanges which is included in HB 1021. It's the ITD budget. It's been growing and snowballing since that time and there have been standards put in place, certifications on the federal level. There has been work going in that area.

Dawn Hoffner, Fargo, Volunteer on Board of Directors, North Dakota Chapter of American Foundation for Suicide Prevention,
Mental Health America ND's South Valley Council,
Cass County Justice and Mental Health Collaborative.
Testimony attached - # 11. Testified in favor of SB 2012.

Senator Grindberg asked for any more testimony and being none, adjourned the hearing.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

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January 18, 2011
13034

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony #12 - 26

Chairman Holmberg called the committee hearing to order on SB 2012. Roll call was taken. Lori Laschkewitsch - OMB; Roxanne Woeste & Sara Chamberlin – Legislative Council.

Maggie Anderson, Medical Services Division, Department of Human Services
Testimony attached - # 12 - Long Term Care-Continuum budget.
Testimony attached - # 13 – Money Follows the Person – program information brochure
Testimony attached - # 14 – Money Follows the Person – Developmental Disabilities

Reading from testimony –

Senator Warner asked about the audit process for MDS 3.0 (Minimum Data Set) in nursing home classifications. What is the integrity of the comprehensive assessment for each resident and the certification process?

Maggie Anderson said they would hear from families if they believe the classification may be too high or too many doctor visits were counted that they didn't think should affect the classification. The Health Dept. verifies the accuracy of the information on their survey and certification reviews.

Overview of Budget Changes – (continuing on page 7)

Total changes in long term care was $45,108,792. (page 7)

Senator Fischer: Could you give me a high and low for 2010 on an average daily medical as well as the other options on the daily rate that are available that would increase the monthly payment whether Medicaid or private. (Yes, they will provide the info)

Senator Warner asked to elaborate on PACE (Program of All-inclusive Care for the Elderly). Do we provide any services to people on assisted living through subsidies or similar?

Maggie Anderson said that PACE is a capitated program, so they make a monthly payment to Northland Healthcare Alliance – they are the PACE provider. The department pays them a premium which is a full risk situation because it's a managed care program. The Clients have to meet nursing home level of care, over the age of 55 and have to live in a Pace area. In ND, the two PACE areas are Dickinson and Bismarck. We make the payment and Northland provides all Medicare and Medicaid services within that payment. Whether it's a clinic charge, flu shot, adult day supervision, personal care services in their home, transportation to medical appointment, PACE is responsible for all that. All the Medicaid and Medicare services are paid for by PACE including if that individual would need to go into a nursing home. The whole premise of the PACE program is to wrap all those services around the individual and keep them in their home and stay independent as long as possible.

Senator Warner: Would any of these people be living in assisted living or do we provide any subsidies to keep people in assisted living rather than basic.

Maggie Anderson said it's possible that someone on PACE could be living in an assisted living. Outside of that, there are clients who may need personal care services. If they meet the SPED or Expanded SPED criteria for that, we'd provide those services. That's not a large area where they have a lot of people receiving personal care. There is no rent subsidy for assisted living which would also have to be state funded like the basic care rent subsidy. We can't use Medicaid money to provide rent subsidy.

Senator Wardner – On page 8 you talk about out of state placements. Can you give me some examples of why we would take care of out of state?

Maggie Anderson – Oftentimes these are situations that might be close to the border, like Grand Forks or Wahpeton, or Fargo. It's primarily, if not exclusively, Minnesota. Because of families moving a lot between MN and ND, it was agreed to many years ago that we would provide services if their clients came here and vice versa, so it's 2 years, that if they live in a MN nursing facility, they retain their ND Medicaid eligibility and the same for MN and it's generally been pretty close numbers. It's being close to where an adult child is living and so they want their parents to be closer to them.

(continuing with attachment E in Testimony 12) & concluded testimony –

Public Testimony –
Shelly Peterson, President, North Dakota Long Term Care Association
Testimony attached - # 15. Testified in favor of SB 2012.

She asked the committee to support the OAR for guardianship services and also want to bring to the attention of the committee the personal needs allowance. On Medicaid, every month you get a personal needs allowance. For nursing facility residents, it's $50/month and it has not changed in the last 10 years. It's hard to live on that amount of money. Last

session, it was increased for the DD population (developmentally disabled) and for basic care. On behalf of families and residents, there is strong indication that the $50/month is not sufficient and they look to an increase of $85/month.

She concluded and asked the committee to fund the 3% annual inflator provided in 2012.

Chairman Holmberg said they hear from constituents when they have problem and someone expressed concern that they felt there was a great deal of insensitivity on the part of a certain nursing home where his mother had died in the morning and they had to have her room cleaned out by that afternoon for someone else to move in. It may have been an isolated case but he wanted to bring it to her attention.

Shelly Peterson replied that when a resident dies, generally the room is not filled that very day. Generally you give time to the family to come and say their good-byes. She apologized on behalf of the facility. Sometimes, there is great pressure from outside community. They may have had a long waiting list in that particular facility and a great demand to fill it. I don't think they meant to be that insensitive.

JoAnn Ferrie, Registered Nurse, Director of Professional Home Care;
Vice President, ND Assoc. for Home Care (NDAHC)
Testimony attached - # 16 & 17. Testified in favor of SB 2012.

Quality Service Provider – (QSP) also known as Skilled Nursing and Personal Care
She urged the committee's favorable recommendation for reimbursement of a travel differential for nurse supervised QSP services by the State of North Dakota.

Chairman Holmberg read an email he received – "Please support a mileage reimbursement for Independent Qualified Service Providers. I'm a QSP from a rural area. Often I'm requested to drive 30-40 miles to do respite care for handicapped and elderly persons in my area. At the present time, I do not get paid for my gas or travel time. This prevents me from taking many jobs because it is just too costly to drive so far for an hour or two of time that I might do. Again, I urge you to support the mileage reimbursement for QSPs." This comes from District 33.

JoAnn Ferrie said they were only asking for mileage reimbursement only for a Medicare certified agency. Individuals are not part of this budget or request.

Senator Christmann –If we were to do this as proposed for the agencies, was there a total cost calculated in or is it still undetermined?

Bruce Murry – APT, INC. Lobbyist # 124.
Representing ND Association for Home Care. We help with some of the tables and the total impact for this request for our membership agencies would be about $400,000/year. We have no objection to other QSPs bringing forward their issues which may be similar. We just don't have a way to estimate their numbers or their expenses. Human Services is working on a refined estimate based on the information that they have. We're working together.

Chairman Holmberg said the committee will recess for 20 minutes. He then called the committee back to order at 9:55.

Tina Bay, Director, Development Disabilities Division, Department of Human Services
Testimony attached - # 18. Testified in favor of SB 2012.

Reading from testimony –
Senator Grindberg asked for an overview of the autism waiver. (68:30)
Tina Bay There are four services that they are maybe eligible for; for birth through the age of four because many were not caught yet by the age of three. The autism waiver, if they qualify under the Autism Spectrum Disorder, then they could elect to participate in that waiver.
Senator Grindberg: How long have we been offering the waiver?
Tina Bay: That waiver was just approved November 1, 2010.

Senator Kilzer: Why would the University of MN study say that we have 2 to 3 times the incidents compared to the national statistics? (Page 2) Both the intellectual disabilities and the residents of the ICF/MR (Intermediate Care Facilities for the Mentally Retarded) – both are at least double the national average.

Tina Bay: It is my understanding with the interpretation of the study is that we provide them with our statistics of the amount of residents we have in these facilities.

JoAnne Hoesel, Department of Human Services
The thing that would be helpful is that in their definition of institutional care, it would include any ICF/MR with any number of people. Our developmental center is actually an ICF/MR which currently has 107 individuals. And we have ICF/MRs in our state that have four people in them. It doesn't matter what number. If they reside in an ICF/MR, they're considered to be in institutional care. There are some reasons why providers would choose that route and one of them is that the Medicaid program pays the room and board for that service, whereas, in a waiver group home, they do not. It's just how things have played out with the de-institutionalization in our states. That is the route that many providers have chosen to build in community.

Senator Kilzer This is probably not a very good sampling to come up with these conclusions, at least in the residents of the ICF/MR area. On the intellectual disabilities, do you know if those had strict criteria so that we're comparing apples to apples? And **JoAnne Hoesel** wasn't familiar with his definition of residential but could get the information.

Senator Bowman asked about the general fund increase which is almost half as much as the whole budget was in two years. Does that have anything to do with the FMAP? Yes.

Barbara Murry, Executive Director, North Dakota Association of Community Providers
Written Testimony attached - # 19. Testified in favor of SB 2012.
Testimony attached - #20 - Public Policy Platform.
Testimony attached # 21 - Recruitment & Retention of Direct Support Professional in ND.

Testimony attached - # 22 - ND Assoc. of Community Providers Turnover chart
Testimony attached - # 23 - ND Assoc. of Community Providers brochure

Reading from testimony – Testified on the developmental disabilities section of the long term care continuum.

Senator Bowman: When you talk about statistics and turnover we have, is it all because of wages or the type of work? Are there other states that have comparable data?

Barbara Murry said she can't definitively answer, but part of it is wages and part is improving the quality of their supervisors and their training. It's stressful, but rewarding. It's not for everyone.

Senator Christmann Do organizations all pay the same for the same experience level in the same positions?

Barbara Murry – No, they do not. It would be easier if there was a uniform pay scale much as state employees, we have 29 different pay scales. The ranges may be somewhat the same, but they use different practices to implement their pay scales.

Senator Christmann: If we approved this, would all employees get a $1.46/hr raise regardless of what they were getting or do you spread that out to the various organizations as appropriate?

Barbara Murry said there are three main ways providers pay raises. Some simply pay across the board and give everyone the exact percentage that the legislature appropriates. Some agencies have a pay scale in place with ranges, so some might get $1.56 and some might get $1.36 depending on where they fall in the range. The third way is that some agencies hold a small percentage back for their high performers so they are able to performance incentives. All the money goes out in raises, but those are the three most common ways of implementing it.

Sandi Marshall, President, ND Assoc. of Community Providers
Chief Executive Officer, Developmental Homes, Grand Forks
Testimony attached - # 24. Testified in favor of SB 2012.

Reading from testimony –
She concluded her testimony. No questions.

Jon Larson, Executive Director, Enable, Inc.
Testimony attached - # 25. Testified in favor of SB 2012.

Reading from testimony – He is asking the committee to consider adding 7.65% to their fringe benefit allowance to stem the steady erosion of health insurance benefits.

Senator Warner asked how much clients participate in their own rent and food costs. Some may not be able to contribute at all and others are highly functional. Can you elaborate on evaluation process and the contributions expected towards rent and food?

Jon Larson said almost all people they serve receive medical assistance. Almost all will also receive supplemental security income or social security disability benefits. Within those benefit packages; there are standard formulas that are applied for determining the amount of recipient liability that each person would need to pay out of their own pocket. Issues such as how much earning they might have or whether they have earnings at all, will determine how much is available for rent, utilities and other necessities. Much of that is determined by the eligibility requirements of the programs that they benefit from. There are standards for food stamp eligibility, housing assistance, fuel assistance, there are formulas for all of those that apply to the people we support as well as other people who might need economic assistance in the state.

Senator Wanzek shared that his baby sister has Down syndrome and is always lobbying him that "home needs more money". She lives in her own apartment, but staff check up on her. She has concern with her earned income and it's starting to impact her Medicaid.

Jon Larson said there are formulas that are applied for medical assistance eligibility that take into account the earned income and your ability to contribute towards the cost of your care. As providers of that service, we don't determine those formulas. Those formulas are determined by medical assistance. There is a balance of being productive and earning an income and paying for your own support and care.

Maggie Anderson: The medically needy income levels are established by the policy makers. Last session the governor's office had funded in the executive budget request to increase the medically needy income levels. We look at the individual's income and then the amount of income that is above that level becomes the recipient liability. Prior to last session, those levels were at 58% of poverty for a family of one and 44% of poverty for a family of two. During the last session, with the change that was made, that level was increased to 83% of poverty – which is fairly consistent with the SSI income level. There was increase provided, but if other income becomes available, the client will need to pay a portion of that. For example, for a family of one at 83% of poverty, the medically needy income level is $750 so anything above the $750, the client will have to pay first towards their medical care and then Medicaid begins to pay. So if someone has $800, they have to pay the first $50 and then Medicaid starts paying the bills at that point.

Teresa Larsen, Protection and Advocacy Project
Testimony attached - # 26 – Developmental Disabilities Grants

(Meter 106:30) - the electricity went out and Teresa Larsen continued reading her testimony.

Chairman Holmberg then closed the AM hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 18, 2011
Job # 13025

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony # 27 -32

Chairman Holmberg reopened the hearing on SB 2012 at 1:30 pm on January 18, 2011. Lori Laschkewitsch, OMB and Roxanne Woeste, Legislative Council were present. V. Chair Bowman introduced his niece who works for the Vocational Rehabilitation Department.

Andrea Peña, Excutive Director of the State Council on Developmental Disabilities (DD) testified in favor of SB 2012 and stated she is here to provide an overview of the Council's budget request. See written testimony attached # 27.

Carol Olson, Director of DHS introduced Jan Egan as the new Director of Aging Services. (Meter 08.42)

Jan Engan, Director of Aging Services of DHS testified in favor of SB 2012 and stated she is here today to provide an overview of the Division's budget for the DHS. Testimony attached # 28.(Meter 35.48)

Chairman Holmberg: If this goes over to the House there will be a conference committee.

Senator Robinson: When is the next publication of this brochure (The Graying of North Dakota 2000-2020) coming out? How accurate have our projections been and are these numbers consistent?

Jan Engan said she thinks it is on target. The 60- plus population is increasing.

Senator Robinson had questions regarding what this means to our state, our budget, the demands on medical services, and the ramifications of all this are significant.

Jan Engan: Before I came on board, there is was extensive research done with data that is available at this time and some of the information that I provided in my testimony was taken from that Aging is Everybody's Business and it is being printed at this time and will be

available in the near future. He asked for a copy of that and if they will be updating that information soon and was told they will be looking at that when the new data comes out.

Tara Lea Muhlhauser, Director of Children and Family Services in DHS testified in favor of SB 2012 and stated she is here today to provide an overview of Division of Children and Family Services for DHS. Testimony attached # 29.

Senator Robinson had questions regarding out of state placement, are they adjacent states, and how many out of state students do we have placed in North Dakota facilities.

Tara Muhlhauser: He was told there is a number of youth placed in Minnesota, Texas and Utah and it is because they cannot be provided the type of care they need in North Dakota. She did not have the information regarding how many out of state students are placed in North Dakota because each facility would have to be polled to find out that number. She continued her testimony. (Meter 52.43)

Senator Robinson: How can you compare the Family Team Decision-making group and the Wraparound program that was in place a few years ago?

Tara Muhlhauser: We are using Wraparound services; it is the umbrella over all our programs. Under that umbrella, Family Team Decision-making would follow as one of those tools that we would use to bring the family in right away, as soon as we know there is an issue that might look like a removal situation or risk situation where removal is warranted, and say to the family, what can we do about this, are there changes you can make immediately, are there other family members that can step in. Something that is right there at that emergent moment. At request, she gave a brief explanation of the Wraparound program witch is an idea where you assess what the family needs and you wrap the services around them. It is a very simple concept and it often involves multiple agencies and our partners, such as law enforcement, the court system, school system, are very important in this process as is our relationship with the family.

Senator Warner asked about the judicial budget and if that includes family court.

Tara Muhlhauser: It depends on how the judiciary characterizes family court. In many states, these kinds of child welfare actions happen in family court. I think the vision for family court in ND, particularly out of Grand Forks and the pilot program, was eventually the juvenile court and the child welfare cases would roll into that. I don't' think they are quite at that point of success, but I think that is a goal so that what we know is one family – one judge, so if there is divorce in custody actions, if there are child support actions, if they are juvenile court – child welfare actions they appear in front of one judge that they interact with. She continued her testimony (Meter 65.45)

JoAnne Hoesel, Director of the Division of Mental Health & Substance Abuse testified in favor of SB 2012 and stated she is here today to provide you an overview of the Division of Mental Health & Substance Abuse Services. Testimony attached # 30 (Meter 78.30).

V. Chair Bowman had questions regarding the cost to persons under treatment and what is the recidivism after they go through treatment, how many of them in 5 years do you see

again? If you go through all this, and they are not willing to help themselves, how much do you spend on someone like that?

JoAnne Hoesel stated it is based on whether they have insurance coverage and then on their income and all services regarding if it's substance abuse treatment or mental health treatment it's based on their income and we have a sliding fee scale and so it would range from zero where they pay none to100%. I do have outcomes regarding your last question that I could bring to you. Generally a person who has an addiction, in terms of their cost it would be very similar to the costs for other chronic disease treatment for other treatment over time. She continued on.(Meter 89.36)

Chairman Holmberg had questions regarding FTE and the block grant program and if that grant goes away, does the state have to pay for these FTEs. He was told by Brenda that they would then look at reducing their FTEs. He commented they would have to agree.

Senator Warner: asked for a flow chart that shows what the Department of Health is doing and what DHS is doing and funding sources. He was told that can be provided and she concluded her testimony. (Meter 91.40)

JoAnne Hoesel: We have that. The Governor's Prevention Advisory Council has put together a matrix and it identifies all of the state agencies that have a role in prevention DOT does preventing people from drinking and driving, the Health Department does tobacco prevention, DPI does prevention efforts in the school, or has in the past and ours is specific to substance abuse prevention, the using of it, wanting to prevent people from moving into the abuse and dependence process of it so while there are multiple agencies, we each do something very differently and that matrix reflects that plus it has the money tied to that. We can provide that to you. She continued testimony and concluded her testimony (Meter 95.26)

Senator Fischer had questions regarding all the funds appropriated, if they are good through October of this year and what the future brings as far as the budget is concerned and the federal government.

JoAnne Hoesel: We will know more about the 2012 budget on Feb 14, even the impact to these block grants. .

Tina Bay, Director of Developmental Disabilities Division of DHS testified in favor of SB 2012 and stated she is here today to provide an overview of the Developmental Disabilities Division for DHS. Testimony attached # 31(Meter 108.52)

Senator Wardner: On the decrease in professional fees due to the cost of administrative hearings, is the department going to handle these hearings themselves rather than have the Office of Administrative Hearings?

Brenda Weisz: It was a mistake in the DD budget last time around so we are fixing it and when I talked about admin and support that's where our budget is for administrative hearings. We still use the Office of Administrative Hearings.

Senator Wardner: What about the decrease in supplies. Is that because you are more electronic now rather than paper?

Tina Bay stated that was correct and concluded her testimony.(Meter 110.27)

Russell Cusack, Director of Vocational Rehabilitation of DHS testified in favor of SB 2012 and stated he is here today to provide an overview of programs and services that make up the budget request for the Vocational Rehabilitation Division in the DHS. Testimony attached # 32.

Senator Wardner: Do you get WSI injured persons in your program? He was told yes.

Senator Warner asked Lori if they could provide a list of all the properties that DHS rents and the square footage of these properties. He was told yes, they can provide that to him.

Chairman Holmberg closed the hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
01-19-2011
Job # 13062

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

An Appropriation to defray the expenses of the Department of Human Services (DHS)

Minutes: See attached testimony.#33- 40

Chairman Holmberg called the committee to order on SB 2012 at 8:30 am on 01-19-2011. Roll call was taken. All committee members were present. Joe Morrissette, OMB and Roxanne Woeste, Legislative Council were present. He stated we will start with public testimony and invited any member of the public to come forward and asked them to sign the registration sheet, whether they are testifying or not.

Dr. Emmet M. Kenney, Jr. Child and Adolescent and General Psychiatrist testified in favor of SB 2012 and stated he is here today to speak on behalf of Prairie St. John's and the North Dakota Hospital Association of which he is a member of the Governing Board. He asked for passage of SB 2012 with an amendment to include the IMD Demonstration Pilot Project Testimony attached # 33.

Senator Warner asked if he could give us some ideas of the psychiatric practice in ND, particularly with regional deficiencies. Where should we be looking to encourage psychiatrists both within the scope of practice and geographical areas?

Dr. Kenney stated he is on the faculty at University School of Medicine teaching medical students and residents for the last 16 years. There is a shortage of psychiatrists, particularly child psychiatrists in the state. He stated the youth suicides have risen over the last 6 years. The rural areas have a severe shortage of doctors. The use of telemedicine will be helpful in those communities. A biannual report for mental health and additions is being prepared at the medical school, and significant recommendations will be coming out of that report.

Senator Warner asked how many residency slots are there in the state and how does that compare to other states?

Dr. Kenney stated there are 4 slots each year and it's a four year training program after medical school. When it is full complement there are 16 residents right now and not every resident makes it through the training. On the average they have had 13 or so that finish

training. There is difficulty with people staying in the state in the field of psychiatry Not many American medical students go into psychiatric practice so a lot of people that fill the residency slots have immigration issues. So if they come to the US on an educational visa they have to leave after they're done with training for 2 years and re-enter if they are going to come in on a regular work pattern. So increasing the number of slots, I think there would be need for 2 more residents a year. There is a need for more psychiatrists in our state.

Chairman Holmberg asked if they have the same issue with retention of medical students who do their residency outside of the state of ND as they do in other areas of medicine, if they go to Minneapolis to do residency, the percentages that come back to ND to practice is much smaller than if they can do their residency here in the state.

Dr Kenney: That's accurate. 70 % of the physicians practicing in ND are trained at the UND Medical School and those that train elsewhere, often are specializing in fields that are not high volume fields here in ND but if they train in primary care they generally stay. Psychiatry is often considered on the verge of a specialty or primary care practice, most of the patients I see I am the only doctor they see.

Senator Wardner: Could you give me more information on the IMD Demonstration?

Dr. Kenney: As part of the healthcare reform bill that was passed in May there is a provision for what is called the IMD Demonstration Pilot Project. Across the nation there are situations where there are specialty centers that provide for treatment for addictions, and according to the way the Medicaid law was set up, if you were a free standing pysc. Hospital you are not eligible for payment from Medicaid for people between the ages of 22 and 65, which is a very large number of people. It's kind of a relic of the idea that the federal government didn't want to pay for the state hospital system but then these non-governmental hospitals get the same lack of funding. For example, at Prairie St. Johns we average 20 patients a day when we are up to 80 patients that have no funding and about 5 patients of those a day have ND medical assistance but we are not eligible for funding for them because they have the adulthood age. The purpose of the pilot would be to say if people can access services in places like pysciatric settings, is there an offset to society at large, for example, people who get treatment rather than attempting suicide, the savings is that they are not in ICUs after they attempted an overdose or seriously injured themselves with a car accident or gunshot wound. There are 5 states that are eligible, ND is one of them. It would require an appropriation by the State Legislature to match the federal portion just as what is often done with Medicaid funding. The rules are still being written on this demonstration project. We need to appropriate the funds now or lose out on the opportunity.

Senator Krebsbach: Is there any limited amount on this the grant we are looking for? She was told $1.4 million for the match.(Meter 12.06)

RECORDER STOPPED IN THE HEARING.

Chairman Holmberg informed Dr. Kenney of the subcommittee on this bill. They are Senator Fischer, Senator Kilzer, Senator Warner and Senator Erbele.

Larry Bernhardt Executive Director of Catholic Charities of North Dakota (CCND) testified in favor of SB 2012 and is respectfully asking your committee to approve increased funding for corporate guardianship services for people with developmental disabilities Testimony attached # 34. (Meter 25.29) He introduced Donna Byzewski, Director of our Guardianship Services with CCND.

Senator Fischer had questions regarding the costs when the court system is involved.

Donna Byzewski stated several factors enter in like the court visitor, doctor report, guardian ad litem, an attorney. She stated they work with Legal Assistance of ND to provide free services to those who qualify. But some fees can be very costly, such as the doctor fee, if it's necessary. If the resources from legal Assistance or the family themselves is not available, it would be up to us to provide the funding for the costs of the court action.

V. Chair Bowman asked what action has to be taken to see these number of cases go down.

Donna Byzenwski stated there is a huge increase in alcohol and meth, pressures on families, I also think it is because we are better at what we do, kids are being diagnosed early, that is not a bad thing, we are recognizing it sooner, families are not able to provide the services and they look to us for help.

Senator Wardner: asked for an example when cases are contested and someone does not want your services.

Donna Byzenwski: an example would be, all our referrals for services, must come from the developmental at Human Services center, they come to us and make that referral to us. A contested situation was where the mother was the guardian, she was homeless, struggling with chemical dependency, her daughter was also homeless, living in a car, because of interventions, we moved the gal into the group home, provided services, and the mother felt she was still the appropriate person and she was able to get an attorney and there was three days of testimony before we were appointed guardian.

Larry Bernhardt: I don't want you to have the impression that people are objecting to Catholic Charities being the guardian. They are objecting to a guardian being established for the person.

Chairman Holmberg: Reminded the committee that we are having a floor session today starting at 12:30 pm because of the incidence of the power outage yesterday, (January 18, 2011).

Larry Bernhardt testified in favor of SB 2012 and Testimony attached # 35. I am respectfully asking your committee to provide increased funding for Special Needs Adoption above the line item in the DHS Budget in SB2012. The AASK Program (Adults Adopting Special Kids) I would like to introduce our program director, Leanne Johnson. (Meter 36.37)

Senator Krebsbach asked how many adoption agencies besides Catholic Charities, are in the state.

Leanne Johnson, Program Director stated there is CCND, Christian Family Life Services, the Village Family Service Center, Lutheran Social Services of ND, Gods Children Adoption Agency, Permanent Family Resource Center and Church of the Latter Day Saints, so seven. (After the hearing she returned to the office and stated there is 9, PATH of ND and All About You Adoption Agency). (written on her calling card and filed with the file)

Brian Arett, Executive Director of Valley Senior Services and a representative of the 26 agencies that are members of the ND Senior Service Providers (NDSSP) testified in favor of SB 2012. I am here to testify in support of the budget for the Aging Services Division of the DHS. Testimony attached # 36. Our request for your committee is to request funding for Older Americans Act Providers for meals and health services by an additional $1.1 million so that we can be reimbursed at the established state rate for every unit of health service we provide. (Meter 44.35)

Chairman Holmberg: In rural areas the home delivered meals, they are frozen meals, is that correct?

Brian Arettt: Yes, it is the case in the remote areas It depends on whether there is a restaurant in a small town that is able to meet the request.

V. Chair Grindberg: Did you want to comment on the senior mill levy match.

Brian Arett: That is another request we are bringing forward in another bill.

Senator O'Connell: This is a better program we have out there, not only the meals but the gathering. Who sets the criteria that goes on that plate?

Brian Arett: The standards as what the meals are made up, are really established through the Older Americans Act, so by the federal government and then they are implemented by the state of ND, the DHS Aging Service Division. They made significant changes regarding diet, adding more fruit and vegetables, decreased sodium, fat, sugar.

Senator Erbele What are the qualifying criteria? Age, physical limitations, things like that.

Brian Arett: The Older Americans Act sets the criteria for who is eligible for services in broad sort of way, that is persons age 60 and older, or the spouse is 60 or older. With respect to home delivered meals, the criteria is a little bit more stringent, persons that are eleble for that are the homebound, they can't come to senior center, or they are unable to prepare meals in their homes.

Senator Erbele Do they pay a portion?

Brian Arett: The Older Americans Act does not allow us to set a price, they do allow us to suggest a donation. Most have a suggested price, and it is usually $3.50 a meal and almost

everybody donates towards the cost of the meal, 98% make a donation for the cost of the meal.

Chairman Holmberg a couple of years ago, we heard concerns, the reimbursement to the small restaurant, we made some changes last session, is that the kind of problem we had 3 or 4 years ago, are we getting the money out.

Brian Arett: In the last session, you increased the amount for meals and that allowed us to increase what we pay the restaurant that helped them feel better about what they are doing. They make a commitment to the community. The increase in last biennium was helpful. Their costs continue to grow; we want to help them every year.

Senator O'Connell: I was under the impression that they bid for that service. Do we know what the ceiling is for the bidding process?

Brian Arett: We bid that out where there is competition, but in many communities, we are not bidding but begging.

Senator Wardner had questions about the different rates between providers and meals.

Brian Arett: That $1.4 million figure that's for uncompensated services we provided in the last two years. We are short of being able to reimburse every meal every unit of health service we expect to be provided in the next biennium.

Senator Christmann asked why we don't suggest a higher price for the meals and why don't we tell them what these meals actually cost.

Brian Arett: The sign we have up says the full cost of the meal you are having costs $7.00. We suggest a donation of $3.50 to help us keep up with the costs associated with this program. Others say please donate what you can, different providers suggest that amount in different ways and a good chance that will be implemented. I think the providers that just list the cost they receive more donations. We've always done it this way, but I think it is time to make a change.(Meter 54.10)

Pat Hansen, Executive Director of South Central Adult Services and I am also president of the NDSSP that provide Older Americans Act Services to the senior population of this state testified in favor of SB 2012 and Testimony attached # 37.

Shari Doe, Burleigh County Social Service Director and also the president of the ND Association of County Social Service Directors (NDACSSD) testified in favor of SB 2012 and Testimony attached # 38 (Meter 70.10)

Senator O'Connell Do we have any idea what the counties pay for their total costs for social programs across the state? He was told they will provide the committee with that information.

Senator Wardner asked with all the computer systems when the new system finally goes on line will the MNIS take care of this. He was told it will not. It is primarily to pay Medicaid providers. He asked if they were asking for a new upgraded system.

Shari Doe: Yes, it is a system that determines eligibility for all the programs that I just talked about that is the system that needs to be upgraded. Comments were made about the expense of upgrading.

Max Laird, Volunteer Representative of the Minnesota-North Dakota Chapter of the Alzheimer's Association testified in favor of SB2012 and Testimony attached # 39 (RURAL HEALTH FACTS) What has happened is simply the fact that this disease has become more prominent in American. Yesterday's newspaper headline in the Life Section, using art to help the mind, is a project sponsored by the Alzheimer's Association Minnesota. It is a direct reflection on the project here in ND. The ND Dementia Care Project is one of a kind in America. It has gained significant prominence in the last year to the extent that the project was presented at the fall NCSL meetings and it is considered a model for legislation nationwide. What we are asking for is to continue this project and continuing gathering data about the ability of ND to reduce the cost of care for those people who have this devastating disease over a period of time. The project is pretty specific. The project is defined as one where we would like to increase family support, decrease depression, delay nursing home placement and reduce unnecessary health services for those who are dealing with this disease. He continued his explanation of the project. It is a disease that has no cure. It is a disease that is affecting more people in different age groups, there is now a defined early-onset Alzheimers, it impacts those individuals in their late 40s and 50s. It is a devastating ailment. The federal government has passed the National Alzheimers Project Act, which in a sense brings Alzheimer closer to a level of cancer and diabetes in the federal government defining a process whereby we are going to move ahead with attempting to find a cure for this disease. I encourage your continued support of it.

Teresa Larson, Director Protection & Advocacy Project testified in favor of SB2012 and Testimony attached # 40 relating to Aging Services, the Ombudsman Program and OAR 408, the Guardianship Services. We have gotten a number of calls for need of guardianship services for people that don't have a developmental disability and the first thing they usually say is the DHS is out of money so that is why they are looking around. It's a serious need.

Senator Wardner had questions regarding the total amount they are asking for. He was told the OAR is more.

Brenda Weisz, DHS, stated the OAR was submitted for just over $65,000. There is a bill introduced for this, it is HB 1199. She shared the costs that the counties paid towards Social Service Programs. The counties combined for the state fiscal year, 2010, $58 million they have paid for administrative expenditures, Child Welfare and Aging Services Programs. That includes the administrative costs for Economic Assistance Programs, the Child Welfare Programs and the grant costs they pay to the state. She will submit the final review We are doing our final review, so once it is finalized I will distribute this information to the committee.

Chairman Holmberg recessed the hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 19, 2011
13084

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony #41 - 46

Chairman Holmberg called the committee hearing to order on SB 2012.
Roxanne Woeste – Legislative Council; Joe Morrissette - OMB

Nancy McKenzie, Director, Human Services Centers (HSC)
Testimony attached - # 41.

Report given by **Marilyn Rudolph, Director, NW & NC Human Service Centers in Williston and Minot** (standing in for Nancy McKenzie)

Reading from testimony and gave an overview of the budget and program trends in the regional centers.

Senator Robinson asked question of 2nd bullet page 5 – You said you get a number of referrals from corrections, could we get the actual numbers? What's happening, maybe last biennium & this biennium, in terms of the number of referrals? 2nd question – It would be interesting to have a snapshot of your caseload at Human Service Centers in terms of the composition of that caseload. How many are addiction and mental health loads? If you could by center and the composite state wide.

Senator Wardner: When the individuals are referred from corrections – is it at the end of their sentences?
Marilyn Rudolph – Yes, it's at the end when they are being integrated back into the community.

Continuing reading – page 5.

Senator Robinson and **Senator Wardner** asked about the Cooper House in Fargo and was told there are 42 beds. It was a community effort and there was involvement with the Homeless Coalition. There was involvement with the community. It was an active topic in

the community of Fargo. There are other communities that are providing services in a similar way. At northwest, we have a contract with the association for the disabled and we provide residential services on a much smaller scale to a similar population. It's temporary housing for people who are homeless and also have issues with addiction and mental health. It was funded as a HUD project. The only funding the department has in its involvement is last biennium, it was approved to hire a 24/7 contracted staff to do the intake at the front door. It was a community effort and not state involvement.

Chairman Holmberg asked for more testimony on HSC – none.

Alex C. Schweitzer, Supt. of North Dakota State Hospital and the North Dakota Developmental Center (One Center), Department of Human Services
Testimony attached - # 42.

He covers two budgets from the State Hospital, the traditional services of the hospital which include the in-patient psych and the Tompkins Rehabilitation Center and the Secure Services budget which is a sex offender program.

Reading from testimony –

Senator Robinson – If the TRC (Tompkins Rehabilitation and Corrections Center) unit is administered by corrections, why are the accounts listed on state hospital accounts? Alex Schweitzer said the program is administered by the state hospital. They are referred by corrections. They pay us to provide this service, but we run the program both clinically and administratively. It's a joint program, but if there is problem, corrections put them back in prison.

Page 5 – Budget Changes

Senator Robinson asked about the fuel source – The main source is coal heat but they have backup systems of fuel oil and natural gas. They can't burn ND coal because they do not have a bag house which keeps down emissions and meets EPA requirements.

Senator Wanzek: How do you distinguish between a .49 and .51 FTE.
Alex Schweitzer: This is basically one FTE. The .51 is just the amount of time they actually work. We are open to the number of hours the employees want to work and depending on their particular expertise; we may not need someone in a fulltime position. It's really an administrative situation.

Chairman Holmberg asked if this occurs in budgets of agencies where there are federal dollars, and if the person is over a certain percentage, we get a bigger share of federal dollars. Or doesn't that factor in to a .51 in some agencies.

Brenda Weisz said that they have to keep time sheets and allocate accordingly so it might very well make a difference how much time is spent on the federal program.

Senator Warner asked about the $1.3M to cover an underfunding left over from last biennium's budget. Usually with an agency the size of yours, could you elaborate on the circumstance where you're going to have such a large number of such a shortfall of money.

Alex Schweitzer: All of this is in respect to roll-up because we always have a lot of roll-up at the institutions because of the number of FTEs and the number of vacancies they have.

Brenda Weisz: It's not what's left over. He will have the turnover to do that and end the budget accordingly. When you start to develop your next biennium's budget, and you determine how many FTEs you need, you start your budget building process to say, to fund this many FTEs, I need this much money in salaries. So you start with a full budget. So in order to start from square one, you put the money back in. He will live within that amount and he will finish the biennium out without using those dollars, but it's part of a budget building mechanism.

Senator Robinson asked about recruiting professional staff and Alex Schweitzer replied that they have no issues in psychology. All the positions are filled there. We needed a couple of evaluators for the sex offender program and found them. We have one opening in psychiatry and just recently recruited and replaced our medical director.

Senator O'Connell – What do you charge a day for bed? When do you write them off and how much?

Alex Schweitzer: We do write off a certain amount of bills. By state law, they are required to charge people and collect. We sometimes write off a certain portion because we come to a negotiated settlement with the patient. We hold some open because we can collect from estates. Depending on the situation, there are different rates and he can get that for him.

Concluded testimony.

Dianne Sheppard, Executive Director, The Arc, Upper Valley in Grand Forks
Written testimony attached - # 43.
Closing the North Dakota Developmental Center: Issues, implications, Guidelines – Testimony attached - # 44. Testified in favor of SB 2012.

Reading from testimony –

Senator Bowman: On the CHIPs program where you are requesting 250% of poverty. Is that gross or net, because there's a lot of difference in the amount of money involved.

Dianne Sheppard wasn't sure and Senator Bowman said ND is figured on the net.

Carlotta McCleary, Executive Director, ND Federation of Families for Children's Mental Heatlh (NDFFCMH)
Testimony attached - # 45.

Teresa Larsen, Protection & Advocacy Project
Testimony attached - # 46. Testified in favor of SB 2012.

She wants to speak specifically to the developmental center. Reading from testimony-

Senator Kilzer: What do the states that have closed their state institutions do? They must have some placement somewhere for these people who are unable to be in their communities to receive the level of care that they need. I don't think these conclusions imply the correct solutions because there are cases that require this level of care that are unable to be a success in a community setting. Are there private institutions or do they go out of state?

Teresa Larsen didn't know the exact situation in each of the states, but knows that they often use community intermediate care facilities for the mentally retarded. That is actually what the facility is at the developmental center. They are icf/mr beds. Instead of having over 100 people live on one campus together in an institution, they're creating smaller 1-4 bed homes in the community. They would still have 24/7 staffing for those individuals. They are just moved from an institutional setting to a community placement where they are integrated.

Senator Kilzer said there are still some cases that will have to be in a very specialized clinical setting to continue life.

Teresa Larsen: I don't disagree, but was trying to make the case that the money that is used to serve these individuals in an institution at $500/day can also provide those same services for those individuals in a community setting.

Carol Olson, Executive Director, Department of Human Services
Closing Remarks –

Chairman Holmberg requested for Roxanne Woeste. We had testimony regarding the utilization of holding over monies rather than turning them back into the general fund and there was a question about that being necessary because of getting into trouble with the federal government. We will get asked that question, so if you could work with OMB and DHS and give us the specifics as to why this was necessary versus those who say it was a method to make the general fund look smaller.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 19, 2011
13095

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

An Appropriation for defraying the expenses of the Department of Human Services.

Minutes: See attached testimony # 47 – 54.

Chairman Holmberg called the committee hearing to order on SB 2012.

Subcommittee: **Senators Kilzer, Fischer, Warner, Erbele.**

Chuck Stebbins, Freedom Resource Council for Independent Living
Testified in favor of SB 2012. No written testimony.

He is organizing the Independent QSPs (Quality Service Providers) around the state of ND and trying to get a mileage reimbursement. Right now, independent QSPs do not get reimbursed mileage for travel. Many of the independent QSPs are in the rural areas in ND and travel 10-30 miles a day. Some of you have received emails from independent QSPs around the state and one said they had to turn down work because they can't afford to drive the miles from one place to another.
There have been a lot of improvements to the HCBS (Home and Community Based Services) system in the state. We're still struggling to close the gap between institutional care, nursing home care and in home care. The choice has to become more attractive to want to stay in our own homes and communities. You've seen the numbers over the years that people are starting to prefer to stay in their own homes and communities. The money still struggles to try and follow that trend. Anything that would improve the home and community based service system in this state would be a good thing.

Susan Rae Helgeland, Executive Director, Mental Health America of North Dakota
Testimony attached - # 47. Testified in favor of SB 2012.
Reading from written testimony – concluded.

Lynn Fundingsland, Executive Director, Fargo Housing and Redevelopment Authority
Testified in favor of SB 2012.
Written testimony attached - # 48.

Testimony attached - # 49 -Initial Impact Report – August 2010 - A snapshot of the Impact Housing North Dakota's Chronically Homeless population - brochure

He reported on the Cooper House and is requesting an increase in the grants line, part of which will be used to cover the contract cost of a second 24-hour staff – primarily for safety.

Senator Christmann - How did this get constructed?
Lynn Fundingsland - This was constructed using the low income housing tax credit program and some federal home dollars. About 60% of the construction cost is private investment and the City of Fargo helped out by providing the land. It's about a $2.4M facility and it was built with no debt.

Senator Wardner: Who are some of the partners, this is a success story.

Lynn Fundingsland – Beyond Shelter, Inc is a non-profit developer who built the building. The Fargo Housing Authority is a contributor of the City of Fargo. The state is through the Human Services department; they are providing the staff. Family Health Care Center in Fargo, Dakota Foundation, ND Coalition for Homeless Persons, Great Plains Food Bank in Fargo provides food and Sanford Health in Fargo is contributing by helping to pay for a part-time nurse in the building. It's a broad community support and it's working very well. .

Senator Grindberg - How much are you looking for additional?

Lynn Fundingsland: It's not a specific line item in the DHS budget. There's a grants line item which these are contracted people we have there and it pays for one additional staff 24 hours/day/365 days/year for the biennium. It's in the range of $300,000

Senator Bowman: Are these all ND residents that are homeless or are they from all over country?

Lynn Fundingsland: One is from MT, but most are local people. A lot of folks have come in from outside of Fargo for the services that Fargo provides; some are from the MN side of border, but they are mostly ND residents. There has been talk of – if we build it they will come, but that hasn't been the case.

Kim Osowski, Director of Programming, Stadter Center, Grand Forks
Written testimony attached - # 50. Testified in favor of SB 2012.

Reading from written testimony –
Requested the Psychiatric Demonstration Project (OAR).

Troy Roness, Inaugural United States Male Representative of the National Eating Disorder Association
Testified in favor of SB 2012.
No written testimony but handed out information from National Eating Disorder (NEDA) - Testimony attached - # 51 & 52.

He is an advocate of an exercise and eating disorders and wanted to extend his support to the DHS budget but also for any legislative initiatives that encompass mental health illness and specifically the education for eating disorders.

Senator Warner asked him to share a personal story with the committee. Troy said he was diagnosed with an exercise and eating disorder about 2 ½ years ago. He was a teacher in Tioga at the time and spent 81 days, twice, in a residential eating disorder center in Wisconsin. He has since come back home and has been advocating youth and college age students with the disorder.

Joe Cichy, Executive Director, North Dakota Dental Association (NDDA)
Testimony attached - # 53. Testified in favor of SB 2012.

Brenda Weisz, CFO, DHS
Testimony attached - # 54.

She was asked earlier in the day for all the OARs requested in the budget and this handout was in response to that request. This covered the IMD Demonstration Project #703 OAR listing. (Institution of Mental Disease). She explained the sheet and discussion followed.

Senator Christmann asked about the 17 employees in central office and wondered if they were the same employees that the insurance commissioner's office needs? Also asked if the mileage for the QSPs is listed here.

Brenda Weisz: The FTEs they are requesting are independent of insurance office because they relate to policy and policy implementation on what's required on the Medicaid side. The travel is not in any of these requests or uniquely coded.

Chairman Holmberg: The request was 17 FTEs, and it was partially funded. I'm assuming that your sheet and the sheet from the Legislative Council saying there are 7 in your dept. that deal with federal health care reform, so then 10 are not funded and 7 were funded? Answer yes.

Senator Fischer asking about the FTEs – are these rules that are here now and you know you have to hire. When the Insurance Commissioner was here, he talked about the FTEs that he needed. He felt he may need them, but they are not solid in the rule.

Brenda Weisz: Our rules are not official and issued either. It's in anticipation.

Senator Bowman questioned why so many people are on programs when our state is doing so well.

Brenda Weisz said it's the fact that there are so few unemployed that is driving the increase in our budget. It's the FMAP. The FMAP is driven on how well we're doing in our economy.

Chairman Holmberg closed the hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
01-20-2011
Job #13180

☐ Conference Committee

Committee Clerk Signature AK for Alice Delzer

Explanation or reason for introduction of bill/resolution:

SUBCOMMITTEE HEARING ON DHS

Minutes: See attached Testimony A & B

Minutes:

Subcommittee for SB 2012. Senator Fischer Senator Kilzer Senator Erbele Senator Warner Roxanne Woeste, Legislative Council, Lori Laschkewitsch, OMB and Carol Olson Maggie Anderson, Brenda Weisz from DHS.

Senator Fischer states he asked for more information from OMB or council.

Senator Erbele asks what the best way to do this, what order do we take?

Senator Fischer states that the green sheet is what we end up. Roxanne will update the green sheets. One of the things that I have a concern about is the federal funds plus the uncertainty of health care. Do we have all the information? How do we set up your budget to prepare for what is going to happen this year. As of today, it's the law. One of the things we discussed was the employees, are they contingent on, reduced the employees by 40 or 44 in Grafton. The increases here in positions and Brenda, do you have paper on that? (It is passed out). Some of them that they are adding, have already been here, they just are not fulltime. The rules on the health care are not published. That is my concern. How we deal with your and the insurance dept. and dealing with that so you are equipped. The dollars that are involved, we have no way of knowing exactly what that is going to involve. That piece is something that maybe you can enlighten us on. The AG is uncertain of federal funds and Lori is trying to comfort me because we go through this every year, federal funds being cut off or not being continued.

Brenda Weisz states federal funds in general.

Senator Fischer states whether that be flood control or human services. It is a lot of uncertainty.

Brenda Weisz states that at the development center, we reduced 40.53% FTE and had those been included in and carried in to the pay plan, that would have been the value or cost of those FTE funded at the FMAP. (Federal Medical Assistance Percentage). What we did before we submitted our budget to OMB, was we looked at the things that were occurring within the dept. and we took 13 of those and redistributed them, before we submitted our budget request. I outlined those for you. (Attached Testimony #A).

Senator Kilzer asks if the new person in medical services, that is not 90-10 is it?

Brenda Weisz states no. 90/10 is better than 50/50 but not 90/10. It is about 75/25 but because they processed some SPED claims that are not quite Medicaid claims, you have to do your funding ratio with some non federal funds. The same with the other staff, these people have been employed with us for over 4 years but they just don't get benefits, both in IT and Medical Services. We are not asking to convert the other temporary employees that Maggie has, just the ones that have served the dept. for over 4 years. We isolated those and felt like they have done a service to the state and should be paid benefits.

Senator Warner asks if the intent is graduate these people to permanent status? Is there a lot of coming and going?

Brenda states that our plan is to keep them on until we get the new system up and running. We want to keep the claims low and providers paid. We will see once the new system is up. Our plan would not be to have temporaries on with the new system. The new system being MMIS. (Medicaid Management Information System). Yes.

Brenda states that Joanne talked to you, in her testimony, about doing the same and trying something different. We were contracting for a Prevention Coordinator. What we did was that we hired these individual as state employees. It would take the federal money, from the contracts line item, and putting them in the salaries line item. No general funds. These would be the federal funds you talked about earlier. 6 FTE's. That is why there are no general funds, it is block grant money. It is not a new funding source but a funding source, none the less. So for the 11 positions, that we used internally, there are no general funds associated with them. The next two, do require general funds, and the position #12 is at North Central Human Service Center. Marilyn talked about that in her testimony. It is to put a psychiatrist at the North Central Human Service Center. We do have trouble finding psychiatrists at our Human Service Centers. We would have to contract for this service. This would allow us to hire one. Mercy closed their behavior health unit in Williston. The psychiatrist would serve both Minot and Williston areas. There are general funds of $270,000, rounded, that would be required for this position. The last one is for a pharmacist position. That would be placed at the State Hospital and it would serve as a TelePharmacy role to assist our Human Service Centers across the state. At our Human Service Centers, we do medication monitoring for our seriously mentally ill clients and it is predominately our nurses that do the medication monitoring. However, we want to make sure we aren't crossing the line. We don't want to do any dispensing, that would be a pharmacist's job. We don't want to add pharmacist's at each of the Human Service Centers. But instead, add one at the State Hospital, working through a TelePharmacy arrangement, and have them guide and assist and do the proper certification with our staff at the Human Service Center. So that they can continue to do the medication

monitoring and not cross the line, as far as making sure we are not violating any regulations, as far as dispensing but to continue to assist our clients with serious mental illnesses.

Senator Warner asks, "A nurse is authorized to receive the dispensing from the pharmacist in the central location, or do you have to have a pharmacy tech?

Brenda states that they would be certified. We would put them through the certification program for the pharmacy tech. Then they would have actually the guidance of a pharmacist through the TelePharmacy arrangement.

Senator Warner asks if there is a prescribing doctor?

Brenda states we do the medication monitoring right now. This assures us we are on the "up and up" and do it in the most efficient manner.

Senator Warner asks, "Do you dispense the drug from the daily basis?"

Brenda states, "We don't dispense drugs". We monitor the medication. They are on location. The nurse can put them in their med tray, I think, but the client themselves has to actually take the medication themselves.

Senator Warner asks, "Do they come in voluntarily?"

Brenda states, yes. It was brought to our attention that we want to make sure we are not doing the dispensing. We want to make sure we are not violating any regulations.

Senator Kilzer states that we have a similar situation in quite a few different areas. In schools, that doesn't have school nurses. The parents give the medication to the school secretary and the kid comes down to the principal's office, at the appropriate time, and the kid takes his medicine out of the pill box. The secretary does not dispense the medications. The child has to take the medication out of the container that is kept in the principal's office.

Senator Fischer states there is no psychiatrist in Minot right now.

Brenda states we contract out at the Human Service Center. We do Telepsychiatry in Dickinson.

Brenda states that the FTE's for the health care reform, for our budget, those are the only health care reforms dollars in our budget are for those FTE's. We are working on putting a schedule together for you that would show you what the costs of those would be, for the full 24 months. Some of those were staggered in.

Senator Fischer asks, "Do you think that as health care reform rolls out, that that will be more shifting of work, than it is going to be increasing work?

Brenda states that is going to be predominately more work because it is a whole new set of regulations and expansion of the program.

Maggie states she would agree with Brenda. It will be more for a couple of reasons. It is a new population, some new decisions will have to be made between now and 2014, whether that new population has same benefit plan, or whether the benefit plan will look like the mandatory benefits, what they are calling the essential benefit plan in the health care reform bill. If it is a separate benefit plan, that actually makes it more complicated. Our estimates in the interim were that our enrollment could increase by as much as 50%. If you figure that a lot of our work is transaction based, phone calls, claims processing, prior authorizations, utilization review, all things transaction based, based on the number of clients you serve, the volume would go up. We are talking about parallel programs or adding those clients to the current program. Parallel programs could potentially create additional work and it could also ease administration if you look at different benefit design. Either way, you will have more population.

Senator Kilzer states he has thoughts about the rules that will be coming from the HHS secretary. I think everything will parallel welfare reform back in 1997. It was a similar situation that welfare reform had been signed into law but there were not any rules out yet. The rules came out at the end of our session, and a lot of the things such as TANF, were really up in the air. I think we are going to have to plan, as the law is now, but have quite a bit of flexibility.

Maggie states that she thinks there will be potential simplification, after implementation, is going to modify adjusted gross income. Everyone, except the aged and disabled, their eligibly will be determined, based on modified adjusted gross income. Today, based on net income, it is a more complex problem.

Senator Fischer states he remembers having disagreements on what gross income was.

Senator Kilzer states when that change is made you will have to be ready for screening, there will be some people, who are eligible for benefits now, under our net income type thing, which even though the percentage will be higher, will not be eligible in the future.

Maggie states we are operating under maintenance of eligibility requirements. For adults, it is until January 2014 and for kids it is through September 30, 2019. Also the law says, everybody has got to go to modified adjusted gross income, on January 1, 2014 and we are suppose to hold people harmless. We have quite a few clients that would be eligible today under net income who wouldn't pass under gross income, so we are not quite sure how we get there. The intent of the law was not to lose coverage. That is why we would like some guidance on this area.

Senator Fischer states that is not a bad idea. I remember when the House had it, didn't finish it and we collaborated it to the end.

Senator Kilzer asks if there a way to send these people a "heads up" letter that you may not qualify.

Maggie states as soon as we have a real picture, we will be communicating with counties and clients and eligibility workers.

Senator Warner states that he is interested in, is that we utilize state general funds, through this whole process. Medicaid expansion is 90/10 correct?

Maggie responds by asking, "What we receive for health care reform? We will actually receive 100% for the grant costs, the costs out to doctors and physicians, for the first three years. (2014-2015-2016) and then it steers down from there. Our administrative costs will be at our regular match, which most of those are at 50-50 or around that.

Senator Warner asks under current law, for quite a number of children, who are covered, Medicaid is more advantageous to the state than Healthy Steps, correct?

Senator Fischer asks if we want to policy changes so we might do in the next couple of years, which would interfere with our ability to optimize the amount of coverage we can get.

Senator Kilzer states there is no premium for Medicaid and there is for CHIPS.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 24, 2011
13297

☐ Conference Committee

Committee Clerk Signature Rose Laring

Explanation or reason for introduction of bill/resolution:

These are minutes of the Department of Human Services Subcommittee meeting discussing long term care and nursing home facilities.

Minutes: See attached testimony - # A - D

Senator Fischer called the subcommittee hearing to order on SB 2012.

Subcommittee members: **Senators Fischer, Kilzer, Erbele** and **Warner.**

Carol Olsen, Maggie Anderson, Brenda Weisz, Alex Schweitzer, Tove Mandigo.

Brenda Weisz handed out
Testimony attached - # A. Health Care Reform FTEs – Cost to Continue Salaries for the 2013-15 biennium

A request was made for the seven FTEs that were related to health care reform and to indicate what the price tag of those would be for a 24month period. The FTEs in the current Governor's Executive Budget were staggered to start anywhere from July 1, 2011 and the latest starting April of 2013. (Discussed the salaries of the FTEs whether in the Governor's Executive Budget or not – and also health insurance)

Maggie Anderson handouts –
Testimony attached - # B – Nursing Facilities – Rates effective January 1, 2011
Testimony attached -# C – LTC Continuum Functional & Financial Eligibility Requirements.
Testimony attached - # D – Services Payments for the Elderly and Disabled (SPED)

Maggie Anderson said the 1st handout is the nursing facility low and high rates by facility. The average cost is in the overview testimony, but here you can see by the facility for the rate year that started January 1, 2011.

Senator Kilzer asked if they are the daily rates. **Maggie Anderson** replied yes and the average is about $205.00 per person per day average.

Senator Fischer asked if the bottom line for average rate of nursing home at an average level of care is $6000/month. **Maggie Anderson** replied that it's the average.

They discussed equalized rates. The decisions that the legislature makes that impacts the Medicaid rates also impact the private pay rates because of the equalized rate law. They are trying to make it more evident that when a 6 & 6 percent inflationary increase is provided or the salary enhancement that was provided in the 2009 session, then that was also passed along in the per day cost that private-pay people pay as well. So when we talk about the average cost in a nursing home being $205.00/day currently, that's the average cost that Medicaid pays and that's the average cost that a private-pay person pays.

Senator Kilzer said the newer facilities looked like they are more expensive.
Maggie Anderson said they are more expensive because of the higher property rates. Older facilities have lower property rates.

Discussed the moratorium bill and occupancy rule -

(Referring to Testimony #C) **Maggie Anderson** explained attachment C as the Long Term Care Functional and Financial Eligibility Comparison and explained SPED (Service Payments for Elderly and Disabled)

Senator Warner asked what are IADL? **Maggie Anderson** replied that it is Instrumental Activities of Daily Living. It may be toileting, transferring, eating, they might be housework, laundry, medication assistance

Discussion continued on basic care, lower rates and caps on cost.

Maggie Anderson explained the SPED services (testimony #D).

Discussed the usage of federal and state money's.

Brenda Weisz said they worked up a sheet that actually shows, by the major programs, it actually gives you an average monthly caseload for the current budget and it gives the average monthly caseload in the Executive Budget so that will show you where the drops and increases are. It also gives you a cost per case for the current budget and the Executive Budget.

Senator Fischer asked how they deal with the decreases because we only see the increases. Brenda said you see a net increase. For example, in her testimony, when she walked them through the net increase, based on caseload or the net increase in cost, it nets out the ins and outs. Referred to Maggie Anderson's testimony #12, page E.

Discussed how the budget was built, cost changes and OARs.

Senator Fischer closed the hearing on SB 2012 subcommittee.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 25, 2011
Job # 13393

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

These are minutes of the Human Services Subcommittee meeting to discuss funding and budgeting.

Minutes: See attached testimony - # E

Senator Fischer called the committee hearing to order on SB 2012.

Subcommittee members were present: **Senators Fischer, Kilzer, Erbele and Warner**.

Senator Fischer said he was having difficulties because they're talking about OARs, flat budgets, the Governor's Executive Budget, etc. and unless he'd get his 2009 budget, he wouldn't know where we began and where we are. It would be nice to know where we are with different divisions today and where we were when we left off. The roll off has been explained and how they book that so it doesn't look like it's been spent twice.

We're talking about the money that's rolled up in budgets, no matter which one it is, and how it's handled. The money that's left over at the end of the biennium or projected money – how is that handled?

Roxanne Woeste, Legislative Council
If you're referring to the authority that's included in SB 2012 to carry forward any unspent general dollars...
Senator Fischer: Right, and then that becomes part of the budget or it looks like it does.

Roxanne Woeste: The authority allows the department – once they get to the end of the biennium, whatever they have not spent out of their general fund appropriation, they can carry forward or continue that funding and spend in 2011-13. Right now that number is estimated to be $12.8 M is not included in the department's appropriation numbers that you're looking at for 2011-13.

Senator Fischer: Maybe it would be better to turn that money back to the general fund, build your budget from scratch without using that – re-appropriate it.

Roxanne Woeste said that's an option.

Senator Fischer: For the sake of what it looks like when people look at the budget, it looks like that money has been appropriated from the general fund the second time – the $12M, because it becomes part of the next budget. If we made a point of having them turn it back to the general fund, and then appropriate it as general fund dollars in the next budget, we'd have that turn-back document to say it went back to the general fund. So it doesn't appear that the money is being appropriated twice.

Roxanne Woeste; It's a little confusing. If you make them turn it back, you're going to have to appropriate it again. What the Governor's Executive Budget is proposing is just saying, you keep it and you keep spending it. The senators will have to decide which way they want to go.

Senator Fischer: That may be an option that is discussed in a lot of budgets.

Roxanne Woeste: It will be a policy decision. Just so you know there are some concerns. If we make the department turn back the money and we re-appropriate it, we will need to come up with some language similar to language that was used by the 2009 legislative assembly in regards to FMAP dollars and not the federal stimulus dollars not being deposited in the rainy day fund because there is a provision where they cannot be.

Senator Fischer: We discussed that in the complete meeting too.

Roxanne Woeste: If that's the road we take we need to make sure it's documented so we're not in trouble with the federal government.

Senator Fischer: Could you put something together to address that? Just a general document that we can look at?

Senator Warner: When you're billed and when you pay, there's a lag time. Are we going to mess up their ability to float on services which are provided in one biennium but they're paid in the following biennium. Is that part of what the turnback dollar manages?

Brenda Weisz said no. Our biennial budgets are built accordingly.

Senator Warner If you are forced to turn back money, would we create a situation.

Brenda Weisz: The reason we have the turnback is because of the enhanced FMAP. It would be turned back whether you budget for it the way it's included in the Executive Budget to carry forward and then we protect ourselves from the federal regulation and see to it that it's not put in the rainy day fund. Or we include legislation to say it will not be put in the rainy day fund.

Senator Fischer: Roxanne Woeste can put it together for discussion purposes. It may or may not work out. By the time the budget gets to the floor it may change several times.

Brenda Weisz said she has a report that's ready to go. It shows by subdivision where they are, where the executive budget is, and the dollar change and the percentage change.
Senator Kilzer asked if there was a difference between a division and subdivision? Answer no.

Senator Kilzer asked are you talking about the 11 divisions of the department. Answer yes.

Brenda Weisz said it's broken down by line item. We call it the "**Senator Kilzer report.**"

(Discussed the total changes, funding and the testimony breaks it down by line item.)

Brenda Weisz asked for and received copies of the **Kilzer Report** – Attachment #E and she walked through the report. She also said her overview testimony would walk through the general fund increases. It wouldn't give you by division, but this would show the committee where they may want to dive in.

Senator Fischer closed the subcommittee hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
01-27-11
Job # 13581

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

SUBCOMMITTEE HEARING FOR DHS

Minutes: Discussion and Attachment

Senator Fischer, Chairman: Opened the subcommittee hearing, in reference to the Department of Human Services. Senator Kilzer, Senator Erbele, Senator Warner were present. Lori Laschkewitsch, OMB; Roxanne Woeste, Legislative Council were also present.

Roxanne Woeste: At our last subcommittee meeting the propose carry over dollar from the 2009- 11 biennium into the 11-13 biennium that is included in the executive budget, you asked me to put forth a couple of options, the short memo is my attempt to do that for you. Memo Attached # 1. She goes over the handout.

Senator Kilzer: Is there a history of look backs by legislators when they request you to answer the question or provide the information on what is the history of carry over's or turn backs, so you go back and look to see what the turn back was, do you get asked to do that?

Roxanne: Typically we haven't been asked for a history of general fund turn backs, going back several biennium's. We are typically asked for the most recent biennium, what the total turn back is and what it was by agency, yes.

Senator Warner: It seems a little unusual that we haven't required turn back in the re-appropriations. Do you recall is there legislative history as to when this practice was started in allowing them to retain?

Roxanne: The different agencies have been allowed to carry over general fund dollars in different budgets for different reasons for several bienniums. I believe this was introduced this way because of the federal requirement relating to the enhanced FMAP, there is a prohibition of those dollars going into the rainy day fund. This is a way for them to show the federal government that none of the general fund dollars that were freed up because of the enhanced FMAP were deposited into the rainy day fund. We kept those dollars and are using them for Medicaid and long term care payments.

Senator Fischer: If someone were to look at it, in terms of writing checks, if the department wrote a check form the general fund, you at least have a record that the money was returned to the general fund and was not expended. It wouldn't be included and look like it was being appropriated twice. You might have a problem explaining that the money that was put in there is not an increase.

Roxanne: I believe either form would be appropriate.

Senator Warner: Asked Brenda when they deal with something like this if they have a first n first out provision?

Brenda Wiesz: I think we would be able to prove that we spent it first because our expenditures in Medicaid are so high and we would indicate that the first money spent is either the money carried over or brought in.

Senator Fischer: Now we would go to long term care, the effect that raising long term care reimbursements has on rates. I would like you to prepare a sheet and show what effect there was from what was done in the 09 session and what the propose governors increases will have. The rates have gone up and no one talks about why.

Maggie Anderson: I just to clarify, do you want something more than the handout provides. She goes over the handout.

Senator Fischer: That explains it. When the state gives more money to a nursing home they put it into their cost because it is as if they are making the payment and the rate goes up because of that?

Maggie: If you provide a salary enhancement and the six percent, it goes into the rates for everybody. The state and federal dollars provide the increase for the Medicaid clients and the private pay individuals have to pay that out of their pocket.

Senator Fischer: Because of rate equalization, but the thing I don't understand is that we are enhancing nursing home wage increases at a rate then is much higher than inflation, so the people who are paying more for the nursing home care, that rate has accelerated.

Senator Warner: Either we are going to pay for those cost of the general tax payers or we are going to ask those people that are at the bottom of the economic later, who are providing that service to subsidize that service through their lack of salary increases or medical care or whatever their contribution may be. The CNA's are not making very much money.

Senator Fischer: I don't know if I agree entirely with that but I know where you are coming from. The inflation of the rates in nursing homes is out of hand. He comments about the good and bad care that nursing home residents receive.

Senator Kilzer: Commented about the increase in nursing home insurance.

Discussion on nursing home police's, the inflation, nurse's aides and RN's pay continues.

Maggie: Testimony continues with attachment two and attachment three.

Discussion on children receiving dental, orthodontic and vision care, children on CHIP and Medicaid receive the same benefits. Quality measures have to be strengthened and they are having them reviewed annually.

Senator Fischer: So you anticipate that FMAP will remain the same on this chart as well as the premium for CHIP?

Maggie: The premium will remain the same for the biennium the FMAP does go down a bit in 2013; it goes from 6936 to 6878.

Brenda: The FMAP is a three year lag. She addresses attachment # 4.

Senator Warner: What else is in the fringe besides the FICA and Medicare taxes?

Brenda: When we increase the seven percent multiplier, whatever they would offer at the DD provider. Currently they are at thirty three so this would take them to forty percent fringe benefit ratio. The eligibility rewrite would have to be in place and operational when health care reform, it would have to be able to interact and be ready the day health care reform takes effect. It is scheduled for January 1, 2014, if it is not repealed, to go into effect at the national level.

Senator Fisher: Nothing else for now. We are adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
January 31, 2011
Job # 13705

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee hearing on SB 2012

Minutes: See attached testimony – # F, G, H, I.

Senator Fischer called the subcommittee hearing to order on SB 2012.
Roxanne Woeste – Legislative Council; Joe Morrissette – OMB.

Senator Kilzer would like to see more detail of human service centers. They have an overall broad view the specific figures for each one, but he would like to go over the details of each center.

Senator Fischer asked about the senior budget for OAA (Older Americans Act) service providers.

Brenda Weisz said is in the Aging Services Division – Jan Engan's testimony (attachment 28.). It's not an OAR. It was funded in the Governor's Executive Budget and there was an additional $300,000 that was added in the Governor's Executive Budget from the general fund on top of the federal funds we receive in the OAA programs.

Brenda Weisz also informed the subcommittee that the human service center directors prepared a budget testimony in the event they would come in. She could distribute that testimony and they actually have the budget chart for their two centers that describe the increases or decreases to their centers.

Senator Kilzer said he'd appreciate that and Brenda said they'd make copies and bring them down.

Senator Fischer said they heard SB 2163 on TBI (traumatic brain injury) that went through the education committee, but funding is proposed to come from DHS budget. Have you any information on that?

Brenda Weisz said they helped develop the fiscal note and they helped the sponsors of the bill determine the physical impact of that. There is the continuation of SB 2198 of the 2009 legislative session for $330,000 general fund.

Senator Fischer asked about the Advocacy Centers and their certification. Also asked about long term care as far as inflators. What does it take to not have rates go up?

Senator Warner said his understanding that the linkage between the private pays and the public pays is that it's a cost limiter on the private pays. If for instance, your total cost of providing nursing home services in the state was a billion dollars a year, and roughly half and half were private pays/ public pays. If for some reason the state came into a difficulty and decided to only fund $400M of that billion, the other half would have to pay the $600M just to keep the entire system afloat. So it becomes a price limiter on the private pays as well as a price inflator. It's a balancing act. **Senator Fischer** said unless the Warner-Fischer nursing home was in business because we'd be competitive.

Senator Warner the Department of Health is the one who determines staffing levels.

Shelly Peterson said there is not a specific requirement on staffing. There is a federal regulation that says that each resident much function on their highest practical level so you determine based what your residency and staffing is. As opposed to some states that require 3.1 per resident. In ND, each specific center determines what they need for staff. That's the major contributor of cost.

Discussion was held on the resident draw down in Grafton and asked if they could be moved to Ann Carlson and should there be more discussion with Ann Carlson at this time looking forward to 4-6 years from now.

Alex Schweitzer said those last 40 residents will need a high level of care because they require skilled nursing and have diagnoses that require a lot of medical intervention. There are 40 of them and they will be the most difficult to transition. If there are facilities out there that are able to provide that, they'll have to be able to build up and provide these people's needs.

Brenda Weisz said they need to make sure there is money to place them into the community.

Senator Erbele: Looking at the funds – federal, general and special, if we mess with the general, which ones will affect the federal? If we make a cut in a general fund item, does that automatically alter then what we can tap from the federal on most or some of them?

Brenda Weisz: Depending on what area you affect or change the general fund, it will affect the federal fund. Predominantly in your medical services area or anything funded with Medicaid. That would be medical services, long-term care and also in the administrative area. We are cost allocated and that means is we try to tap as much federal funding as possible so any change in general fund will impact the federal fund as well as our human service centers. With FMAP now, we're at 55.4% but a lot of our funding is 50-50 on the administrative side.

Senator Kilzer asked about the additional in-patient psychiatric beds – adding 4 to the already 10 existing in Bismarck and 15 new beds in Fargo and 10 in Minot. Can you go a

little bit into detail on the numbers? I understand they are patient facility beds but they're no hospital. What is their place?

Brenda Weisz: Those facilities that we're adding for residential capacity are not really in–patient. They're residential facility for a crisis. Starting in Minot – the 10 bed crisis residential facility is for immediate short term individuals that are in a crisis situation. Minot is the only region in the state that doesn't have a crisis facility.

Senator Kilzer: The seven other regional centers all have this already. Answer – Yes, they have some sort of crisis stabilization function.

Senator Kilzer: What does Minot do now in a crisis?

Brenda Weisz: They will either try to stabilize with Trinity – the hospital contract or ship to the state hospital.

Senator Kilzer: So this would keep people out of the hospital? Answer – Yes, that's the intent. Most crisis residential that are set up across the state are about a 10 bed or a 12 or up to 15.

Senator Kilzer: Who mans this? Is it around the clock? **Brenda Weisz** – it's contracted with someone in the community and they would have staffing through a contract. Then the facility in Fargo would be for a chemical dependent residential facility in that community for 15 beds there.

Senator Kilzer: How many do they have now. Answer – this would be the only one. It's a long term facility.

Alex Schweitzer said those are people they continually see in the emergency room. This is deep end, very difficult to serve.

Senator Kilzer: So these 15 beds would be a new unit and Brenda Weisz said that right now they don't have a long term residential facility of this type so this would be the first long-term in Fargo.

Senator Kilzer: This would be chemical dependency and the only one in the state?

Brenda Weisz: In Fargo, we do have them in other regions. Minot has one for the addictive population – 9 beds, long-term residential. Northeast has one for the seriously mentally ill. West Central has one for the addiction.

JoAnn Hoesel, DHS said a specific program that has been put into place is called Integrated Dual Disorder treatment. And it's specific for individuals with very chronic addictive disorders plus a mental illness of a varying degree. It's specific into engaging them into the treatment process.

Senator Fischer discussed the contract with Merit Care and running short of emergency beds.

JoAnn Hoesel said often these beds are dually licensed for long-term residential but also for social detoxification services. That is another option so they don't end up in the emergency room.

Senator Fischer asked for the price of the contract a couple years ago. Answer – it was $234,000 but was running $400,000 or more per biennium. Brenda said those costs are reflective in the in-patient psychiatric.

Senator Erbele: In P&A, there is a line for TBI. What's source of those funds?

Teresa Larsen – Protection & Advocacy: We do have a federal grant for traumatic brain injury and it is $50,000/year. It is specifically for advocacy services so it can't be used to purchase services or treatment for people that have TBI. We work in collaboration with the DHS and with UND and with the Traumatic Brain Injury Association so we're not duplicating services, but we're trying to work together so people's needs are being met.

Senator Fischer closed the subcommittee hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
February 2, 2011
13878

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a Department of Human Services subcommittee hearing discussing the critical access hospitals and the human service centers.

Minutes: See attached testimony - F,G,H,I,J,K and L

Senator Kilzer called the subcommittee hearing to order on SB 2012.

Sub-committee members present: **Senators Fischer, Kilzer, Erbele, Warner.**
Department of Human Services – **Brenda Weisz; Maggie Anderson, Alex Schweitzer.**

Roxanne Woeste & Becky J. Keller - Legislative Council; Tad H. Torgerson – OMB.

Jerry Jurena, President, ND Hospital Association
Testimony attached - # J – later presented the committee with attachment # L

They were requested to provide some information to the subcommittee on the difference between total cost to providing Medicare services and allowable Medicare costs that were reimbursed. There was a study done on rural health clinics through the Department of Human Services and they determined that the difference between what they were paid and their true cost was $844,300 for the biennium.

(The discussion continued on cost differences of critical access hospitals.)

Senator Kilzer asked about his Medicare statements in a Human Services budget –

Jerry Jurena apologized saying he misspoke. These are all Medicaid figures.

Senator Kilzer asked about the 100% rebasing that the legislature instituted last session.

Jerry Jurena said yes. The 100% reimbursement was based on a Medicare allowable fee schedule. What you're reimbursing us for is Medicaid, but the Medicaid and Medicare fee schedule are very similar. So in 2007, when you gave the CAH got 100% of their allowable cost – that's based on what Medicare pays. In 2009, the PPS hospitals were brought up to

Medicare allowable costs for their Medicaid patients, that's the fee schedule that is being used.

Senator Kilzer (to Brenda Weisz or Maggie Anderson) - When the rebasing figures that we used two years ago, I thought they were based upon costs rather than Medicare.

Jerry Jurena explained that they are based on cost, but it's the Medicare allowable costs, not their true costs.

(Discussion continued on true costs and allowable costs and rebasing.)

Senator Kilzer – Proceeded onto the Human Service Centers (HSC).
(Attachments F, G, H, I)

(Discussion centered on the Human Service Centers – their beds, FTEs, salaries and any budget changes.)

Alex Schweitzer commented on the state hospital budget and said the only increase is the salaries. They actually have a break even budget and even a reduction in a lot of areas.

Brenda Weisz presented a handout – DD Provider Wage Increase – Attachment # K.
The increase starts July 1, 2011.

Senator Kilzer closed the hearing on SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
February 7, 2011
Job # 14124

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee hearing on the Department of Human Services budget - SB 2012.

Minutes: See attached testimony - # M, N, O, P

Senator Fischer called the subcommittee hearing to order.
Roxanne Woeste – Legislative Council; Lori Laschkewitsch - OMB
Subcommittee members present were: **Senators Fischer, Kilzer, Erbele, Warner.**

Brenda Weisz - Asked Brenda to continue from the last meeting.
Testimony attached - # M - Inflation scenarios.

These are the inflation scenarios that were requested and Brenda continued and explained the different scenarios of provider inflation.

The only two items left outstanding for requested information as a subcommittee was the report on the Golden Manor in Steele and also the Critical Access Hospitals (CAH) supplemental payment.

Maggie Anderson –
Testimony attached - # N. Estimate of Critical Access Hospital Supplemental Payments.
Testimony attached - # O. Golden Manor, Inc.'s Report to Dept. of Human Services.

Maggie Anderson explained the handouts.
You can see by facility what the estimated amount of supplemental payment would be to each of those facilities on an annual basis. The 2nd page provides the total costs and the breakout of that. The total amount is $3.45M of which $1.5M is of general funds.

Senator Kilzer – Is there a percentage above the 2009 appropriation or how are the figures calculated on page 1?

Maggie Anderson replied that these amounts are above the 2011-13 Governor's Executive Budget. This would be in addition to payment methodology that is in place for critical access hospitals for Medicaid to pay them at 100% of cost. There is a federal statute that indicates that they have to pay specifically off of the Medicare fee schedule, but

then you can do arrangements through a supplemental payment. This document represents dollars that would be above the current expenditures for critical access hospitals and above what is in the 2011-13 budget requests.

Senator Kilzer – What are the actual values of the present biennium? And **Maggie Anderson** replied that for the critical access hospitals, they are expecting to spend, as stated in the Governor's Executive Budget request, which is $34.8 M.

Senator Kilzer asked if this appears anyplace as an OAR? The answer was no.

Maggie Anderson - Discussed the payments for CAH.

Senator Kilzer: What was the amount of Rolla's request last time?

Maggie Anderson: It was $400,000 – that was appropriated to the department as all general fund dollars because at the time, we didn't know if they could secure federal approval but we later got federal approval. They're making annual payments. The first one was March of last year and the 2nd one will be April of this year. They are about $128,000.

Senator Kilzer: As I recall, two years ago, there was something about - a request had not gotten in on time or was not approved. Was that all done correctly this time?

Maggie Anderson said the issue that was there last time continues to exist because it's that federal statute piece. The Hospital Association and Rolla came to the department asking why they couldn't pay lab at cost. The reason was because of a federal statute that says Medicaid has to pay lab off of the Medicare fee schedule. So the Hospital Association came forward last time and asked for the $400,000 to be added for the supplemental payment. We didn't approach any additional work in the interim on that because they were very clear that it would take a change in federal statute.

Senator Kilzer: Is $167,000 going to be enough for Rolla – on the lab end of it?

Maggie Anderson - They were receiving $128,000 /year and this $167,000 is an annual figure so we think it will cover what we have already been providing.

Senator Kilzer Was this amount reduced in the Executive Budget?

Maggie Anderson: It was indicated as one-time funding so it was not included in Governor's Executive Budget request.

Senator Fischer closed the subcommittee hearing on SB 2012.

Additional testimony from:
Testimony attached - # P - **North Dakota Hospital Association, Jerry Jurena, President**
He wanted to reiterate that what was approved in 2007 for Critical Access Hospitals (CAH) and in 2009 for the six large hospitals was to reimbursement at the Medicare Allowable Costs based on the Cost report.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
02-09-2011
Job 14290

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

Subcommittee hearing on Department of Human Services budget.

Minutes:

Chairman Fischer called the subcommittee to order on SB 2012. Present were: Senators: Kilzer, Erbele, Warner; Lori Laschkewitsch , OMB; and Roxanne Woeste Legislative Council. Others present were: Brenda Weisz, Maggie Anderson, Alex Schweitzer, Teresa Larsen, Carol Olson and Tim Cox.

Tim Cox, President of Northland Healthcare Alliance and representative of Northland PACE (Program all-inclusive care for the elderly), testified in support of the PACE program. Testimony attached # 1.

Senator Warner asked how private long term care insurance customers fit into their funding stream.

Mr. Cox answered that they have a program where they can accept long term care insurance clients. They have had two clients that have been reimbursed through the long term care insurance. He added that they had to bill it out in an interesting way and it did work. They also can provide service to those private pay participants but the fees are expensive and they haven't had a lot of interest when they hear the cost. He explained the handout, Estimated State Expense – 2-year expansion. Testimony attached #2. What they are asking for is the expansion in the general fund to expand this program over the next two years. Their goal is to keep the elderly independent and at home as long as possible. He talked about the money saved by the state if clients were able to stay at home versus going to a long term care center.

Senator Kilzer when you compare the cost of nursing home care to your costs, you are not really comparing apples to apples because you are talking about people who are able to get along at home.

Mr. Cox that was correct. This is the worst case scenario that I presented. The point is that this model of care will keep these folks in their home longer.

Senator Kilzer is your eligibility the same as nursing home eligible. The patient has to be deficient in two activities of daily living.

Mr. Cox yes, same as long term care.

Senator Warner once they are enrolled in PACE it is a commitment until death. When they reach a certain level of requiring care, which is so expensive, do you make a business decision to have them referred to be served some other way?

Mr. Cox we make a death til us part commitment. They can voluntarily disenroll. The only way we could disenroll, is in the case of noncompliance to the direction that we give them, otherwise we are committed.

Senator Warner does the department have recourses to the estate for the expenses incurred under this type of care?

Maggie Anderson replied no.

Senator Fischer said that we need to discuss if there is agreement on psychiatric and the IMD. The funding would be 1.1 million general funds and 1.4 million in fedederal funds, and the other is already funded in the governor's budget.

Senator Warner asked if they had reached some agreement on the level of funding.

Senator Fischer said that the committee has talked about the enhancement to wages.

Senator Warner commented on the dollar raise and inflators.

Brenda Weisz spoke in relation to the IMD demo, it is a competitive grant and only five will be issued in the nation. There is no guarantee that North Dakota would get that. She added that the inpatient psychiatric hospital days are included in the executive budget.

Discussion followed on the budget and funding and what it included. Specifically, related to psychiatric hospital coverage.

Senator Fischer adjourned the subcommittee.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
02-15-11
Job # 14567

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

SUBCOMMITTEE HEARING on DHS

Minutes: You may make reference to "attached testimony."

Chairman Senator Fischer opened the subcommittee hearing on SB 2012. Senators Warner, Kilzer, Erbele present. Lori Laschkewitsch,OMB and Roxanne Woeste, Legislative Council present. Brenda Wiesz, Maggie Anderson, Carol Olson and Shelly Peterson were present.

Senator Fischer: Senator Kilzer and I discussed this. I would kind of like to put some more money into it, because it is for Meals on Wheels. It is a service that if we put that in, we expand it and possibly 2 things. One, it expands to smaller communities, they go out further from some of the larger communities, the other thing is that the restaurants that provide the meals are having to charge more because of cost of living has risen, inflationary issue even for the people who do pay as well as the people who can't. Senator Warner: I think some of the requirement for the food has gone up too, they have less canned vegetables, more fresh vegetables, less canned fruit.

Senator Kilzer: Taxpayers think why should I be supporting this, because the people can afford it? It is just the federal government that insists that they don't be expected to be reimbursed the actual costs. As I mentioned before, on page 11, of Jan Eggan's testimony, she says an increase of $526,000 for congregate nutrition, $300,000 of the increase is from the General Fund, a decrease in Federal funds of $485,000 due to the removal of stimulus funds of $325,000 related to congregate nutrition, and $160,000 for home delivered nutrition. A decrease in federal funds to the nutrition services incentive program of $45,000. I am in favor of keeping the general fund as it is and reducing it by the amount the federal fund is not.

Senator Warner: We have been interested there is a distinction in the costs of a $4.5 on long term care, versus $3.3. That one of them was more expensive than the other one. They weren't revenue neutral as though they were in DD.

Brenda Weisz: Essentially everything is pretty much revenue neutral, just a slight decrease, except for the nursing home. The reason the nursing homes are higher, is because they are on for their rate setting rules. They are based on cost basis, historical costs increases that there costs are just historically increased because of rate setting rules. Then put inflation on top of

that, so they benefit with the one year. That is why on the handout, they actually will see an increase when you go from a 3 and 3 to a 4.545.

Senator Warner: Does that explain the difference? **Brenda Weisz**: By provider group, it shows the difference going from a 3 and 3 to a 4.545 and then with the net increase or decrease would be. That's an increase going for all categories, and then for most of them it's just a slight decrease, but it is the most budget neutral of all scenarios.

Senator Fischer: So, with $10,000 month, in long term care; and we give them a 3 and 3, what would your bet be that it's going to be about $13, 000 a month? I am only asking for the numbers, not using the percentage. It is how far are they going to jack it up because of rate settings and rate equalization? If you put all that together, so all we're doing is subsidizing long term care so they can charge the state more money. When most of the time you subsidize a business if somebody is subsidizing another business it's to lower the cost. You want to come with something to fix that. Otherwise we ought to kill this section. I have a lot of emails. The thing is the discussion of higher health insurance. I've got some basic philosophical problems of treating businesses one way, and while I understand that we're taking care of the elderly, the thing is I think that some of this is out of hand. **Senator Warner**: Is there a fix?

Senator Fischer: There is no fix. Not unless we get rid of rate setting and rate equalization. I talked to a member of the House on Human Services that should've done it years ago. The effect of it now, is that what we really need to do, is to take a look and see what the effect would be short term, medium term, and long term by not subsidizing or to get rid or rate setting and rate equalization just arbitrarily; is a little risky. Because it could, and I think the small community nursing home would survive. The big ones would be the ones that would get hurt the worst. Example cited. I have been through this for several years and I think the time has come to either do it, or at least make some effort to begin the process of getting this under control. Shelly, I want you to tell me how its fixed because it's not, it's broken Shelly and you can talk about all of the need you want to, but so does everybody in the state can claim the same thing.

Senator Warner: Do you have somewhere a list of rate comparisons between states? How does North Dakota rank in class? **Shelly Peterson**: Between states, I could possibly check and see, we have the Medicaid rates. **Senator Warner**: At least within the region.

Shelly Peterson: We have the Medicaid rates; we don't have the private pay rates in North Dakota and Minnesota which are the only two states that control the private pay rates too. On the issue of subsidizing a business, North Dakota nursing facilities, the way the rates are set is SB 2212 just pays for the Medicaid portion of the cost. Let's say out of a 100 bed nursing facility, you have 52 people in that nursing home that is Medicaid recipients. So when you set, the 3 and 3, that means there rates are inflated for that facility. On the Medicaid portion we'll go up 3%and that is what's in this appropriation is to just cover just the Medicaid population. In North Dakota law then and in every law in the nation, Medicaid is the lowest payer. It is the floor at which rates are set. The private pay according to law, cannot be charged less than the Medicaid rate. So in all states the Medicaid rate, whatever it is, is the base low. Example cited. Medicaid learned long ago that when we set rates, you cannot give sweetheart deals to people who are on Medicaid or to the private pay. They have to pay at least what Medicaid is paying.

Senator Fischer: The other part of that was, so that nursing homes didn't put it to the people that were private pay. **Shelly Peterson**: That's North Dakota. In North Dakota and in Minnesota, we can't charge the private pay a nickel, a penny more. **Senator Fischer**: You overcharge Medicaid. **Shelly Peterson**: Well you guys determine the Medicaid system. It is in statute what, how and what happened twenty- two years ago. **Senator Fischer**: Why is then the same care in Minnesota to North Dakota, it is double the money? **Shelly Peterson**: Well what happens when you go into a nursing home and how your rate is determined. Let's say on day 1 you go into the nursing facility. The nursing staff in ND and Minnesota will do an assessment of you to determine what do you need, what is your diagnosis, what do you need help with? So your assessment is called the MDS in ND and Minn. Then you send that MDS to the state. The state then determines based on that assessment the care needs of that person and they assign the rate. The state assigns the rate, then it goes back out to the facility, and the family is informed of what the rate is. That same process occurs so if you go. Senator Fischer: Take it or leave it, right? But the thing is the very first thing you send to the state is subjective. **Shelly Peterson**: Absolutely not, really. When you're trained because the Health Department comes out and checks to see if you have completed that accurately and fairly and what we have actually found, is nurses are very conservative. They will be very careful. Everything is documented; it is based on documentation to determine where that person falls. **Senator Fischer**: Subjectivity can come in. It depends on who writes on the documentation. Shelly Peterson: What we have found is that we are very accurately completing the MDS. We're not seeing that we are making errors. We are not seeing that you're up-coding anything. You're being fair. The Health Department comes in and they check. **Senator Fischer**: They audit. Shelly Peterson: There is a check and balance, so we can't cheat the system. Well we also have the ombudsman. I guess there is a degree of trust too. We don't find nor does the Health Department that we're cheating residents. If anything it's difficult. You hate to see their rates increase too; twenty-four cares is very expensive. We look at 75% of the residents can't feed themselves, bathe themselves, they need help getting in and out of bed, so it's that constant help. **Senator Fischer**: And that is what exactly costs $4700 at Pioneer House at Fergus Falls, that service, and $9400 in Mandan. Shelly Peterson: You know the Mandan case you're talking about the person requires an enormous amount of care. What we also find in North Dakota is that we have one of the highest proportions of people that are private paying. People that have income and assets to pay for their care, and do you know where they're going to get their care, in a nursing facility. They have the income to get home care but they are not choosing that. We are one of the five top states of private pay people. That means that people who have income and assets who have other options, for whatever reason are choosing the nursing home.

It is hard to compare state to state and go across lines unless that person actually comes into North Dakota; an assessment is completed and the rate is determined. But generally the thing that drives costs is the composition of your staff. Facilities that have higher staffing have higher costs. **Senator Fischer**: Why would you have more than the adequate? **Shelly Peterson:** Well, because of quality of care issues. You want to provide the best possible care. **Senator Fischer**: If you didn't provide adequate care you would have an empty building. **Shelly Peterson:** Potentially yes, people aren't going to go there unless you're providing good care. But what is adequate care? The Federal regulations say that you must have that person function at their highest practical level, which means PT, OT. That is where you do the assessment and you identify what are their care needs? **Senator Fischer**: Especially at the end. **Shelly Peterson**: Twenty four cares costly, we discharge 1/3 of the people that come into

a nursing facility to go back home, and the rate system is determined by state statute and that's 3% that if you provide in SB2012. Then the private pay has to pay their rate. **Senator Fischer**: What are going to do for the client if they get a 3% raise? **Shelly Peterson:** Well we're going to give an increase to our staff. **Senator Fischer**: And that's going to improve care? **Shelly Peterson**: Absolutely! If we don't have staff to care for those residents, well look at what happened in Parshall. No we're not going to treat them different. But we may not have them, they may go down to the hospital, they may go to the DD system or if we don't have staff, then we have to rely upon contract agency staff. Last year two out of five nursing facilities had to use contract agency staff at triple the cost. And then what happens is that care giver who is coming in to your room you do not know them. **Senator Fischer**: where do people go? **Shelly Peterson**: They go all over North Dakota. Senator Fischer: No, I mean if you we don't subsidize the industry? **Shelly Peterson**: Well if you don't provide us the rate increase that we feel that we need, then we will not be able to provide raises, health insurance because that 3% covers health insurance, pension. But what will happen is those people will quit, they can find jobs in other states or other in hospitals that need nurses and then we won't have them. We will then have quality of care issues.

Senator Fischer: What did you do with the 6 and 6? **Shelly Peterson**: We put it in to wages, health benefits. We spread it out to whom. We'll spent that money and actually, on the upper payment limit, when they look at how much we are spending in allowable costs versus what the state is giving us in their rates that will pay for them. **Senator Fischer**: Part of it. **Shelly Peterson**: Because their social security check and everything else still has to go to pay for their care. It's not like their getting it free. But we have a good fair reimbursement system that we can provide some of the highest quality of care in the nation. The major part is staffing. If you didn't provide us with that 3% how could we give them a raise or pay for health insurance? **Senator Fischer**: The thing is you also have self-paid people in there that are still paying income tax, and they are still taxpayers and charging them. It is a convoluted system. **Shelly Peterson**: Just like when go out and buy a car, don't we have to pay for that when they need long term care. Don't we have to pay for that? Are we expected to pay for whatever we need as we age or are young? **Senator Fischer**: That's true. **Shelly Peterson**: If we don't and Medicaid paid for it, we would never be able to afford anything else. **Senator Fischer**: But the thing is I don't go nor am I forced to buy a car that is $90,000- $115,000. **Shelly Peterson**: Nope that's your option, if you have the money. In North Dakota we have the options. Maggie provided the range in all nursing facilities of the lowest rate and the highest rate. People can look at this and decide whether I am going to Strasburg where its' cheaper or Ashley if it is, it means that historical costs of what we find in rural North Dakota is they pay their staff less, but we have some significant staffing issues in rural ND. They are going to start to have paying them more money or they will not have staff. Then we sit next to Minnesota too that has higher nursing wages. **Senator Fischer**: They also have a $6.8 billion dollar deficit. **Shelly Peterson**: We don't want that. But we think 3% is fair and reasonable and it will go into the pockets of our; in long term care and all of nursing homes basic care, assisted living we employ 16,000 people, in nursing homes we employ 11,000. The budget report yesterday North Dakota is doing well and the personal income. **Senator Fischer**: Don't count that money. As far as I am concerned that money doesn't exist. **Shelly Peterson**: Well, we really believe that 3 and 3 is necessary. We really debated that we would appreciate your support on it. It doesn't go to subsidize it goes to deliver care to people that need it. Thank you for letting me say something. **Senator Fischer:** It's not a subsidy. **Shelly Peterson**: Well it's for people that have run out of money; that is a safety net. Medicaid is a safety net for people that are poor and don't have it.

Senator Fischer: Not to call it a subsidy is not true. It is a subsidy. **Shelly Peterson**: Well, but you don't subsidize the private pay; they have to pay their own fair share. **Senator Fischer**: Sooner or later you own all of their property. Or at least someone does to pay your way. **Shelly Peterson**: That is why all of us in this room need to look at what are we going to do when we age, how are we going to pay for our long-term care? **Senator Fischer**: Build my own nursing home. **Shelly Peterson**: We need to get insurance. Because we will not be able to pay for everybody; but we might need care and if people haven't saved, then Medicaid is a safety net for them. If they have saved it is expected that their assets will pay for their care. **Senator Fischer:** You need a little over $3 Million dollars at least that to generate enough passive income to pay your tab. **Shelly Peterson**: My tab? **Senator Fischer**: Your tab, or long term care, either way. **Shelly Peterson**: It's expensive. 24 hour care is expensive. **Senator Fischer**: It could be less expensive with the quality if it was managed in a different way. **Shelly Peterson:** I would invite you to come on a tour. We are proud of our quality and it's directly related to the staff that we have. They do an outstanding job and we need to pay them or we will not have them and then quality will go down.

Senator Warner: Did you include any salary increases for administrators? **Senator Fischer**: At nursing homes? **Senator Warner**: Yes, they are non profit.

Senator Kilzer: Would you like to speak about the meals? **Senator Fischer**: That is kind of where we left off.

Senator Warner: I understood your positions differed on that. **Senator Fischer**: I think that it is a good program but I understand our differences. My argument was that as you said, it is sometimes the only time that people get together. But I also agree that if there is a mechanism so that everybody, if they all paid the same thing, it would make me feel better, or some sort of, but I don't think that is allowed. **Senator Warner**: What would you think about putting a small grant together for an advertising campaign targeted at recipients so they would have post their actual cost of the meals and there is a way of nuancing the message in such a way that would encourage people who actually can pay to pay the full price or maybe even be recognized as all-stars or gold star contributors if they threw in $10 a meal when the meal was less priced, and helping to pick up the tab for somebody else. A relatively small amount of money might design a poster or something like that could be posted at feeding cites that would encourage people to kind of step up to the plate or take a leadership position on the issue. It wouldn't be in contract with the federal mandates not to provide a means. **Senator Fischer:** I would guess that the meals costs different, as there are different prices in every community. Senator Warner: They could put in a white board concept to write it in everyday for what this meal costs this much. **Brenda Weisz:** I don't think you can identify what has been contributed by the individuals. I don't think the federal government will allow you to identify what someone has contributed. You could identify the cost of the meal, but not a gold star poster or identify the people that were the recipients. You can't identify people by name, you couldn't do that. **Senator Warner**: What do you think of the marketing concept of putting this together? **Brenda Weisz**: I do think Brian Arndt from Fargo Senior Meals even talked about the facilities even doing that without legislation. That some of them do that already list the price of the meal, but that was something they were talking about all could do. **Senator Warner**: Continued with suggestions concerning this concept.

Senator Kilzer: If that would work, I would certainly support it. But what we're faced with here is the feds pulling back and the department on page 11 asking for a general fund substitution for the lost federal funds. And to me that is not acceptable and if some sort of other reimbursement outside of expecting more state funds to the tune of an increase of $526,000 for congregate nutrition, that is a pretty big jump and if it can be found in the people who can afford it who apparently are not expected to pay. If you can put the guilt on them or something, okay.

Senator Fischer: Is there any record of when they provide the meals. Let's say that they provide 200 meals at $5, do they keep a record of how much is paid on that? Do they do that on any given month, day, year? Do they keep that kind of record so, we know how many people the percentage of people who are paying? **Brenda Weisz:** They wouldn't have any direct record of who is paying; they would have a pretty good idea as to knowing the people that come into the site because they can't keep actual record of who drops into that jar. **Senator Fischer**: But if you take the meals and divide by the money in the jar, it just tells you overall. **Brenda Weisz**: Yes, they are supposed to be keeping track of that. Because they report that money that they collect in that jar, it is part of our match for the program. **Senator Fischer:** Is there a percentage of people are putting overall and paying? **Brenda Weisz**: That I don't know. It is all tracked at the field sites and then they report that into aging services and she didn't have that information readily available. Do you want us to get that for you? What percentage? **Senator Fischer**: No, just overall. **Senator Kilzer**: Those are things that faces us is replacing their money and if we just say no then if there are other ways of finding the money would come into play I would hope or just not expanding the service. **Brenda Weisz**: We as a department have never come forward to ever replace the federal funds that have ever changed in the congregate meals; last biennium was the first time. I do know that they've had a lobbyist group that has come in and worked for them to have the $900,000 of general funds on top of congregate meals placed in the budget and this $300,000 is a continuation of that effort. That is what it is tied too. It isn't tied to the loss of federal funds. They've been relatively flat for the congregate meal and the federal funding for that. **Senator Erberle:** From what Senator Wardner is saying, do we want to do anything at this level or is it to just get the word out to the meal sites. Should they post their prices, and then post your deficits? **Senator Fischer:** Can they do that? **Senator Erberle**: Our costs aren't what we collected. You need to put a little onus on them to say, hey I want this to continue and we're running short. **Senator Fischer**: Which one is closer to break even, congregate or delivered meals? **Brenda Weisz**: I would be guessing, but I would definitely think it would be congregate meals because you have people that come in that would probably be dropping more into the jar. The congregate meal sites when you have coming, but you are expected then obviously to contribute because I am not eligible and then I would pay for my full price of my meal.

Senator Fischer: Well its decision time. Not everybody wants to. **Senator Erberle**: Are you looking for a motion on this. **Senator Fischer**: Well, yes I would kind of like at least start the discussion so that Senator Kilzer and I can. I am not tied to either way. I understand the situation, that he is talking about and what we face, but I also think that we need to provide. How much of that error fund, I mean last time the funding, did it run out or is there money left in there? **Brenda Weisz:** What happened is there's about $485,000 of ARRA funds, the governor's budget included $900,000 of additional general funds over and beyond. So how we work that so that the providers wouldn't notice any decrease of funding is we do our contacts with providers on a calendar year. We did the ARRA funds at $485,000, and then the next

contract period we gave $450,000 of that and then the next contract period $450,000, so there not seeing any decrease. We didn't do a one- time influx. This $300,000 of general funds that were added over and beyond will just be added probably again split. We haven't made firm plans because we need to survive through the session. But how I would see them doing it would be consistent again where they would split it between the two contracts cycles, and then add it to the allocations in two contract cycles for the next biennium of $150,000 and $150,000. **Senator Kilzer:** On the $300,000 of the increase, is from the general fund and this is on page 11 of Jan's testimony. Just before that she said, an increase of $526,000 for congregate nutrition, $300,000 is from the general fund. Is that a matching so that if we don't put in the $300,000 the rest of the $526,000 wouldn't be matched? **Brenda Weisz**: No, the $526,000 is in total so $226,000 is federal and that is just an increase in the federal award. That is still coming to the state. **Senator Kilzer**: And it's not dependent upon. **Brenda Weisz**: No, it is not dependent upon that $300,000. The match is derived from the jars that are out at the meal sites, so we obtain our match there. The $300,000 was added by OMB and the Governor's office after we submitted our budget. **Senator Kilzer**: That is the part that I would not favor that increase not be granted. **Senator Warner:** I would favor the governor's recommendation. Senator Fischer: Neutral. I like the budget that the department put together. It was additional money in, the governor put the additional $300,000. Senator Warner: ARRA funds couldn't sub-plant other funds, right? We had to do the maintenance of average. Do we run into any issues here by putting the AARA funds in early and then? **Brenda Weisz**: The maintenance effort in sub-planting more of the AARA funds are more related to Medicaid. Each federal funding source with the AARA funds has their own specifications and rules that they had to follow. And so with the aging money, those were used to put towards additional meals and that is what we did with those funds. **Senator Fischer**: how many sites are there? Do you have any idea of the meals? **Brenda Weisz**: No, but I don't know how many sites exactly we have but I do know that we do eight contracts that we bid out the congregate meals. Then those sites in each of the regions then subcontract sometimes with restaurants and local meal sites then to get the meal out there. **Senator Fischer**: I will support the $300,000 if the department takes care of the signage that is posted in everyone of those congregate meal sites doing exactly what Senator Erberle's said is that, how things went last week and the meal for the day, I will go along with that. I think that this should be least that could done. With that, I think hopefully it improves things, and we should find out in two years and make changes.

Senator Kilzer: At the bottom of page one on this handout, it's not a lot of money but on the developmental disabilities special funds increase of 1412% going from $9,900 up to $150,000. I am sure it's not a major item, but it looks pretty big. Brenda Weisz: We have a provider tax that we tax DD providers or DD beds. That provider tax comes back in and it funds a great share of the Medicaid budget. The thing that's happened with CMS is that required us to do some quality work that we have to do under the DD waiver in order in be eligible. One of the federal requirements that has been put on the agency, we have taken some of the money from that provider assessment that will assist us to do the quality work or meet our federal requirements, so that we don't put our waiver at risk. For the contract work we have to do to comply with those waivers. We are using some that funding or the provider assessment to take care of that. **Senator Kilzer**: Why would it show such a huge increase? **Brenda Weisz:** Because right we're not doing that work. CMS has told us we have to start doing that quality work; we don't have the resources to do it and so we are building and doing the planning to do that work, so we are in compliance. **Senator Kilzer**: Do you think you'll be able to keep it at $150,000 special funds? **Brenda Weisz**: Yes. Instead of using general funds we're using the

provider assessment piece of it for the cash match or the non-federal match. The Federal government will kick in the 50%, it's an administration cost. It is a requirement for the waiver so we can pay for the DD grant, so that will take care of the nonfederal share. We are contracting to do. **Senator Fischer**: So that is not a general fund, it from the tax. I think the tax is a couple of biennium's old and that was to be returned to the providers to get it back in directly, in other words of what you're saying. **Brenda Weisz**: The DD, the group that is being taxed, according to federal regulations cannot benefit from that tax. In their rates they do get the money to pay for the tax and then the tax comes back in and then we have to fund a different part of the budget.

Senator Kilzer: In the area of the State Hospital and generator, we had discussed putting back the $160,000 of the $960,000 that was a blue line on the OARS, partially funded. **Brenda Weisz:** The generator is in the budget. The whole thing is in the budget. **Senator Fischer**: So we don't need to deal with it. **Senator Kilzer**: How come it was in blue? **Brenda Weisz**: Because he had other projects in addition to the generator. So it almost like looking a gift horse in the mouth and telling you not to give us the money, but if you still feel like you need to, go ahead. **Senator Kilzer:** Because it was listed as a project at $960,000. **Brenda Weisz**: Your saying fund the whole OAR's correct, is that what you're saying? **Senator Fischer**: Just the one that was partially funded. The three OARS'. **Brenda Weisz**: For the state hospital? Senator Fischer: It was not funded; it was not funded, developmental or capital project. **Brenda Weisz:** So for the state hospital, we submitted in capital projects and we put them on one line. In there is the generator for $1.5 Million, which the Governor's office did include; and then we had a couple of other projects for wiring and JAKO requirements. There were a couple of other projects that was the difference between was in the Governors budget of $1.8 Million and the $1.96. **Senator Fischer**: And that is the $160,000? **Brenda Weisz:** And that's not tied to the generator. It is a little different capital project. Senator Fischer: What was the rest of, for wiring was in there? **Brenda Weisz**: On page 7 of Alex's testimony from the state hospital says that he is replacing the emergency generator for $1.3 Million, testing the fire and smoke dampers for $200,000 and $300,000 for rewiring and updating the electrical equipment in the new Horizons building which is the treatment building. All of that together is the $1.8 Million that the Governor's office has included in our budget on page 7. And then he had another $161,000 of capital projects that weren't included in the Governor's budget but we submitted to OMB as additional capital projects that we wished to have considered. **Senator Kilzer**: So the $160,000 is the other capital projects then on the state hospital grounds? **Brenda Weisz:** Correct. **Senator Kilzer**: Is that all general funds? **Brenda Weisz:** Yes it is.

Senator Fischer: What do we think? **Senator Warner**: What we're talking about is the State Hospital? Is just the Governor's proposal with no additions or deletions? **Senator Fischer**: Why is it partially funded? **Brenda Weisz**: Because we submitted all of our whole capital projects list and with the many priorities that I am sure the Governor's office and OMB has to fund, they picked our top priorities of our request. **Senator Kilzer**: So is the $160,000 in the Governor's budget? **Brenda Weisz**: No, but the generator is. **Senator Warner**: To replace an existing generator. **Brenda Weisz**: It is replacing the emergency generator. Senator Kilzer: I previously did favor the $160,000, but if we're going to put other things in front of it and fund them, then I still favor the $160,000 but I think we have to be careful with that we're changing things around. **Senator Fischer**: We thought the $160,000 was the balance to buy the generator. **Brenda Weisz**: No, it is not. **Senator Kilzer**: The $160,000 is more of a priority to me than the $300,000 of the general funds for nutritional services. **Senator Kilzer**: I would like

to see the details of the way it was, but my priorities, have been switched around by some of the actions. **Brenda Weisz**: It's flooring in some of the various areas of the building to maintain safe environment for the patients. **Senator Warner**: It is an orthopedic issue. **Senator Kilzer**: I think safety comes ahead of supplemental nutrition.

Brenda Weisz: We were just talking about the $161, 840 that was part of OAR request that was not included in the Governor's budget and Lori Laschkewitsch provided that it was flooring for the patient building. **Senator Fischer**: I've got operating costs increased by $109,000 with primary cases, educational supplies, health supplies, office supplies, flooring costs. Are they all in their or just flooring? We don't want to talk about $160,000. **Brenda Weisz**: That is for secured services. This is for traditional. Also includes the forensic work. **Senator Fischer**: On these other costs, are these all in the budget, on page 6? **Brenda Weisz**: Yes, they would be. We would be outlining all the costs that are in the budget in our testimony. **Senator Fischer**: Do you feel funding for another $160,000? **Senator Kilzer:** I think so yes. **Senator Warner**: I would be leading to it. **Senator Erberle**: Either way I was thinking more of leaving it out. Senator Fischer would like to put it in; Senator Erberle agreed with Senator Fischer to leave it in the budget.

Senator Kilzer : Another item is the family services the $4.5 Million decrease in stimulus money because the stimulus money has made kind of anomaly, we've like to go back 2 or 3 biennia and pick it up from there. **Brenda Weisz**: That stimulus money that is in CFF is FMAP. It is not separate stimulus. **Senator Fischer**: The decrease in FMAP is what makes it. **Brenda** Weisz: FMAP affects all parts of the agency not just Medicaid because part of our child welfare money is in FMAP. The only thing that isn't FMAP in child welfare is the separate bill that passed for over $3 Million dollars for the child care quality which wasn't included again for a request. **Senator Kilzer**: Let's go back to before the stimulus and see once what it was, state and federal part of it. **Brenda Weisz:** What the funding was for child welfare was? **Senator Kilzer**: Children and family services area that we see here. Brenda Weisz: You want me to pull information back to '07-'09? **Senator Kilzer**: Start with '07-'09, and pick it up there because the stimulus has made effected what we see on here. **Brenda Weisz:** I think another thing you're going to see though is they are entitled to the inflationary increases that were passed as well. **Senator Kilzer**: We understand there will be inflationary increases in each biennium to the next. **Senator Fischer**: In foster care are the trends increasing or decreasing? **Brenda Weisz:** For this time around, they are increasing. We just gave the monthly increase where it's trending on that attachment. **Senator Warner**: Are there any concerns on your regional experiences, is it increasing in the west, decreasing in the east? **Brenda Weisz:** I will check with Tara. **Senator Erberle:** What decision do we have to make on this one? Senator Fischer: What do we have to have changes in this one? **Senator Kilzer**: Which one is this one? **Senator Fischer**: Children and family services. **Senator Kilzer**: My note on this area was the $4.5 Million decrease in stimulus for the upcoming biennium and for that reason that's why I asked to reach back for. **Brenda Weisz**: None of that was replaced with general funds. It is just one time funding. There is some separate bills that are being introduced for the HB 1418 on quality that requires $6 million, they have some separate bills introduced to deal with child care issues. The one time subsidized employment of that $870,000 was an opportunity to use one time ORA funding of TANIF funds to help with that and was federal funds and that's not available after September 30 either and those weren't replaced at all in either program. **Senator Kilzer:** Is that bill still alive in the House? **Brenda Weisz**: It is a couple of bills. One was heard before this committee, SB 2298, put into resource specialists; a bill on the House

side that is looking to deal with the same situations with the AARA. We will bring that information to you.

Senator Kilzer: There was the large increase in FTE's relating to the Health Care Reform. I don't remember what division that was in, but, it's something that we need to look at again. **Brenda Weisz**: There were seven that were added, one was in child support in an entire biennium; another one was added in economic assistance policies just starting in April 2013, so for the last 3 months of the biennium to train on new policy; remaining five of the seven are in medical services. **Senator Kilzer**: Was that in your overview testimony or if you've already given it to us? **Brenda Weisz:** The Medicaid ones were in Maggie's testimony; and I'll check from my overview testimony. On page 8, Maggie's she outlined her five, my testimony I mentioned all of them, also the FT in my testimony. **Senator Kilzer**: Why do I have it my mind there were seventeen FTE's? **Brenda Weisz:** Because in the OAR list, we had requested 17 in our requests that we brought forth to the Governor on our OAR list. Seven were added of the 17, requested. **Senator Fischer**: Seven were funded? **Brenda Weisz**: Seven were funded. **Senator Fischer**: There is one in there you asked for the rewrite? **Brenda Weisz:** That OAR, yes there was a FTE tied with the rewrite of the eligibility system. **Senator Fischer**: Is the rewrite of that eligibility system is not in the budget? **Brenda Weisz**: The rewrite of the eligibility system was brought forth as an amendment by Representative Keiser, in the IBL committee on the Health Care Reform bill, HB 1126. It's not funded. They will reconcile it on their side. ITD will rewrite it. **Senator Fischer**: We should fund them and have them do it. That has to be done right by a certain date? Are the other seventeen, could those be continuously positions or are they positions you need now**? Brenda Weisz**: Some are slated to begin on July 1, and then some are slated to begin of the seven. The child support one is slated to begin on July 1, and the eligibility policy in Maggie's shop for July 1. The next one would be in Maggie's shop in Oct of 2012, another break until January 2012 for program integrity. January 2013 for two others in Maggie's shop and the last one is April of 2013, the trainer in economic assistance policy to implement or train on the policy changes. **Senator Fischer**: These are in current federal law, are you going to need these? **Brenda Weisz**: Right.

Senator Kilzer: Where do you find these kinds of people that are trained this way and ready to step in and go to work and carry out these things? **Brenda Weisz**: There would be people you will find right here in North Dakota. They would be eligibility policy folks that we do already hire, they would have to come on board and just get up to speed on federal policy, one a nurse, a surveillance utilization review analysts that we currently hire or have on staff right now. A administrative support person we would need; child support attorney, we have economic policy trainers that right now we hire people to train our county people that carry out the eligibility policy, so it's a matter of hiring them and then allowing them to get up to speed on federal policy and department policy and then carry forth and become subject matter experts. **Senator Kilzer**: Would I be qualified to apply? **Brenda Weisz**: Yes, you would. The sheet I handed out looked this one of our very first subcommittee committee. Because the request came as to what it would cost, for the full 24 months, because in the budget not all of them are funded for 24 months and we're coming in at staggered times, if that helps. **Senator Fischer**: We have to decide on funding or unfunded with contingencies. We need to put intent in that as each employee with the dates providing their rules requiring the position from federal law. Senator Warner: I wouldn't have any trouble with that policy. **Senator Fischer**: I would just put a statement in there that if the rules, if there are changes made, that position is not needed that they need not be hiring. In your discussions of CMS have you or is there any indication of

anything else on the rules of the court. But there are being written, have they ceased doing that or are they continuing to work on them? **Brenda Weisz**: They are working 24/7 on those to help in writing them. Senator Fischer: If you have 2400 pages in the law its usually ten times in length. **Senator Kilzer**: If they are working 24/7 are they catching up on some of the deadlines that they've missed then over the last six months or so? **Maggie**: We have not received any guidance specific on any of the Medicaid implementation where we're seeing information come out is about grant opportunities and funding opportunities. But in terms of providing us any information about who, how we determine gross income and what we need in order to move forward with the benefit package and what those increases, we have not seen anything. So it's primarily been about some of the IHAP funding opportunities. **Senator Kilzer:** The secretary in her office are getting further behind on the benefit mandates that we're supposed to be coming, is that correct then? **Maggie**: I don't know if we're getting further behind, I know that is one of the things were working on trying to get our in May or June of 2011; a defined benefit plan. I just know from a normal operation size that things are falling further behind. **Senator Kilzer:** Are there other departments besides Department of Human Services, like IET and others that you're working with in order to not overlap too much on these seventeen/ seven FTE's? **Brenda Weisz:** We are working the ltd, the Insurance Department; they have taken their own course. So we haven't had too much interaction with the insurance but we are working with ITD. The thing about our positions are really specific to the policies that are going to impact us because of the impact on Medicaid and then re-determining child support orders on the requirements of families and the Medicaid coverage that families will need to provide and what we have to prove the coverage for kids in the child support arena. So the work we're having to do will tie specifically to the regulations that will come down through Maggie's area through CMS. They will impact the exchange however it won't impact the work the insurance commissioners FTE's do, directly since we'll be the one carrying out the policy. That's what our FTE's are associated with. **Senator Kilzer**: I would think down the road, that there is going to be quite a bit of overlapping between you and the exchange within the insurance dept. **Carol Olson**: One thing I would like to add to that, is that the first determination will have to be made in regard to the insurance exchange whether or not the insurance department is going to be the location for the insurance exchange because I don't think that the decision has been made. Because our eligibility system can hook on to whomever, if it's the insurance department, non-profit, decision is made for the feds to do it, it doesn't matter for the eligibility system one way or the other who that entity is; if it's one of the three options are only limited as to who/what the decision is and who does the exchange. Once that is decided then that is when the interaction really does start to take place and the decision could be the federal government or a non-profit entity or the insurance department. But, again that decision has yet to be made. Senator Fischer: We should with the employees, is just use that legislative intent, that they hire contingent on federal rule. That way there is latitude enough to hire and at the same time there is some direction. **Senator Kilzer**: That's the way they will do it anyway. **Senator Kilzer:** Vocational Rehabilitation. The question there was on the 11 FTE's. I mentioned one that I thought wouldn't take very much time, but I kind of got out of order in doing it. **Brenda Weisz:** It was one of the last ones, around January 18th right near Alex's testimony, after Tara M. and after Tina Bays' on the DD policy division. **Senator Kilzer**: Was it Russell Cusack? Brenda Weisz: Yes **Senator Erberle**: It doesn't mention new FTE's at all. It just says has eleven of them responsible for the administration of the title program. I just made notes on here Brenda about the rent for the Prairie Hills Plaza and part of that is an increase of $50,000 for rent. Are we needing to rent more space there? Why the increase or do they physically raise that much for a biennium or what is happening?

Brenda Weisz: At Prairie Hills Plaza when we entered into the lease agreement with them, we did negotiate and we worked with OMB, John Boyle up there, and in our lease agreement we do have a 3% operating increase every year for the operating costs of the lease. **Senator Warner**: It's actual but it should not exceed 10%. **Brenda Weisz**: Not for that line. **Senator Warner**: It's a 3% inflator plus, you have separating costs to operate, it is allowed to expand at the rate of inflation but not to exceed 10%, to the bottom line. **Brenda Weisz**: Yes, your right! That's operating! And then we have the standard 3% for the base. So we have two components to it and then when he renovated over at Prairie Hills Plaza which used to be the bowling alley, he was exempt from real estate taxes for a period of time. The exemption expired this year so that is part of the increase is we share in that cost of operating because of the expiration of his real estate tax increase. This was the real estate year where the changes were made. **Senator Warner**: I have an amendment later regarding Senator Erberle's concerns that we reconsider the title.

Senator Fischer: I find the zero FTE; Senator Kilzer: On this chart is 35 for each biennium. **Senator Erberle**: In his first paragraph he mentions his 11 FTE's that are in the report in the title. **Brenda Weisz:** Then on the next page within Vocational Rehabilitation is the disability determination services the work we do for social security and determined disability and that's where the other 24 are to give you the 35 for Vocational Rehabilitation. No increase.

Subcommittee adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
02-17-2011
Job # 14672

☐ Conference Committee

Committee Clerk Signature Alice Dulzer

Explanation or reason for introduction of bill/resolution:

SUBCOMMITTEE HEARING FOR DHS (SEVERAL BILLS WERE DISCUSSED AND ACTION WAS TAKEN BY THE SUBCOMMITTEE CONCERNING THOSE BILLS. They are as follows: 2029,2043,2163,2212,2240,2264,2298,2334,2357.

Minutes:

Senator Fischer, Chairman opened the subcommittee hearing in reference to the Department of Human Services. Senator Kilzer, Senator Erbele, Senator Warner were also present. Lori Laschkewitsch, OMB and Roxanne Woeste, Legislative Council were also present.

Senator Kilzer states he would like to go through the nine "stand alone" bills.

The bills that this subcommittee is assigned are: 2029, 2043, 2163, 2212, 2240, 2264, 2298, 2334, 2357.

Senator Kilzer asks Lori about SB 2029. Is there a $200,000 appropriation in the governor's executive budget for that item?

Lori Laschkewitsch states that in SB 2029, the $200,000 is included in the department's budget.

Senator Kilzer states that this bill is the "youth works expansion" bill. They wanted to double the $200,000 and the $200,000 is in the present biennium and I would like to keep it at that level and not expand it for at least another biennium.

Senator Kilzer state**s, I would vote for the recommendation of DO NOT PASS ON SB 2029.**

Senator Erbele seconds the motion.

Roll call vote is 3 yes and 1 nay.

Senator Kilzer states it will go before the full committee.

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Senator Kilzer states the next bill to be talked about is SB 2043. This bill will provide us with a pilot project system and that is something that has been looked in the past. It is the long term care committee that has brought this bill forward.

Senator Erbele recommends a DO NOT PASS.

Senator Kilzer seconds the motion.

Roll call is 4 yes. It was carried. (SB 2043).

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Meter: 8:50 for SB 2163.

Senator Fischer states that SB 2163 is on traumatic brain injury services.

Senator Kilzer states that traumatic brain injury is a very serious situation but it is a clinical situation. It is not very specific as to the breakdown of training and whether or not there is clinical application of the funds. For those reasons I would recommend a DO NOT PASS.

Senator Erbele seconds the motion on SB 2163.

Senator Fischer states he has a problem with it in DPI.

Roxanne Woeste states that in SB 2163, the only part of the bill that relates to the DPI is section 1 of the bill. Section 2 relates to a new section, Chapter 50, 06.4 and that is the Dept. of Human Services.

Senator Fischer states it is not very clear.

Roxanne Woeste states it is difficult being that the first section of the bill that relates to Century Code that relate to elementary and secondary education.

Senator Fischer calls role. 4-yes. Motioned carried. DO NOT PASS.

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METER: 13:34 ON SB 2212.

Senator Holmberg states that we will now talk about SB 2212.

Senator Kilzer states that this is the one that we had trouble with the definition of "catastrophic". I don't think it was ever resolved. I think it could be a moderately severe injury to an inherited condition. It is very broad. $60, 000 wouldn't scratch the surface in accomplishing what would it be like. **I recommend a DO NOT PASS.**

Senator Warner states that he would like to **resist the motion.** My understanding of "catastrophic" is that it has nothing to do with the disease. It has to do with the financial mechanisms that the family would have. A collision, of a lack of insurance coverage, plus an extraordinarily high cost, that causes a catastrophe, not any particular characteristic of the disease. We have out of great compassion, on occasion, approached these diseases, one at a time. I think we need to be looking for, systematically, taking a more intellectual look at what constitutes the criteria for when the state should intervene and provide coverage. I think the disease, as devastating as it is to an individual, is not the focus of this. It is the collision of the lack of insurance coverage plus the extraordinary costs that are entailed. So I would **resist the motion for a DO NOT PASS.**

Senator Kilzer states that "disease" is the noun and the "catastrophic" is the adjective that modifies it. So it says, "catastrophic diseases". Even if you do shift it over to how it affects the families, you are still going to have to put some "defining limits" and that is not present here.

Senator Fischer asks Roxanne, when this was written, did you have a definition of how you see that sentence structure was intended by the author. She will be here in a little while. It appears **Senator Warner** and **Senator Kilzer**, seem to have a definition issue over "catastrophic diseases" and you say, Senator Warner, when you signed onto this, you felt it was though "catastrophic diseases", such as inherited metabolic diseases, that is a catastrophic disease and that would be the metabolic disease, that would be the ones that were studied.

Senator Warner states that when I signed on, it had to do more with the financial situation of the family. A disease, which could not be covered by insurance, and at the same time, would have a devastating effect on the finances of the family.

Senator Kilzer states that there would be room in the Health Dept. budget, when we get it after "crossover", if we would want to put it in there.

Senator Warner states he would be amenable to that.

Senator Fischer states at least we can address it at that time.

There is a **second by Senator Erbele for a DO NOT PASS.**

Senator Warner states if we fail to pass the bill, it's gone.

Senator Fischer asks about amending the motion. Is it at $60,000 or $30,000?

Roxanne Woeste states that bill, as introduced in Appropriations, is $60,000.

Senator Kilzer states, "No, he does not have an amendment".

Senator Fischer states that we will have to take a vote as DO NOT PASS and leave the money in it.

Roll is called and vote is taken 3/yes and 1/No.

Motion for DO NOT PASS is carried.

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Meter: 20:47 on SB 2247.

Senator Fischer states that SB 2247 was taken care of. That went to the AG dept. and it cleared the floor yesterday afternoon.

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Meter: 21:16 for SB 2240

Senator Kilzer states that there was some question if it was going to be ready.

Senator Fischer states that SB 2240 requires that the DHS to study and develop a plan for restructuring the Human Services Delivery System.

Senator Kilzer states that on his notes Senator Krebsbach was going to have some amendments to lower the appropriation.

Roxanne Woeste states that if I am looking at SB 2240 correctly, the first engrossment, there is no appropriation in the bill. It is strictly is a study requirement. There is a fiscal note attached to the bill but there is currently no appropriation in the bill.

Senator Kilzer states that there was originally for $389,000.

Roxanne Woeste states that SB 2240 does not have an appropriation in the bill. There is a fiscal note attached to the bill of approximately $450,000 and $350,000, which is from the general fund but there is no appropriation in the bill.

Senator Erbele makes a motion for DO NOT PASS.

It is seconded by Senator Kilzer.

Roll call vote is 4/yes. Motion carried.

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SB 2264 Meter 24:00

Senator Kilzer states that SB 2264 would change the eligibility for CHIPS. It is at 160 now I think. This has a price tag of $3 million. I think this belongs in SB 2012 and that is where we should address it and for that reason, I recommend a DO NOT PASS.

Senator Warner states that he would be more comfortable if we passed SB 2012 first.

Senator Warner makes the **motion for a DO NOT PASS on SB 2264.**

Senator Erbele seconds the motion.

Senator Kilzer states that we will have to remember in 2012, about this subject, as we also do in Health Dept. on the previous one.

Roll call vote taken 3/yes and 1/no.

Motion carried.

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Meter 26.06 SB 2298

Senator Fischer states **that Senator Heckamann** asked me to, when we consider this bill, (passes out amendment 11.0313.02001). review this and take the amendment into consideration. They were dropped off at my desk and I did not go over it with Senator Heckamann. Maybe this is a bill we should "hold up on" until we can find Senator Heckamann and she can come down and explain this.

Roxanne Woeste states you may still want to Senator Heckamann to come down but I have written down in my notes that "when Senator Heckamann appeared before the committee, she was concerned that the "engrossed bill" excluded some information about the grant program. Perhaps, it was an inadvertent omission that the bill came out of policies. I am thinking that the amendment does is, puts back into language, that she was concerned that the "engrossed bill" was missing, as it came out of policy.

Senator Kilzer states that he would like to hear from her and the Dept. because it says, "the department shall establish an early childhood services inclusion grant program". So they would have to set up this area.

The question is asked of the committee if they have any specific questions about the "inclusion grant?" I know that Jennifer Berry, our child care administrator, had worked with Senator Heckamann on this earlier, to take a look at both "why this was needed and how it might work". We would anticipate that we would be using some of our contract providers, to assist us in setting up this process.

Senator Kilzer asks if that would affect the fiscal note?

Brenda states that the bill itself has an appropriation and the money they are using is coming from the lands and minerals trust fund. The reason the dept. is named is because we currently work with the vendor that they anticipate would be a possible recipient of the "inclusion grants". We carry out the childcare quality program as it stands today.

Senator Kilzer asks, "Would the vendor have additional fees?"

Brenda asks if that meant, would they have additional fees to pass on to the families?

Senator Kilzer states, "or to you?"

Brenda states, no. What this would do our understanding, is that we would go out on a RFP and then have the money that is included in the bill for the "inclusion support" and for the grant program. Then have people respond to those dollar amounts, that are appropriated to the dept. and have them submit a proposal for the amount that is appropriated to the dept. and then vendor that is most responsive, according to procurement rules, would then be awarded the granting program and the inclusion specialist for the dollar amount appropriated.

Senator Fischer states that the "engrossed bill" shows $750,000 fiscal note.
I believe it is from the land and trust fund appropriation.

Senator Warner states a DO PASS ON THE AMENDMENT.

Senator Erbele seconds the motion.

Roll call vote on amendment 11.0313.02001.

Vote was 4/Yes.

The amendment was carried.

Senator Judy Lee, District 13, states that the reason that program for childcare for kids with special needs was very favorably reviewed, is that, there is an extraordinary challenge for people who want to work and want to continue to work and have to work. Sometimes there are people that are not trained to do it and sometimes there may be some physical adaptation that would be needed. We were particularly looking at things that would train these childcare providers on how to best serve these children. They are being shuffled from one to another, which isn't good for any child, but certainly is not good for one that has some kind of special needs. That was why the committee looked favorably at it and we were trying to be responsible, as well. This is a big deal, actually, to the families with kids that have special needs.

Senator Fischer states to Senator Heckaman that we have already adopted the amendments, if you would like to speak to the bill.

Senator Heckamann states she doesn't know what Madame Chair has already presented but her end of the conversation was exactly what I would have said also. This came about as identification out of the governors' autism task force that I serve on. It was one of the things that we found was a severe need, significant need, in our state, was a lack of child care, if you have a special needs child. Instead of specifically pointing to the autistic children, we went with anyone with special needs. That would include Down's syndrome and any type of developmental delays. Every child is unique. We can have someone, a daycare provider; have one child with Down's syndrome and the next week have a different

child with different needs. That is what these "inclusion specialists" will be working on. They will be people specifically trained to help with any kind of questions that the provider would have. We don't expect these providers to become well trained specialists in child care, as far as special needs children go, we aren't expecting them to know every single disability across the spectrum. We do expect to be able to provide them with some technical assistance. That alone, may be able to have some parents, access the workforce again. Relating to me, some parents have tried to get their children into daycare and have been accepted, and then all of a sudden, have to take them back out. It has been a hardship on some families, because of the fact, that they need the employment and need the health care that is provided as a benefit, from that employment because their child has special needs. We are looking for these "inclusion specialists" basically to help. When we looked at the bill, we had a larger amount of funding and we moved it back down. One of the reasons we moved it back down, is that, we feel that this is important. The amount of money we asked for, we figured you wouldn't think kindly on it, and this is an important program to get started, so we want to work with you, on what you think is a funding amount that could make this work. The support people will be working first. The "inclusion specialists", we will be taking applications, we will be setting up the criteria for accepting day care providers into their service, and then the $300, 000, won't start right away. There is going to be some work to be done, in the background, by the "inclusion specialists" and the program developers, to get that going. We originally started with enough funding for 62 day care providers per year of the biennium. This is now cut down. Our thoughts were about $5000 per grant, to the providers, and that would basically help them fix any accommodations, that they may have. It may also help them add staff, to help with these, and part time staff. Some of these children may be in some other programs too. They may be in part time Headstart or some other program, and not be in daycare full time. Then a service provider may need someone part time to help them with a special needs child. We took some recommendations from people, specialists in the field, and this what we started with. We don't even know if we will need all this right away because we are on the ground level with this program.

Senator Fischer states, "What you are looking at, is specialists that go around to day cares and provide them with information of what they have to do and maybe find some people that are already qualified. You are not talking about, let's use autistic kids, because I dealt with a case some years ago got bumped. This little guy did very well in kindergarten amongst regular kids. When he was put in day care, with other autistic kids, he regressed. So you are suggesting that there may be only one or two at a provider.

Senator Heckamann states that we don't know right now. We are looking at this as a beginning. I know Senator Lee has some comments that she wants to add. This can be any kind of a provider. This could be an in-home provider that only accepts 7 children. If that person and there is a need for childcare in that small community, or in a large community, and they have an in-home facility, adding one child with special needs, is really going to make a difference in their day. If you are an in-home provider, you may have to add a support staff person or you may have to drop down in your count. So I am thinking it would be similar in large facilities. Larger facilities are more difficult for autistic children. Due to my background in special education, that makes a lot of difference. The smaller setting that they could be in, the better off, I think the most of them would be. There are a couple of

special service providers right now for autism. One is in Fargo or West Fargo. They are a day care for autistic children. Every kid is unique. You can't say by putting one autistic child in a large number of kids, is going to be bad. It may be good for that child. However, with another child, it may be bad for that child. So these specialists are trained in helping facilitate what needs to be done in a day care provider's home.

Senator Kilzer states on your governor's commission, you must have recommended this to the governor, to include in his executive budget, but he did not do it. Is that correct?

Senator Heckamann states, that is not correct. We did not make any recommendations, financially or fiscally, on any programs right now. What our focus was on the first year, was to look at what services there are for children on the autism spectrum disorder, and look at what we see as weakness and strengths, in our state. When we got done, we didn't find very many strengths, right now. We do have some specialty services around there for children. Most of our area is focused on weakness. All we have done so far, is look at what we think needs to be done and we presented that plan to the governor. It was not presented to him until July 1. As a result of that, the task force is still going to continue working. This was my own undertaking, to start in this area for day care. Basically, because I have seen a need in my district, for this kind of a service and connecting it to the day care issues, that the task force saw. The task force has many other issues too and we never made any other recommendations to the governor for any funding of anything right now. We just have a "bare bones plan" in place and then we are going to continue to work on that. There may be recommendations in the governor's budget in the next biennium but we did not have time to do that. This is separate from anything from the plan itself.

Senator Kilzer asks Senator Heckamann is this an OAR or not?

Senator Lee states, that is extremely important to make clear, that we are not looking to set up autism or Down 's syndrome child care facilities. All of the people that came in to testify as parents, talked of the fact that they are living in a community where they have been trying to find child care facilities that would be able to accommodate the needs of their kids. It was very challenging for the day care provider to do that. Not only is it important, as you mentioned Senator Fischer, for these children to be involved in a more mainstreamed setting in child care, but also in school. Dr. Ken Fischer, is a real expert in autism services in Fargo, states that the schools should be the focus; we shouldn't be doing everything 40 hours a week, in some separate setting somewhere, is his position. What we are looking at here, is not establishing new child care facilities, not making them specialty service providers but rather, that if I have a child that has Down's Syndrome or some other special needs, and you are a child care provider and you don't know how to communicate with this child, due to this child "signs" but doesn't speak well yet, that there is a way to increase that communication skill. Each one is going to be unique to the kid. This bill is to help the kids that are already there to do, what they can do, even better if they have a family who comes to them for child care. The families that spoke to us, weren't looking for government support for child care, they were able to pay for child care. They were paying privately for child care. That is not even an issue here. They just couldn't get child care for any length of time.

Senator Heckamann states that is very true. We are not looking to start up new facilities any place. We are looking at enabling present day care providers to be able to facilitate one or two additional special needs children into their program. This bill is more specific, such as, if I run a day care and I haven't had any experience with special needs children before, someone brings in a child with MS, and a lot of specific needs for moving, transporting, carrying, feeding, I would need some kind of technical assistance with that. These people, that we are attempting to fund with this program, are not going to have all the answers but they will have a network to find answers to.

Senator Fischer states it has nothing to do with the teacher. I don't think everyone is capable of handling certain situations.

Senator Erbele states that Senator Heckamann indicated earlier that you weren't sure how much money you need, or where it is all going to be spent, but do you have some idea of what the flow of the money is and what it will be spent on, who would get it, what is it used for?

Senator Heckamann states the $450,000,that will be to provide funding across the two years of the biennium, for "4 inclusion specialists", one in each quadrant of the state. I don't know if the quadrants have been delineated yet. A person to work in the NE section, one in the NW and that will be the funding for those people. We are hiring 4 people in developmental disabilities and have background in that. I would guess they would have some credentials and special needs children along the way. We are going from infants to age 12. The $300,000, are grants out to the providers. They could be in the form of assistance in hiring an aide to help them in their service or finding equipment that would work better for the child that the day care provider would not have to provide themselves and the parents wouldn't have to transport back and forth each day. It may be equipment for feeding. We are not expecting this to start on Day 1, when the program starts. We are hoping the 4 specialists could get hired right away and with the depts. help, set up the criteria for accepting applications and get this done in a timely manner. Timely manner depends on other programs and who we can get hired right away. The four "inclusion specialists" would be hired right away. They would develop the plan for accepting applications from day care providers. They would get the word out, that this program is available, and start accepting applications and determine how they are going to accept the facilities and accept the providers. The $300,000 will be used in the next 18 months. We are guessing that about $5000 per provider, either to supplement other staff that they would need, or equipment that they would need.

Senator Erbele asks if they would need 4?

Senator Heckamann states that they are looking at dividing the state into 4 quadrants. I don't know if anyone here would be able to address the other issues, if they went to 3.

Senator Lee states that rather than have this go away entirely; I would like to see us be able to at least get this program launched. I think there is room for 4. I would like to see this possibility exist, even in some small way, so that we can have this "inclusion specialist"

concept available to child care providers, who need it. I would encourage you to consider moving it forward, even if you can't support the amount of funding that came to you.

Senator Fischer states that we have to deal with the money.

Senator Warner states that I am not going to move this quite yet but could I propose $150,000 for 1 person. I think that would cover 2 years of the biennium plus benefits plus a little office space. Would that be open to discussion?

Senator Kilzer states that this would be a new program. The $150,000 would be the "camel's nose". I don't know if there is an academic program or some sort of training program. There is not nearly enough people out there that are trained in this type of day care.

Senator Warner states that my understanding of the American Disabilities Act would consider a differential rate, based upon need, to be a form of discrimination.

Senator Heckamann states we are not in the business of training teachers. If you have a day care and there was 6 children and someone from your community came and asked if they would take a special needs child and think of how a person would react to that? My first response, thinking of people in my community that are day care providers, would say, "I wouldn't know where to start with that child". The 'inclusion specialist' aren't going in there and make teachers out of these day care providers. They are going to come in and they would say, you have a child with MS, that they want daycare for and we will come in and we will bring someone into your home or we will bring examples into your home, how you can help with this specific child. Every child is different so they are treated differently. We would make sure our "inclusion specialist" found out some information, maybe visited with the parents and also brings in suggestions so that they would be more comfortable accepting that child for day care.

Senator Heckamann states that she agrees with Senator Lee's suggestion of "wherever you feel financially, that the minerals and land trust fund can absorb this or accept this." I would be willing to get something going rather than nothing.

Senator Erbele states he is not ready to act on this.

Senator Fischer states he is not ready to act on this and we will put a hold on this for more discussion and thought.

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Meter: 58.21 SB 2334

Senator Kilzer would expand Medicaid coverage for pregnant women from 133% of the federal poverty level up to 160% of the federal poverty level. To further discuss this at the present time, I was told that 31% of the deliveries in ND, are Medicaid. If the threshold was raised up to 160%, I don't know how many more people that would put "in the wagon". It

would be another 10% to 15% of the deliveries. We have a problem already with family physicians and smaller hospitals, not offering services because of increased equipment and on-call coverage that is needed for obstetrics. The malpractice premiums are much higher for a family doctor and for a hospital, who has that service as compared to providers that do not offer that service. I think if we did this, it is a disincentive, particularly reimbursement wise, to offer this service since there is such an increasing number of patients being on Medicaid. We would drive women to other providers and that is not a good thing. In the larger scheme of health care reform, the feds will probably tell us, how to do it anyway. For those reasons, **I recommend a DO NOT PASS.**

Senator Erbele seconds the motion.

Senator Warner asks if a fetus is considered a person, for the purpose of calculating poverty rate?

Maggie states, yes. The mother with no other children and unborn baby would count as two.

Senator Warner states that he would like to resist this on a couple of lines. One of these is that I very firmly believe that life begins at conception and that this is a human life. The instant that this child is born it is eligible for medical coverage. From the providers standpoint and the infants standpoint, that this is sound public policy. I think that this is a good idea.

Senator Fischer states that the lack of hospitals providing care is another issue. The concerns, in that realm, is that the alternative to be able to get to the hospital because they have no insurance. I have a problem with the large fiscal note.

Senator Erbele asks if we have an estimate of what the note could be?

Senator Warner states that it is $4.5 million in general funds and $5.5 in other funds.

Maggie states that for a mom and the unborn child at 133% of poverty is $1615/month and that is net income as well and at 160% of poverty, it would be $1,943/mo.

We have a motion for DO NOT PASS AND A SECOND.

Vote taken: 3/yes and 1/no for a DO NOT PASS.

MOTION CARRIED FOR A DO NOT PASS.

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SB 2152 is not on my list. That is to emergency services.

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Meter: 68:03 SB 2357

Senator J. Lee, District 13, concerning the family impact initiative. It is itemized by program. The healthy families program would just expand to one more district. Right now, it is in Grand Forks area, very successful intervention for families at risk. Intensive, in home family therapy is a program that is handled right now, one of the providers is the "The Village Family Service Center" and they have been doing this since 1986. They have an 80% preventional placement rate for keeping kids out of foster care. What they do is family counseling, crisis intervention and skills developing to the children and their families in the home, to reduce the risk factors that can result in placement outside the home. In-home family therapy would be expanded to the Williston region. There isn't any intensive in-home services available in that region, at this time. They are finding, especially with all the energy and oil development, going on in the western part of the state, there is always been a need for services throughout the state but more critical need to expand that service into that area. This would provide services to that region, Divide, Williams and McKenzie counties. The Family Group Decision Making has been in existence since 2006 and that helps families make critical decisions for a child, that would involve kinship decisions for a child, that would be considered for substitute care, when their biological parents cannot make a decision. We have had 415 people served and they have had an excellent impact there. Family Group Decision Making is more of an intensive program. PATH supports adoption services for kids with special needs. They have been serving families since 1994 and it is designed to support families, whose kids have severe mental health issues that place them at risk of out-of-home residential treatment or hospitalization and in some cases out of state. They have developed a wrap-around team approach that includes mentoring support to the family, the parents by highly trained licensed foster parents, crisis interventions services, and respite care, as needed. Post adoption services expansion is not a large number. A lot of the adoptions that are being done are children with special needs. There have been extraordinary challenges for these families that are adopting kids with special needs. These are not experimental new programs, we have them various parts of the state and it would be fabulous, if we could have them all throughout the state. we knew that wasn't going to work. So I would encourage you to consider, continuation but some small expansions of these programs that have demonstrated great results and I think in the end result in less cost to the state because we are not looking at foster care placement, which never has as good an outcome as something that really helps the family to be able to function well again and it also means we are not looking at residential care for those children who have serious needs.

Senator Warner moved a DO PASS ON SB 2357.

Senator Kilzer states that these programs are expansions of existing programs for the most part. As I understand it, there is money, at least in most of these programs, in the governor's budget. This would be an expansion. And most of these are OARS on our sheets, they are not yellow or blue and for that reason I would move a DO NOT PASS.

Senator Warner Stated I think you have a motion on the floor that is awaiting a second.

Senator Fischer seconds the motion for DO PASS ON SB 2357.

Senator Kilzer asked if there had been a second on the first motion and Senator Fischer said he did second that.

Senator Warner states that most of these programs are initiated in the larger cities in the East. We are seeing that the oil has put some tremendous pressures on societal life in the west.

Roll call vote taken on DO PASS ON SB 2357.

Vote is yea: 2; Nay: 2. MOTION FAILED.

The subcommittee will bring to full committee without committee recommendation.

Senator Kilzer stated that is the last bill he has to bring before the subcommittee.

Senator Fischer said we will take a 10 minute break and come back at 10 after 10:00 on the subcommittee hearing for SB 2012. (Several bills were acted on by this subcommittee in this hearing.)

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
02-17-2011
Job # 14685

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

SUBCOMMITTEE HEARING ON DHS (second hearing starting at 10: 00 am.)

Minutes: See attached testimony.

Chairman Fischer called the subcommittee back to order at 10:25 am. (this is the second subcommittee hearing this morning) Different Bills were discussed and voted on by the subcommittee in the first meeting. This meeting will discuss more fully the appropriations to this Bill. Lori Laschkewitsch, OMB and Roxanne Woeste, Legislative Council were present.

Chairman Fischer: We will deal with SB 2298.

Senator Erbele suggested we leave this up to the entire committee and just move it out without recommendation. **I make this motion. Seconded by Senator Kilzer.**

Chairman Fischer: We have a motion and a second to take 2298 to the full committee without recommendation. Discussion. Call the roll please on 2298. **A ROLL CALL VOTE WAS TAKEN: YEA: 4; NAY: 0; ABSENT: 0. Motion carried. (vote #1) Proposed amendment 11.0313.02001 for SB 2298 was presented but not acted on as the subcommittee voted to take SB 2298 to the full committee without recommendation.**

Chairman Fischer: Now we will move on to the budget in SB 2012. Rather than go through it we should consider the amendments rather than go through the entire budget. if anyone has any they would like to bring forward, I would welcome that at this time.

Senator Warner: On private conversation, both Senator Erbele and myself have been concerned with some of the leases on some of the buildings. And so I did some investigation. I'd like to pass out a workup I did on two of the buildings, one in Health and one In Human Services. I am going to ask Brenda to at least challenge the numbers. These are done as the best I could, but they may not be entirely accurate. What I have done is chosen two buildings: the Gold Seal Building which is rented to the Department of Health (DOH) and Capitol Lanes Plaza, which is rented to the Department of Human Services (DHS) I'd like to compare the two. They're both enormous buildings. There is a difference in square footage. They are about a mile apart in the same market. I want to point out a couple of peculiarity of lease of Capitol Lanes Plaza, it's really become an outlier in our system. It's growing at a much faster rate than

any other building and it's getting very close to the highest square footage costs, clearly the most expensive building we rent but it is also getting close to the highest per square foot cost that we have. The lease on the Gold Seal Building allows for a 4% escalator per year and these are the best I could determine what we've been paying for square foot over the last 2 biennium plus projected costs for the 3rd biennium which actually won't become a real number until April 30th. I understood the negotiation was due by April 30th. There's two peculiarities in the lease, it has a 3% escalator, which sounds like it would be a lesser escalator that would increase at a lower cost but it also allows for a cost of operating. And the initial year, as best I could determine, that was $1.74. The base number is only allowed to escalate by 3% but costs of operation is actual costs, not to exceed 10%, but that doesn't include the taxes. There are actually two leases here, the numbers you see are the blended rate for the square footage and for the totals. One is about 10 times the size of the other but they are combined costs and combined square footage are the 64,164 square feet. The second factor is this building has had two overlapping 5 year property tax exemptions and I wasn't able to determine exactly why there were two separate ones. One expires, I believe this year and the other one in 2013 and the owner is allowed to renegotiate and build those into the operating cost rent. And so that's why this building is escalating in costs so fast. While I certainly invite Brenda, and I know this has caught you off-guard, I don't expect a detailed response, I would hope that you would challenge my numbers and my recommendation, the **Motion I would like to propose is that the Department of Human Services by limited to paying no more than $12.50, which is still in excess of what the Gold Seal Building pays for the coming biennium per square foot.** I had hesitation about whether we had the legitimate authority to do this and my understanding from reading the leases is that in every case these are two year leases subject to legislative appropriation. (Meter 7.25)

Roxanne Woeste: I do believe leases do say "Subject to legislature appropriation".

Senator Warner: The Gold Seal Building is a nice building and it's still a relatively high and this would bring Capitol Plaza more closely to what the market was rather than allowing to be outlier. I think you all received earlier the listing of what we pay in various properties. I only have the one copy with me but I can hand that around. Some office buildings we are paying in the $7.00 per square foot. I did find one clause at ? which is about 190 square foot at about $25.00 a square foot, but that was really an outlier.

Senator Erbele: This Capitol Lanes is that the same as Prairie Hills? He was told yes.

Brenda Weisz, DHS: When we were looking at moving, part of the reason we picked Prairie Hills Plaza is at the time we were moving we had situations and the space we were at and the only space at that time that was available was Capitol Lanes Plaza, which was, the owner was closing the bowling alley and was willing to convert and it was the only space large enough at that time. The Gold Seal Building at that time wasn't available. It was occupied by MDU Resources at that time and they weren't renting out or relocated their offices. They have since built on Century Ave and it freed up space. We also worked with John Boyle, from OMB in negotiating our lease and the cost of our lease and the per square footage was based on his building costs at the time and the renovation of that building. The real estate exemption was his part in what he was granted by the city in renovating that space from what it was to office space. The reason for the two exemptions on the real estate was vast majority of the space was renovated initially and then a second part was renovated later that was what used to be

for all those Bismarck diehards, the Hair Hospital, and then we took over that spa, that is the second real estate exemption he received. The cost for renovating that space was higher at that time, so I believe that rent is a little bit higher for that space and that factors into the higher per square space rental costs for that section and in order to keep the second half of the Department located together as much as possible, we had him renovate that space so we could keep the locations in Bismarck down. We have to do a mail run to all our locations. All the mail comes here and the more you disperse yourself across the city the more mail run and overhead you are going to have with that. We occupy all of Prairie Hills Plaza this time at a higher rate than some agencies were able to get at other office buildings so that's the history of the rate and what we were able to negotiate with John Boyles's help back in 05.

Chairman Fischer: I don't' think we discussed rents or leases since the Northeast Human Service Center.

Senator Warner: Mr. Boyle was very forthcoming in providing me with information.

Chairman Fischer you pay $16.00 per square foot for JPR in Fargo for child support enforcement. I checked it. I knew it before I talked to John.

Senator Warner: Part of it is just the volume discounted on most of these things. It's really pricy, but it is only 190 square feet but this is 64,000 square feet. It is the largest building we rent.

Chairman Fischer: The state owns the Human Service Center in Fargo.

Brenda Weisz: May I ask a question? With the amendment, if that is adopted in limiting the space ,if we are unable to negotiate that or the land lord is not willing to accept that rate then I think what you are telling us is to move?

Chairman Fischer: I defer to Senator Warner to get some intent.

Senator Warner: We are still in the first half of the session. I am sure this will certainly get his attention. It seems it's becoming a real outlier. It's growing in such a fast rate and in two years we have another property tax exemption coming off that he will be allowed to build into the rates. We will see a major bump in another two years. I think that is only on the smaller component on the spa.

Senator Warner I make the motion to move Amendment #11.8152.01001. seconded by Senator Erbele (vote # 2) See attached comparison lease rates for Gold Seal Builidng and capitol Lanes Plaza Testimony attached # A.

Senator Kilzer: These tax breaks for the owner, isn't that known by both parties in negotiating the lease so that is a consideration?

Senator Warner: I believe they were part of the consideration.

Brenda Weisz: Yes, and when we worked with the landlord and Mr. Boyle at the time we knew that and we knew also the situation we were in and the predicament we were in at the

time of the move and the office space that was available for us at the time. And then the decision to be made when we needed the space whether you locate and find a physical location or do you adopt that space that's down there.

Chairman Fischer: Do you and Mr. Boyle when you have a need for space, does he do all the research, then you have some approval? He was told they work with OMB.

Senator Warner: My understanding at the time the Department I was just correlating two things because I went to the tax records. The building was valued at about $1.1 Million before the conversion and it's now about 5.4 after the renovation. In the first case we are paying for this building in about 14 months we paid for the entire building, the cost of buying it or if you consider after the renovation we are paying for the building about every 5 years.

A roll call vote was taken on the Amendment # 11.815.01000. YEA: 4; NAY: 0. Motion carried.

Chairman Fischer: I think most of everything we discussed is that the things that are included in the budget, there are some adjustments, there are things in here if we agree on or not, one is the OAR 301, (Meter 18.06) the SMI Crisis Stabilization Unit, those three, behavioral health issues. Is it the consensus that we all support those? He was told yes. And the Psychiatric Inpatient piece 201. They agreed. And now we get down to Alex. We've had some different discussions on 501 at the State Hospital so we want to clarify that before we act on it.

Senator Erbele: The generator is the original 1.8 we understand that, right? He was told yes.

Senator Kilzer: Couple of things, going back on the yellow inpatient hospital rates, if this goes through the whole legislature that we would expect to see some effect in the state hospital admissions and length of care so we need to put that in the back of our head that we are expecting that as a result of putting in these additional behavioral items to a total of $6.1 million. It's my understanding down on the partially funded ones that the $160,000 difference was for flooring. He was told yes. You are saying, Mr. Chairman, that that is included someplace now?

Senator Fischer: The 1.961 is the generator and flooring. Are there more dollars needed to complete that: It's partially funded. What part is it? You need another $160,000? Not for the generator but for other things.

Alex Schweitzer, Administrator State Hospital: The capital requests for $1.8M, remember that was broke out by $1.5M, $1.3M for the generator, $200,000 for the fire and smoke dampers and $300,000 for the rewiring of the new Horizon building.

Senator Fischer: if we put another $160,000 in this partially funded one then you are whole. He was told yes. Senator Fischer: then it's fully funded?

Alex Schweitzer: Yes as long as it is funded at that $1.8M. As long as it's funded to $1.8M in that particular area, that's what I need.

Senator Erbele: Then what's the 1.9? He was told it is the flooring.

Senator Fischer So the total should be $1,961,840.00 and he funded 1.8 of it. So this is the number then. Do we want to include that? It was agreed. 601 to 605 – I have one for 603 that I would like to propose and I would like to amend that inflator, that's a 3 and 3, and I would like to move that to a 2 and 0.

Brenda Weisz: Within that category there is also long term care provider inflation for that particular category includes home community based services, DD grants, nursing homes and basic care.

Senator Fischer: Roxanne, could you draft an amendment for that section that will break it up?

Roxanne Woeste: We are looking for clarification on what you are looking for. I am sure we can get the numbers calculated to what your request is but I think Brenda's concerned with if you want the 2 and 0 to apply to all of long term care under that OAR or if you wanted to apply it to a particular sector. She was told just nursing facilities.

Senator Kilzer: It's all listed as one item here, what is the figure for long term care; for the breakdown for those 4 different components?

Brenda Weisz: It's on the sheet, colored, when we did the inflation scenarios for you like this we broke it down a little bit differently, the inflation for the nursing homes, for 3 and 3, we have the inflation for DD grant providers broken down and we have inflation for the other long term care providers broken down so we have all three of those listed separately than the OAR, The breakdown will be shown on this sheet. **Testimony attached # B.** So to change the nursing homes to go down from a 3 and 3 down to a 2 and 0 would be a decrease of 5.7M of general fund decrease of 2.557M.

Senator Erbele: 3 and 3 or 2 and 0, does that go to each and every person employed there starting from the administrator on down to the janitors, CNA's or is there a breakout in there.

Brenda Weisz: When we do an inflationary factor we don't factor or wage increase we just take the rates that are paid and inflate the rates by the percentage. They disperse accordingly. They use the right set of rules; we provide the inflationary increase. The difference between , we've worked through some scenarios you had requested, specifically for an increase to the DD provider, a wage increase, and to contrast the two that one would pass through directly in the budgeting guidelines to DD providers if I can contrast the two scenarios so the inflation is provided to the providers and the providers are allowed to take that inflationary factor and apply it to their operations.

Senator Erbele: I don't' have any assurance that my $9.50 worker necessarily gets the 3%? He was told right, that's their discretion. Is there any way of directing the money? He was told there has been legislative intent.

Brenda Weisz: By and large the providers have taken their inflationary increases and given it to their employees. They also have operating costs as well and the inflation is intended for that as well.

Chairman Fischer: Do we have consensus or do we want to vote. **Call the vote on 2 plus 0 for nursing homes. A roll call vote was taken resulting in 1 yea; 3 nay. Motion failed. (vote #3)**

Senator Warner: Could I offer an amendment relative to this line?

Chairman Fischer: The fact - I want to be on record as when rates goes through the ceiling again for nursing homes that I voted against any increase so that they can take the tax payer and pick their pocket once again. Thank-you. (Meter 31.13 through 31.34)

Senator Warner: I have an amendment here # 11.8152.01002. We can discuss it before I pass it out. It will be a pass through raise for DD workers for $.50 cents. I hope you really open some discussion on a past-due raise for the DD workers; I think they are about $.26 cents behind the nursing home employees.

Chairman Fischer: That's about a million dollars a dime, just so you know.

Senator Warner: I mentioned they are about 26 cents behind but I think if we take a tactable position if we send it over at 25cents it will come back as a dime or less.

Senator Warner made the Motion on Amendment 11.8152.01002. Seconded by Senator Erbele.

Senator Kilzer: Are you proposing anything for the other group.

Senator Warner: No. I propose this as a tactful decision for the Senate to propose to the House that they might have other thoughts.

Chairman Fischer: Call the roll on Amendment # 11.8152.01002. A roll call vote was taken. Yea: 4. Motion passed. (Meter 34.25) (vote #4)

Senator Warner: Will this be brought before the full committee on Monday?

Senator Holmberg: The amendments will be done over the weekend. If it's possible, Roxanne, could they be emailed to the subcommittee members so they could see them?

Roxanne Woeste: Yes, I can do that.

Senator Holmberg: How far along are you on the bill itself? Are you wrapping soon?

Senator Fischer: I lost. The people lost.

Senator Holmberg: You put up a noble fight. And the record does show what you said.

Senator Erbele: If you want to consider anything else, I don't have amendments but on the long term care, if you want to consider something besides 3 and 3.

Chairman Fischer: it's fully funded in here.

Senator Erbele: On the 3 and 3. Would you like to consider something other, 2 and 2, 3 and 1, 4 and 0?

Chairman Fischer: comments on not having the carry over cost regarding the 2 and 2.

Senator Warner: My understanding, 4.545 works for DD workers. But it's actually $400,000 more because of the way the nursing homes bill and the way the rates are structured they actually would get a bump of about $400,000 by doing a 4.545. I suspect 4.5 might be closer. I would be open to front loading the system but I don't know what the right number is.

Chairman Fischer: then it should be considered for both DD and the other ones.

Senator Erbele: There would be no way to make that an inequitable number for both.

Senator Holmberg: Is it not possible to direct the Council to work with those folks to come up to the numbers that you are willing to spend in the area to see how it works. I'm not exactly sure but that's how we did it with the state employees compensation or have done it. You've got the experts here.

Senator Warner: Could I ask a question of Brenda? Are we actually appropriating a percentage or dollars? The percentage will just follow the dollars regardless.

Brenda Weisz: We appropriate the percentage in language but it is the dollars that go out. So it's the dollars that go out.

Chairman Fischer: This is all based on 3 and 3. Another percentage and she can come up with a number.

Brenda Weisz: We could do our best to back into a number and then it would modify the percentage a bit. If your concern is going to the inflation on the first year only, and because it results in a little bit higher number for the nursing homes, to change that percentage for the nursing homes so that it's more flat and consistent with all the others, all the others are a smaller decrease, we'd have to back into it and it would play with the percentage a little bit and then come up with the number. The percentage itself wouldn't be quite the same but the intent would be the same. (Meter 39.05)

Senator Erbele: I'd like to see the number with 2 and 2 but front loading it. Moved a motion for 2 and 2 frontload it. Senator Kilzer second. It was verbally approved by all four members of the subcommittee. (vote #5)

Chairman Fischer: In other words take 2 and 2 but frontload it.

Brenda Weisz: 2 and 2 but frontload it like you did with the 4.545. We'll work on that.

Chairman Fischer: Get an amendment ready and we can finish on Monday with that. Then the entire bill would be done.

Senator Holmberg: So you would have the opportunity to look at them and maybe Monday afternoon the full committee could react to them because you still have another day before it gets up to the floor. And all these bills are rolled over so whoever carries it gets to carry the amendment and then the Bill.

Chairman Fischer: We've got an expert to carry it.

Brenda Weisz: So I'll do a 2 and 2 and front load it so we're just giving a whatever and 0, whatever that 2 and 2 calculates out to be and then never mind about the what a 3 and 3 frontloaded coverts out to be to equalize it. Just skip that.

Senator Kilzer: We already know that a 3 and 3 that is frontloaded is 4.545.

Brenda Weisz: I was just clarifying for the nursing homes because they get a little bit of a bump we were talking about bringing that down so that they wouldn't get quite the 4.545 the nursing homes.

Senator Warner: The number works for DD providers but not the nursing homes. They actually get a $400,000 bump with that number. They get more money because of the way they structure their billing. Senator Erbele, would you be interested in a 3 plus 3, which would direct some of the money towards salaries specifically as we did similar to DD workers? It would still be the 3 plus 3 but it will guarantee the salary bump to long term nursing home workers.

Senator Erbele: Are you asking if I want to consider a different rate? Or dealing with the 2 and 2 with my motion but still put it with intent language would go to the lower tier worker? Or a higher percentage would anyway?

Senator Warner: Either scenario. I think if we were going to do that we should just put more money in than a 2 and 2 because that's actually less than normal inflation. I only raise the issue as a thought.

Roxanne Woeste: I would like to clarify a few things with you. Would you like the amendment drafted with the new 2 and 2 front loaded or do you want to discuss that separately? Do you want it included in your amendment? I am going to start working on your amendment for the big bill and maybe I should start from another direction. The other day, I jotted down a few things that I felt the subcommittee had come to a consensus with so I would like to go through those right now to make sure if you'd want them included in your amendment.

1. To remove $10,000 from general fund for the silver haired assembly.
2. State hospital extraordinary repairs, you want to fully fund that OAR.
3 Add a section of legislative intent relating to the health care reform positions that they should be contingent upon the Department receiving federal rules.

Chairman Fischer: Yes, rule or what other direction from the federal government. I guess the only thing that I was wondering if the need time between their notification and the date that may be in the rule that they have to have people on board. I know that's Maggie's thing. They will give you plenty of time if you already have the people lined up already. Define benefits?

Roxanne Woeste: That's legislative intent section so once we get that amendment drafted if we'd like to tweak that language that's a pretty simple change. Then I have, continuing on with my list:

4. The lease office space leases that you adopted this morning
5. Salary increase for DD providers.

So right now that's my list so I was just wondering in regards to the most current conversation you were having regarding inflationary factors, would you like me to incorporate, once I can get that information from the Department, the 2 and 2 front loaded, do you want me to incorporate that into this big set or do you want me to keep that separate so you guys can discuss that separately?

Senator Warner: Keep it separate.

Chairman Fischer: Anything else? Thank you we are adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2298
02-17-2011 (later hearing)
Job # 14685 (Meter .00 to .53)

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

Early childhood provider grants. (Subcommittee hearing for 2012)

Minutes: See attached testimony."

Chairman Fischer called the subcommittee back to order at 10:25 am. (this is the second subcommittee hearing this morning) Different Bills were discussed and voted on by the subcommittee in the first meeting. This meeting will discuss more fully the appropriations to this Bill. Lori Laschkewitsch, OMB and Roxanne Woeste, Legislative Council were present.

Chairman Fischer: We will deal with SB 2298.

Senator Erbele suggested we leave this up to the entire committee and just move it out without recommendation. **I make this motion. Seconded by Senator Kilzer.**

Chairman Fischer: We have a motion and a second to take 2298 to the full committee without recommendation. Discussion. Call the roll please on 2298. **A ROLL CALL VOTE WAS TAKEN: YEA: 4; NAY: 0; ABSENT: 0. Motion carried. (vote #1) Proposed amendment 11.0313.02001 for SB 2298 was presented but not acted on as the subcommittee voted to take SB 2298 to the full committee without recommendation.**

Chairman Fischer then went on to discuss the budget in SB 2012.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012 subcommittee
February 18, 2011
14724 & 14753

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

This is a subcommittee meeting on the Department of Human Services budget – concerning related bills

Minutes: See attached testimony # Q,R,S,T and U.

Chairman Fischer called the subcommittee hearing to order.
Subcommittee members **Senators Kilzer, Erbele and Warner** were present.
Roxanne Woeste – Legislative Council

Senator Fischer brought up SB 2163 and said there was additional information that was being brought forward.

Senator Warner said that **Senator Robinson** has an amendment for SB 2163 that removes all appropriated money except for $110,000. It specifically directs that money to go towards a case worker to serve the eastern part of the state. It is amendment # 11.0335.02001 and he didn't know if it was more appropriate to amend during subcommittee or amend during the main committee when **Senator Robinson** has a more ample opportunity to explain the purpose, intent and need of the amendment.

Senator Kilzer said that they had already passed SB 2163 out of subcommittee but it will be coming to the full committee. He has no objection to the full committee taking consideration of this amendment.

Senator Warner said he was going to ask for a reconsideration because he would like to see SB 2163 come to the full committee without recommendation rather than a do not pass.

Vote 1
Senator Warner moved to reconsider the action of the subcommittee.
Senator Erbele seconded.

A Roll Call vote was taken. Yea: 4 Nay: 0 Absent: 0

Senator Kilzer said he has no problem explaining both fiscal notes because that's really what this is, is a fiscal note to the committee and let them have as much evidence as possible in putting together each person's vote.

Vote 2
Senator Warner moved that SB 2163 be returned from the subcommittee to the main committee without committee recommendation.
Senator Erbele seconded.

A Roll Call vote was taken. Yea: 4 Nay: 0 Absent: 0

2264 – CHIPs bill –

Senator Fischer asked information of Roxanne Woeste.

Roxanne Woeste said the subcommittee recommended do not pass on SB 2264 and right now this is not included in SB 2012. Eligibility remains at 160% of poverty level.

Senator Warner: And 2264 would have moved it to 200%. Is that correct? Yes, engrossed SB 2264 goes to 200%.

Senator Kilzer: The fiscal note of January 19, 2011 is still the correct one? Answer – yes.

Senator Fischer asked **Brenda Weisz** if they had ever given other options of funding.

Brenda Weisz said they did 185% net and that would add 673 children. The general fund for that would be $873,000 general fund and federal fund of $1,949,507. That is the grant cost. It wasn't proposed in the bill, just a scenario that had been requested.

Senator Erbele asked if they had a 175% number and Brenda said they had not run that number.

Senator Fischer asked if they could present other levels. They will get them.

Senator Fischer asked how many kids at 160% of poverty level are eligible and Senator Kilzer said his notes show a figure of 937 children eligible, but he didn't know if that was the new children that would be eligible from 160% to 200% - and that's probably what it is.

Senator Erbele is not opposed to seeing a little increase, but he's more comfortable with 175% than 185%.

Senator Warner asked if they should put it into SB 2264 or SB 2012.

Senator Fischer said he preferred they put it in SB 2012 because it is safer there and they have a better chance of bargaining.

Vote 3
Senator Kilzer moved 175% of poverty level and put into 2012.
Senator Warner seconded.

A Roll Call vote was taken. Yea: 4 Nay: 0 Absent: 0
Motion carried.

Senator Erbele asked for numbers from Brenda on QSPs at $.50 an hour increase.

Brenda Weisz handed out information on inflation increases.
Testimony attached - # Q - $.50/hr increase
Testimony attached - # R, S & T - Provider Inflation charts

They will recess until after floor session today.
Reopened hearing at 3:00

Brenda Weisz gave new information-
Testimony attached - # U - Cost to Increase Healthy Steps Eligibility From 160% to 175% Net of Federal Poverty Level.

The subcommittee continued discussion on SB 2264 and said it will go into SB 2012.

They discussed going through the amendments one at a time and **Senator Fischer** said it would be discussed as a whole. The amendment will be all as one piece. We will just refer to different pages, lines or policies.

Senator Erbele asked if someone wanted to change something, they'd have to make an amendment to pull out a specific line.

Senator Kilzer said there are still two chances for amendments; one would be in front of the whole appropriation committee and the other would be a floor amendment during the session.

Vote 4
Senator Warner moved Do Pass as Amended on SB 2012
Senator Kilzer seconded.

A Roll Call vote was taken. Yea: 4 Nay: 0 Absent: 0

Senator Fischer closed the subcommittee hearing.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
01-25-2011
Job # 13373 (Meter 14.51-20.49)

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A DISCUSSION ON THE DEPARTMENT OF HUMAN SERVICES (Several bills were discussed on this Job: 2001, 2002, 2003, 2004, 2005, 2009, **2012,** 2013, 2018, 2020

Minutes: You may make reference to "attached testimony."

Chairman Holmberg: SB 2012 DHS In addition to salary issue, there is the one new program, 6 plus million that the committee needs to look at carefully. And also there will be discussion about that issue of money staying in their budget and a few other budgets rather than going back to general fund, like it has in the past. There are two ways to do it. One way is as OMB did, which takes fewer words. The other way to do it is to do roughly what we did last time, we have language that puts the money back in to the general fund, increasing the requirements for the Budget Stabilization Fund by $1.2M but at the same time having language in there to show the feds that we clearly are not putting any of this money into the rainy day fund. There's two routes to go in that direction. The majority leader leans toward the latter rather than the former on putting all of this funding back into the general fund and counting it as general fund money.

Senator Kilzer: Talking about the Director of Human Services, she is quite strong on the $6.1M for inpatient psychiatric care that she requested and was not in the executive budget, I asked her about how did they get along, because they didn't have it funded last time and it's not in the budget this time; well, they scrambled and at times some of the inpatient facilities were not paid their full price. Anyway, that's still up in the air. there is some breakdown, as I recall it's about $3.4M of pretty hard funds that they're seeking so maybe we can come to some sort of agreement. As you recall last time, we did fully fund the 8 human service centers and I think some of shortfall was made up by stealing from Peter to pay Paul a little bit. Maybe Senator Fischer has some other comments, but that was my take.

Senator Fischer I agree. We are a long way from being done with discussion on those issues as well as nursing homes and DD. They're asking for substantial increases and by the time we are done, we will discuss them and maybe not fund all they want. One of the problems they've had is that hospitals are no longer accepting, they're cutting back beds. The fact of the matter is that they are losing money taking indigents off of the street that the police are required to do; they have to take them there as a matter of liability, so we need to discuss how much of that

there is compared to how much they just want to start another program and get more involved in some of the other issues.

Chairman Holmberg: There will be more issues from Human Services committee I am sure will go to your subcommittee for your consideration.

Senator Kilzer: We do have a whole list of OAR's and you can tell, when they start with the number 403, you know that there's a lot of them there.

Chairman Holmberg: We've got to pass these bills today. But that should be the last big dump that we get, then we'll get them coming in from committees. But if you look at some of the committees, they don't have that many bills. We haven't got a final count yet, do we? The House was down 102 or 103 bills from last session.

Senator Christmann: I looked at noon, they were down about 60.

Chairman Holmberg: We passed one bill out of this committee already.

Discussion closed on SB 2012. (Meter 14.51-20.49)

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
02-21-2011
Job # 14780

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A ROLL CALL VOTE FOR A DO PASS AS AMENDED RE: DEPARTMENT OF HUMAN SERVICES

Minutes: See attached testimony.

Chairman Holmberg called the committee to order in reference to SB 2012. Roxanne Woeste, Legislative Council and Lori Laschkewitsch, OMB were also present.

Senator Fischer asked Roxanne Woeste to explain the amendment.

Roxanne Woeste: I am going to start on page 4 of Amendment # 11.8152.01007 under the Statement of Purpose of Amendment. Top of the page under the division for DHS management division the only change made to that division is we added a section of legislative intent to the bill relating to office space leases and that section provides that the department may not expend more than $12.50 per square foot per year for leasing office space in the Prairie Hills Plaza in Bismarck for the 1113 biennium. Go to the next page, DHS-Management –Senate Action so we added a section regarding their office space leases capping how much they can spend per square foot.

The next changes are in the program and policy sections. Under Medical Services Program, this amendment adds funding to increase eligibility for the State Childrens' Health Insurance program for 160% of the federal poverty level to 175% of the federal poverty level.

Senator Fischer: It comes from the Human Services Committee and it does away with SB 2264 at 200% we put it in the budget at 175%.

Roxanne Woeste: The next change is under long term care. We added funding for supplemental payment to the developmental disabilities providers to allow for a 50 cent salary and benefit increase for their employees.

Under aging services program this amendment removes funding that was added in the executive budget for a grant for the Silver Haired Legislative Assembly of $10,000 in the general fund.

Continuing on page 5, the last change under Program and policy, this amendment adds a section of legislative intent that provides that the 7 new FTE positions that have been included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Finally under the State Hospital, this amendment adds funding of $161,840 from the general fund for some additional extraordinary repairs that had been requested by the state hospital. There is a slight typo there, the lead in there says add funding for extraordinary repairs to provide a total of, it should be just be $1,961,840, not $11M. That is the amendment. (Meter 5.06)

Chairman Holmberg: Discussion amongst committee members on these amendments.

Senator Fischer: There is one other thing and we can ask Carol or Brenda. Several people talked to me about this IMD demo, and if we go forward with that demo, that would not be expended if the grant was not awarded, and if the grant was awarded for 3 years that would make certain facilities Medicaid eligible including the State Hospital. Brenda said no. So then it would only be for Stoddard.

Carol Olson, Executive Director of DHS: The two facilities that would be eligible would be Prairie St. John in Fargo and Stoddard in Grand Forks.

Senator Warner: This is a pilot project. The intent of the Congress was to assemble some data, I should speak more to the primary sponsor which is Senator Snow at the federal level. Her concern was we didn't want to go whole hog and reverse a major pattern of social policy which has gone on for a long period of time in which the federal government has refused to take over the state's obligation for taking care of the mentally ill through the State Hospital system so this is opening the door to experimentation to allow for some data gathering to try to come up with some cost projections and do a responsible job of making that transition. I think the intent is if the 5 pilot projects at the federal level make it look as though this is a worthy project, if it was cost effective to do it by funding through Medicaid, perhaps after the 3 year experimentation period, then they would recommend going to the state hospital system as well. That would have to be offered to all the state hospitals in all of the states in order to be fair, not as a pilot project. These are little experimental pilot projects, 5 of them nationally. The money we are being asked to appropriate is contingent, it's only expended if the grant is received. We have a little better than 1 in 10 chance of getting it. We have a very progressive mental health community in ND and I think they will be very aggressive at seeking this grant. It is a good worthy idea.

Senator Fischer: who writes the grant? He was told DHS does. But it's an OAR # 703, and I have the emails to prove it.

Chairman Holmberg: We should adopt this amendment first and then further amend. Discussion on the amendment #.1007.

Senator Fischer moved the amend # .1007. Seconded by Senator Kilzer.

Senator Christmann: It sounded like a large increase and I have some concerns about that but I will support the amendment. I don't know if I support all the changes.

A roll call vote was taken on amendment # .1007. Yea: 13. Motion carried.

Chairman Holmberg: Now Senator Warner has an amendment.

Senator Warner presented Amendment #.1005 which would address the issue of federal grant for institutions of mental disease demonstration grant.

Senator Warner moved the amendment #.1005. Seconded by Senator O'Connell.

Roxanne Woeste: This amendment would appropriate, if you look on the bottom of page 2, this amendment adds funding of approximately $2.6M, which approximately $1.1M from the general fund for the DHS for an IMD demo grant, it's a competitive grant from the federal government that's being made available to states under the federal health care reform.

Chairman Holmberg: The state will put in a little less than half, and then match a federal grant. What are our obligations if we accept this money down the road?

Maggie Anderson, DHS It is a 3 year demonstration grant, it's competitive and at this point I am not aware of any future obligations. Of course, any part of a demonstration is providing reports to the federal government to determine whether the purposes of the demonstration are being met so we would fully expect to have reporting requirements through-out the life of the demonstration during the 3 year period.

Senator Fischer: I was under the impression this was further reaching and I thought it included the state hospital. What I would suggest doing if this amendment is accepted is sunset it in 3 years. The feds could come back and say we owe them, but we would go on record as sun-setting when the demo is over and then we can take the sunset off. I have my doubts about getting additional funding for this. I am not sure how I feel about it now because the hospital is not included.

Senator Warner: I understood it was only for the private hospitals. The state hospital might come later after the 3rd year. As far as the sunset, I have no problem with that.

Chairman Holmberg: Is your motion to pass 1005 and a second and having Roxanne Woeste adding a sunset? He was told that would be fine with him.

Roxanne Woeste: the amendment appropriates dollars for a two year period so in itself is a sunset, I could add a section of legislative intent would state something to the effect that the department would seek funding for this competitive grant and they could only do it for the two year period. I guess I am not clear how you would like the sunset to work. It's not like we are adding new sections of the Century Code that in essence we could sunset after a period of time.

Chairman Holmberg: So what you are saying this is a natural sunset by the way it is presented. By the end of July 2013 it is gone unless we do something proactively in the 2013 session.

Roxanne Woeste: We could add legislative intent, however the committee wishes.

Senator Wanzek: What kind of demonstration project are we looking to fund?

Maggie Anderson: Currently the Medicaid regulations and statute prohibits us from paying institutions that are called institutions for mental disease. They are institutions that have 16 or more beds and their primary purpose is to serve individuals with a mental illness. So we are prohibited from making Medicaid payments to those individuals in those institutions. This demonstration would open that up and say for this 3 year period of time we are going to allow Medicaid to make payments in those institutions so that's why you see in the request that there are both general funds and federal dollars because it is not totally federally funded.

Senator Wanzek: Could you give me an example of a facility?

Maggie Anderson: Prairie St John in Fargo is an institution for mental disease and so individuals who are between the ages of 21 and 64 we cannot make any Medicaid payments for those individuals while they are in the facility. There is an exception for kids under 21 but that's really not part of this. The 21 to 64 year old group, we currently do not pay them even if they are Medicaid eligible when come in the door. This demonstration would allow that payment to kick in.

Senator Christmann: If the federal health care program is not funded, do we still spend our share of this money if we pass this, and secondly Is this a new idea or was it looked at when the governor was preparing his budget and declined?

Maggie Anderson: If the federal government did not fund the demonstration then none of the federal or state dollars would be spent. And this was an optional adjustment request that was submitted with the department's budget request and it was not funded in the governor's budget. (Meter 18.51)

Senator Warner: When my daughter was two she was run over by a truck and she was in the emergency room. The only other person in the emergency room was a psychiatric patient. And I have to tell you a two year old who's been run over by a truck and her mother are a piece of cake to handle next to a psychiatric patient in an emergency room in a conventional hospital. It took 4 or 5 or 6 times the resources of that hospital to handle that patient, to restrain him and to deal with his issues and my daughter is just fine. I think we need to recognize that psychiatric patients in conventional hospitals really tie up the resources of that hospital. It's marginally cheaper to handle them through institutes of mental disease and something on the order of $100 to $200 a day cheaper to handle them through institutions that are specialized in that kind of care rather than a general hospital where you need ex-rays and all kinds of high technology which is not applicable to the treatment of mental disease, which is mostly pharmaceutical and talk therapy. It would be much more cost effective to divert these people to institutions in which they are actually prepared to treat the diseases at the core of the problem rather than just the symptoms.

V. Chair Bowman: Where does the money go if the grant is allocated, who actually gets the money? The two different places that treat these people or the people themselves?

Maggie Anderson: If we got the grant the dollars would be paid to the institutions for mental disease so to Prairie St John and Richard P. Stoddard, the two IMD's we have in ND. It would be made on behalf of Medicaid eligible clients, 21 to 64 years of age who are in those facilities and it would be based on their per diem, the amount we pay them per day for each day that a Medicaid client is in their facility for the services actually received.

Chairman Holmberg: Now we have to resolve whether or not we are having a sunset clause on this bill. Roxanne has mentioned it will sunset in two years If it's gone in two years, it's gone unless we take action in 2013. I don't think that's a policy question. What do we accomplish?

Roxanne: I guess it is the decision of the committee how you feel, it is a 3 year grant, assuming ND applied for the grant, ND received the grant, we would need funding for a 3 year period,. That would be a decision before the 2013 legislative assembly and how much of that you'd continue and I don't' know if we'd run into federal problems if we got to the 2013 legislative assembly and we were working on that budget and said no we are not going to fund that portion. If the department was awarded the grant they would be required to fund it for those 3 years.

Chairman Holmberg: We can't bind that session, 2013.

Maggie Anderson: Typically with these grants, of course, the solicitation for the grant has not been issued yet so operating with a lot of un-knows, but typically something that is multi-year-ed we can express a reason why we were not able to fulfill, it was not the desire not to go forward, we would probably need to provide reasons for that but we won't be obligated to fill all three years of the grant.

Senator Fischer: If this were to be implemented at the federal government, what kind of savings would there be for the state?

Maggie Anderson: Today these facilities do not receive any Medicaid payments. Not necessarily state savings, it's that these facilities such as Prairie St. John and Richard P. Stoddard are caring for these individuals today, and I can't speak for them as to whether all of those payments, if they are receiving them or if it turns into uncompensated care.

Senator Fischer: if it were fully implemented and they picked up the state hospitals that would be quite a savings.

Maggie Anderson: If the demonstration went beyond what was in the health care reform law, certainly, there would be savings at the state hospital but the law the way it was written specifically excludes publically owned institutions for mental. **Senator Fischer:** Your feelings of that are slim or non? **Maggie:** I certainly know there have been discussions about

amendments to the current health care reform law but expanding the IMD demonstration is not one I have heard.

V. Chair Grindberg: On intent and sunset recognizing this is a competitive grant if it's awarded I am not so concerned it carries in to 13, what about 15 or 2017. Is this the intent with the folks that are working on this, this is a one-time deal or potentially is it 4 years from now when we are back here? I understand the sunset, this is going to overlap, what about 4 years from now?

Roxanne Woeste: I would guess it depends on the results on what the feds get from their reports from the 5 states, depending on their outcomes the federal government would have to decide if they want to expand or to continue, discontinue, depending on their decisions would result in what the state would have to do. I think we are at the mercy of deciding what the federal government wants to do with this particular demonstration. Right now, it looks like they are awarding 5 states a demonstration grant.

V. Chair Grindberg: At the risk of going into micro-management do we have the authority to dictate the grant application that it is the intent of the 62nd legislative assembly that if upon conclusion of a report and recommendations the federal government funded?

Chairman Holmberg: Any other comments. How do you want this resolved so that Roxanne can do exactly what the committee wants and we want to know exactly what we are voting on.

Senator Fischer: The uncertainty of this concerns me and I won't support it for that reason. The odds are too long.

Chairman Holmberg: You are not supporting the sunset or the amendment? **Senator Fischer:** the amendment. **Chairman Holmberg:** Let's vote on the amendment. Call the roll on the amend .1005. It was seconded by Senator O'Connell.

A roll call vote was taken on the amendment .1005. Yea: 4; Nay: 8; Absent: 1. The motion failed. (Meter 30.37)

Chairman Holmberg: Four to 8 with one going to vote later. So 4 yes, 8 no, so that amendment was not attached. Could we have a motion on the bill?

Senator Warner moved a DO PASS AS AMENDED ON SB 2012. Seconded by Senator Kilzer.

Senator Christmann: Not withstanding the amendment we put on that would add some general fund, I think whether we talk about dollars or percentages, we need to be fair to the department, and recognize the change in the FMAP percentage. It is something that happened and the fact that we used stimulus money last time for a big chunk of it but now it needs to be replaced with general fund, the percentages will look big here and we need to keep that in mind. But what I had laid out With FMAP, that $171M taken out, aside from that, ongoing general fund increase is about $106M or 16.4%. Now if salaries are going up 3 and 3, and that nursing home reimbursement is on the order of 3 and 3, DV providers, this amendment alters that a little bit, I don't understand where are the areas where we are going up by significantly

more than 3 and 3% or 6% for the two years. I look at the bill and some categories, the Southeast Human Service Center from a $30M base, an increase of $8.3M and the Northeast, a $25M base, and an increase of only $2.4, that doesn't really mean much to me because I don't know what exactly they are doing. Before I can vote on this, I need something more in the areas outside of FMAP where we are going to spend the money.

Chairman Holmberg: Roxanne is looking up some information. A question I would ask that is also what Senator Christmann is getting at is the equity money that came into the department last time, particularly in small agencies, this is a large agency, but I don't know how much of that increase was. The equity money and I know we can get that.

Roxanne Woeste: Major general fund increases in the DHS budget, aside from that 171 in FMAP, the 3 and 3 inflationary providers, that alone is $25.5M of general fund dollars.

Senator Christmann: That is for DD and nursing homes?

Roxanne Woeste: The 3 and 3, this is for everyone. Medical services program, long term care, providers at the Human Service Centers, Department wide, all those eligible for the inflator increase of 3 and 3 is $25.5M from the general fund.

Chairman Holmberg: Do you have the equity dollar amounts?

Roxanne Woeste: I don't think the equity in this particular agency really skews that; there is $24.4M of net cost changes relating to their grant programs and I believe that just relates to changes relating to rate setting rules, federal mandates, and cost to continue the second year increase from the previous biennium. There is $21.6M of a net increase relating to caseload and utilization changes in Medicaid and long term care.

Senator Christmann: What change we added, more people qualified, did we change the qualifications?

Roxanne Woeste: That would be when they put together their budget request they look at current case loads, utilization rates, depending on the program. For example under Medicaid I think they look at to see what kind of services are being reimbursed, and then they try to build their budget based on those historical rates, so they want to make sure they are budgeting to the most current case load and utilization rates.

Senator Christmann: In this $21.6M we covered the nursing homes, the DD's with the 25.5 this is the case load of who? What kind of case load is this?

Roxanne Woeste: It could be in the Medicaid program, dentist positions, inpatient – outpatient hospital, also TANIF, it would include all the department's programs.

Senator Christmann: What would happen if we chose not to increase it by $21.6 but some percentage lesser than that, would it run out at a certain time in the biennium? Or would that lower the reimbursements or lower the qualifications? What would happen if they are short?

Roxanne Woeste: The department would monitor their expenses through-out the biennium to see how they are providing expenditures. If they are short of funds, they could appear before the legislature for deficiency appropriation. In the past the appropriation bills for the department has provided authority for the department to seek a line of credit at the BND if they do see their case load and utilization rates being higher than we had budgeted or appropriated so they could be able to make their payments to their providers and then the legislative assembly would need to take care of that loan.

V. Chair Bowman: All the different programs we have in this budget take care of so many people. Are we seeing a huge influx of people on these programs? As our state seems to be doing better financially, is the number of people getting eligible for a program growing or are we growing the department to take care of what people we have. I think that is imperative that we know that. If we've got 5,000 people or 10,000 people two years ago, why do we have such a huge increase? As an example, we know it takes more money to fund these programs, how many people are we taking care of and all these programs compared to our last budget.

Senator Wardner: I do have a question. I've got the **Kilzer charts. Testimony attached # 1**. Two of the areas that have huge increases are medical services, $160M and long term care, $100M. Those are the two big ones on the sheet. I'll turn it over to Senator Fischer, he's the one that ordered this thing and Senator Kilzer asked for it. It's a subcommittee thing that I happened to pick up. On this sheet it tells you where the big increases are and from what I can tell it's from utilization.

Chairman Holmberg: We don't have that sheet, maybe the sheet will answer the questions.

V. Chair Bowman: All I wanted to know is the number of people. If the number of people is the same then where is the money going and why is it going up so fast?

Senator Kilzer: This sheet it goes up through the executive budget, bit I was going to have a new one after we had acted on it. The big increases from the last session, particularly in the areas that were mentioned, medical services and long term care, a lot of that comes from re-basing and we did that last time. That accounts for a goodly part of it but I am sure the 5 and 5 that we issued previously also has a lot to do with it. I don't think the utilization, or the numbers. You know the numbers of people in nursing homes or the number of people receiving medical services, I don't think that has changed an awful lot, I think it is price for service.(Meter 44.26)

Roxanne Woeste: I am working with the department on trying to put together some caseload information. It's not quite ready yet but it would address some of Senator Bowman's concerns and I would be happy to share it with the committee once it's available. The dept doesn't have one number we can share with you, because there are caseloads for all the different programs. I am trying to put together something so hopefully it will be available soon.

Carol Olson: I don't have specific numbers, like Roxanne Woeste said, when you look at the growth in the department, Senator Bowman, you did ask are we growing the department, the answer to that is no we are not growing the department. We have a number of challenges that affect our budget. One is the inflation to providers, the current biennium, we got 6 and 6%, and that goes to all providers across the board from your hospitals to your doctors, to your

pharmacists, to your nursing homes, everybody that provides a service so that certainly helped this next current biennium, the 1113, we are going with 3 and 3, that will affect our budget, of course you have the salaries, but that's relatively small when you look at our over-all budget when you figure our budget is made up of 62% Medicaid, health care, inpatient-outpatient, physician services, pharmacy. We are a health care provider. We are dealing, now adays, because the marvels of medical science we are dealing with situations where those individuals who come to us have more challenging, not only medical conditions but behavioral conditions as well, which challenges us to offer treatment and services that are a lot more complex then they have been in the past so the services that we do provide are much more challenging and complicated and costly. So if you really look at the growth in our budget it's in the area of nursing homes, the aging, and the developmentally disabled, we are looking at the growth in Medicaid because that is health care and that is where the growth is coming. You all have seen the FMAP challenges that we face what we have coming and when you are done taking action on our bill, I do have a handout that I would like to give you from Senator Grindberg's request. **Testimony attached # 2.** It is self explanatory as to where we have come in the last 4 or 5 decades in human service world but you can see where everything has crept along over the last decades. We are getting much more sophisticated in our treatment of folks who are challenged both medically, mentally and behaviorally and it costs money to do that. Just so Senator Christmann understand that Medicaid is an entitlement program, meaning that we can't turn anybody away, as far as utilization and caseload we don't' have controls over that. they come, we serve, that's just the way it is.

Chairman Holmberg: Any questions of Carol. Thank-you. We have a motion.

Senator Christmann: I had asked about $106M worth of general fund things and Roxanne had laid out about 70, are there some more big ones that I should know?

Roxanne Woeste: There is approximately $16.2M included in the executive budget that's replacing some funding sources that were in the 2009-11 biennium legislative appropriation that are no longer available so we need to replace those with general funds dollars. They're related to stimulus money relating to Child Support Incentives Funds, BND loan, a health care trust fund dollars and some use of the community health trust fund.

Senator Christmann Are those mandatory things?

Roxanne Woeste: They are not mandatory. They were funding sources that were used for the 2009-11 biennium and their just no longer available for 11-13. There is approximately $14.3M included relating to the governor's salary and benefit compensation package for the department's employees. There is approximately $6.9M for an increase in Medicare Part D for claw-back payment and there's approximately $6.1M to address behavioral health needs at the human service centers. That is the large items at this time.

Chairman Holmberg: Before this bill is carried on the floor I am assuming that we will have an updated color coded chart which will help because for example, the one passed out does have, relating to the governor's recommendations, the various percentage changes that occurred in this particular budget and they go all the way from 4%, 4.6% up to 26%. Any other questions on the bill?

Senator Robinson: We've had good discussion. I appreciate the data we have. We did pass out a resolution last week trying to get a handle on increased case loads, and Carol did a good job describing a number of things that are out of their control, aging population is certainly a part of that, with the discussion we had on the floor in the Senate with the strong economy, low unemployment, and yet we have increased case-loads. I think we all know some of the reasons, but it's important that we have a better understanding and I hope the resolution is approved by the House, and approved by the legislative management committee because I do think it's important and there are things we can do policy wise to shape that.

Senator Christmann: Outside of that FMAP we are looking at a 16% increase. In order to fairly evaluate it you can completely look at it as completely outside of the FMAP because I suppose since the feds are broke, they will alter their formula so that we pay more, so we have to draw a line here. I don't think our tax payers can continue to sustain over the long term 15 to 20% increases in our largest budget. I am not a good enough expert to say how we draw the line on it, but if we don't want to be the next Wisconsin, we are going to have to. And the answer is not always going to be available, we'll just take the oil money, imagine the level of human service support we would need to be dishing out if that prosperity weren't there for at least a good number of our citizens and I am not talking about severely disabled, at least we don't have a big unemployment problem with healthy people. Imagine if we had that on top of the problems we have but there has to be a way to get this under control and have less increase in this.

Chairman Holmberg: Would you call the roll on a DO PASS AS AMENDED ON 2012?

A ROLL CALL VOTE WAS TAKEN ON A DO PASS AS AMENDED ON 2012: YEA: 11; NAY: 2; ABSENT: 0. Senator Kilzer will carry the bill. It won't be up tomorrow.

Carol Olson: Thank you very much. It was a pleasure working with the subcommittee, very cordial and very professional. You made it very pleasant to work with you and provide the information that you requested on a daily basis and the department appreciates that. it makes it much easier to get the job done. I appreciate the full committee's support of the budget. I know there are increases, it is a difficult decision. She talked about the handout that Senator Grindberg had requested (#2) and stated that Senator Christmann is right, we do have the challenge of where the federal government is going to go in the future with these entitlement programs. As far as the FMAP is concerned the percentage that we pay can only go to 50%, it can't go any lower, and of course the FMAP is decided upon what our individual income is in ND and because it has been going up over the years, that's what determines what the federal government will pay the state, and it can't go below 50%. With that, the feds will be looking, I am sure to figure out some other ways, and we will be looking at that and try to figure out how to manage with additional flexibility, more flexibility from the federal government, that's the only thing I can see that is going to help us in the future. Thank-you. .

Chairman Holmberg: Thankyou,Senator Grindberg for asking them to put together this information. The hearing on SB 2012 was closed.

Prepared by the Legislative Council staff for
Senator Heckaman
February 11, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2298

Page 1, line 10, after the underscored period insert "The department shall establish an early childhood services inclusion grant program for licensed early childhood services providers that provide care for children with disabilities or developmental delays. The grant program must be designed to:

a. Increase the number of staff in the adult-to-child ratio to expand supervision and the ability to care for children with disabilities or developmental delays; and

b. Assist in modifying or adapting the early childhood services setting as needed to address the health and safety needs of children with disabilities or developmental delays.

2."

Page 2, line 9, replace "2." with "3."

Page 2, line 18, replace "3." with "4."

Page 2, line 27, replace "4." with "5."

Page 2, line 29, replace "5." with "6."

Page 3, line 7, replace "6." with "7."

Renumber accordingly

Date: 2-17-11
Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2298

Senate Subcommittee for 2012 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number (11.0313.02001 - not acted on)

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Erbele Seconded By Kilzer.

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer			Lindhey	✓	
Senator Fischer			Erbele	✓	
Senator Krebsbach			Kilzer	✓	
Senator Erbele			Warner	✓	
Senator Wanzek					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

the intent is to take this back to full committee without recommendation.

Date: 2-17-11
Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2298

Senate Senate Subcommittee (2012) Committee

☐ Check here for Conference Committee take it to full committee

Legislative Council Amendment Number 11.0313.02001

Action Taken: ☑ Do Pass ☐ Do Not Pass ☐ Amended ☑ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Warner Seconded By Sen Erbele

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner			Fischer	✓	
Senator Kilzer			Erbele	✓	
Senator Fischer			Kilzer	✓	
Senator Krebsbach			Warner	✓	
Senator Erbele					
Senator Wanzek					

Total (Yes) 4 No 0

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

11.8152.01001
Title.

Prepared by the Legislative Council staff for
Senator Warner
January 27, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2012

Page 4, after line 7, insert:

"**SECTION 6. OFFICE SPACE LEASE LIMITATION.** The department of human services may not expend more than twelve dollars and fifty cents per square foot per year for leasing office space in the prairie hills plaza in Bismarck for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

Date: 2-17-11
Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate DHS SubCommittee Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8152.01001

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Warner Seconded By Erbele

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer			Erbele	✓	
Senator Krebsbach			Kilzer	✓	
Senator Erbele			Warner	✓	
Senator Wanzek			Fischer	✓	

Total (Yes) 4 No 0

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Regarding Lease payments,

Passed

Date: 2-17-11
Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate DHS Subcommittee (Sen. Approp.) Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 2+0 – (inflationary) wage increase for nursing facilities

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Fischer Seconded By _____

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer			Erbele		✓
Senator Fischer			Kilzer		✓
Senator Krebsbach			Warner		✓
Senator Erbele			Fischer	Y	
Senator Wanzek					

Total (Yes) 1 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

amendment failed

11.8152.01002
Title.
Fiscal No.1

Prepared by the Legislative Council staff for
Senator Warner
February 1, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2012

Page 2, replace lines 4 through 7 with:

"Grants - Medical assistance	1,300,642,323	318,777,327	1,619,419,650
Total all funds	$1,870,492,778	$377,139,483	$2,247,632,261
Less estimated income	1,381,801,240	131,851,180	1,513,652,420
Total general fund	$488,691,538	$245,288,303	$733,979,841"

Page 2, replace lines 29 through 31 with:

"Grand total general fund	$646,349,516	$283,524,890	$929,874,406
Grand total special funds	1,549,066,932	137,765,602	1,686,832,534
Grand total all funds	$2,195,416,448	$421,290,492	$2,616,706,940"

Page 4, after line 7, insert:

"**SECTION 6. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES PROVIDER SALARY AND BENEFIT INCREASES.** The funding appropriated in subdivision 2 of section 1 of this Act includes $5,682,032, of which $2,510,748 is from the general fund and $3,171,284 is from federal funds, for providing supplemental payments to developmental disabilities providers to allow for a salary and benefit increase for employees beginning July 1, 2011."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Senate Action

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
DHS - Program/Policy			
Total all funds	$2,241,950,229	$5,682,032	$2,247,632,261
Less estimated income	1,510,481,136	3,171,284	1,513,652,420
General fund	$731,469,093	$2,510,748	$733,979,841
DHS - State Hospital			
Total all funds	$73,473,200	$0	$73,473,200
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$0	$53,326,797
DHS - Developmental Center			
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
DHS - Northwest HSC			
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
DHS - North Central HSC			
Total all funds	$22,433,884	$0	$22,433,884

Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC			
Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
DHS - Northeast HSC			
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
DHS - Southeast HSC			
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
DHS - South Central HSC			
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
DHS - West Central HSC			
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
DHS - Badlands HSC			
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
Bill total			
Total all funds	$2,611,024,908	$5,682,032	$2,616,706,940
Less estimated income	1,683,661,250	3,171,284	1,686,832,534
General fund	$927,363,658	$2,510,748	$929,874,406

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037		487,016,037
Grants - Medical assistance	1,613,737,618	5,682,032	1,619,419,650
Total all funds	$2,241,950,229	$5,682,032	$2,247,632,261
Less estimated income	1,510,481,136	3,171,284	1,513,652,420
General fund	$731,469,093	$2,510,748	$733,979,841
FTE	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of Senate Changes

	Add Funding for a Supplemental Payment to DD Providers[1]	Total Senate Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	5,682,032	5,682,032
Total all funds	$5,682,032	$5,682,032
Less estimated income	3,171,284	3,171,284

General fund	$2,510,748	$2,510,748
FTE	0.00	0.00

[1] This amendment adds funding of $5,682,032, of which $2,510,748 is from the general fund and $3,171,284 is from federal funds, for a supplemental payment to developmental disabilities providers to allow for a 50 cent salary and benefit increase for employees beginning July 1, 2011.

Date: 2-17-11
Roll Call Vote # 4

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate D/S Subcommittee Committee

☐ Check here for Conference Committee H. 8152. 01002

Legislative Council Amendment Number Senate to propose to House 50¢ wage increase

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Warner Seconded By Erbele

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer			Erbele	✓	
Senator Krebsbach			Kilzer	✓	
Senator Erbele			Warner	✓	
Senator Wanzek			Fischer	✓	

Total (Yes) 4 No 0

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

passed

Date: 2-17-11
Roll Call Vote # 5

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate DHS Subcommittee Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 2+2 (frontloaded) 4% (4.545)

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Erbele Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer			Erbele		
Senator Krebsbach			Kilzer		
Senator Erbele			Warner		
Senator Wanzek			Fischer		
			Verbally Approved		

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Unanimous vote

Date: 2-18-11
Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2163

Senate Senate Appropriations DHS Subcommittee Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☒ Reconsider SB 2163

Motion Made By Warner Seconded By Erbele

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer			Erbele	✓	
Senator Krebsbach			Warner	✓	
Senator Erbele			Kilzer	✓	
Senator Wanzek			Fischer	✓	

Total (Yes) 4 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-18-11
Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate Senate Appropriations DHS sub. Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment SB 2163

☐ Rerefer to Appropriations ☐ Reconsider w/o Com. rec.

Motion Made By Warner Seconded By Erbele

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer					
Senator Krebsbach					
Senator Erbele			Erbele	✓	
Senator Wanzek			Kilzer	✓	
			Warner	✓	
			Fischer	✓	

Total (Yes) 4 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion carried

Date: 2-18-11
Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2264 DHS sub.

Senate Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 175% of poverty a puts in 2012

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Kilzer Seconded By Warner

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer					
Senator Krebsbach			Erbele	✓	
Senator Erbele			Fischer	✓	
Senator Wanzek			Warner	✓	
			Kilzer	✓	

Total (Yes) 4 No 0

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 2-18-11
Roll Call Vote # 4

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate Senate Appropriations Human Services Subcommittee Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

passage of SB 2012

Motion Made By Warner Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg			Senator Warner		
Senator Bowman			Senator O'Connell		
Senator Grindberg			Senator Robinson		
Senator Christmann					
Senator Wardner					
Senator Kilzer					
Senator Fischer					
Senator Krebsbach			Erbele	✓	
Senator Erbele			Kilzer	✓	
Senator Wanzek			Warner	✓	
			Fischer	✓	

Total (Yes) 4 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

11.8152.01007
Title.
Fiscal No. 5

Prepared by the Legislative Council staff for
Senator Fischer
February 21, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2012

Page 1, line 2, remove "and"

Page 1, line 2, after "exemption" insert "; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program"

Page 1, replace line 24 with:

"Salaries and wages	$41,389,716	$8,956,495	$50,346,211"

Page 2, replace lines 3 through 7 with:

"Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	326,293,701	1,626,936,024
Total all funds	$1,870,492,778	$384,645,857	$2,255,138,635
Less estimated income	1,381,801,240	136,289,446	1,518,090,686
Total general fund	$488,691,538	$248,356,411	$737,047,949"

Page 2, replace line 20 with:

"State hospital	65,641,609	7,993,431	73,635,040"

Page 2, replace line 22 with:

"Total all funds	$264,143,530	$26,033,115	$290,176,645"

Page 2, replace line 24 with:

"Total general fund	$131,355,655	$33,179,288	$164,534,943"

Page 2, replace lines 29 through 31 with:

"Grand total general fund	$646,349,516	$286,754,838	$933,104,354
Grand total special funds	1,549,066,932	142,203,868	1,691,270,800
Grand total all funds	$2,195,416,448	$428,958,706	$2,624,375,154"

Page 3, replace lines 12 and 13 with:

"State hospital capital projects		0	1,961,840
Total all funds		$92,329,503	$2,481,015"

Page 3, replace line 15 with:

"Total general fund		$4,296,298	$1,961,840"

(4) Prescription medications;

(5) Preventive screening services;

(6) Preventive dental and vision services; and

(7) Prenatal services; and

e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Senate Action

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
DHS - Program/Policy			
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
DHS - State Hospital			
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
DHS - Developmental Center			
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
DHS - Northwest HSC			
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
DHS - North Central HSC			
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC			
Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
DHS - Northeast HSC			
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
DHS - Southeast HSC			
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
DHS - South Central HSC			
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
DHS - West Central HSC			
Total all funds	$26,740,493	$0	$26,740,493

Legislative Assembly

Children and Family Services Program	
No changes	0
Mental Health and Substance Abuse Program	
No changes	0
Developmental Disabilities Council	
No changes	0
Developmental Disabilities Division	
No changes	0
Vocational Rehabilitation	
No changes	0

Total Senate changes - Program and Policy	0.00	$5,578,856	$7,609,550	$13,188,406
Senate version - Program and policy subdivision	374.50	$737,047,949	$1,518,090,686	$2,255,138,635

Other changes affecting program and policy programs:

Adds a section of legislative intent that the 7 new FTE positions included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Senate Bill No. 2012 - DHS - State Hospital - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51

1

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	467.51	$53,326,797	$20,146,403	$73,473,200
State Hospital - Senate changes:				
Add funding for extraordinary repairs to provide a total of $1,961,840 from the general fund		$161,840	$0	$161,840
Total Senate changes - State Hospital	0.00	$161,840	$0	$161,840
Senate version - State Hospital	467.51	$53,488,637	$20,146,403	$73,635,040

Date: 2-21-11
Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8152.01007

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Fischer Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Warner	✓	
Senator Bowman	✓		Senator O'Connell	✓	
Senator Grindberg	✓		Senator Robinson	✓	
Senator Christmann	✓				
Senator Wardner	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Prepared by the Legislative Council

February 18, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2012

Page 2, replace lines 4 through 7 with:

"Grants - Medical assistance	1,300,642,323	315,675,757	1,616,318,080
Total all funds	$1,870,492,778	$374,037,913	$2,244,530,691
Less estimated income	1,381,801,240	130,120,052	1,511,921,292
Total general fund	$488,691,538	$243,917,861	$732,609,399"

Page 2, replace lines 29 through 31 with:

"Grand total general fund	$646,349,516	$282,154,448	$928,503,964
Grand total special funds	1,549,066,932	136,034,474	1,685,101,406
Grand total all funds	$2,195,416,448	$418,188,922	$2,613,605,370"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Senate Action

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
DHS - Program/Policy			
Total all funds	$2,241,950,229	$2,580,462	$2,244,530,691
Less estimated income	1,510,481,136	1,440,156	1,511,921,292
General fund	$731,469,093	$1,140,306	$732,609,399
DHS - State Hospital			
Total all funds	$73,473,200	$0	$73,473,200
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$0	$53,326,797
DHS - Developmental Center			
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
DHS - Northwest HSC			
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
DHS - North Central HSC			
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC			
Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041

General fund	$6,882,190	$0	$6,882,190
DHS - Northeast HSC			
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
DHS - Southeast HSC			
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
DHS - South Central HSC			
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
DHS - West Central HSC			
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
DHS - Badlands HSC			
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
Bill total			
Total all funds	$2,611,024,908	$2,580,462	$2,613,605,370
Less estimated income	1,683,661,250	1,440,156	1,685,101,406
General fund	$927,363,658	$1,140,306	$928,503,964

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037		487,016,037
Grants - Medical assistance	1,613,737,618	2,580,462	1,616,318,080
Total all funds	$2,241,950,229	$2,580,462	$2,244,530,691
Less estimated income	1,510,481,136	1,440,156	1,511,921,292
General fund	$731,469,093	$1,140,306	$732,609,399
FTE	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of Senate Changes

	Adds Funding for an IMD Demo Grant[1]	Total Senate Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	2,580,462	2,580,462
Total all funds	$2,580,462	$2,580,462
Less estimated income	1,440,156	1,440,156
General fund	$1,140,306	$1,140,306
FTE	0.00	0.00

[1] This amendment adds funding for a competitive institution for mental disease demonstration grant available through federal health care reform.

Date: 2-21-11
Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8152.01005 IMD Demo grants

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Warner Seconded By O'Connell

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg		✓	Senator Warner	✓	
Senator Bowman		✓	Senator O'Connell		
Senator Grindberg		✓	Senator Robinson	✓	
Senator Christmann		✓			
Senator Wardner		✓			
Senator Kilzer		✓			
Senator Fischer		✓			
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek		✓			

Total (Yes) 4 No 8

Absent 1

Floor Assignment

If the vote is on an amendment, briefly indicate intent: failed

O'Connell

Date: 2-21-11
Roll Call Vote # 3

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number on SB 2012

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Warner Seconded By Kilzer

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Warner	✓	
Senator Bowman	✓		Senator O'Connell		✓
Senator Grindberg	✓		Senator Robinson	✓	
Senator Christmann		✓			
Senator Wardner	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 11 No 2

Absent 0

Floor Assignment Kilzer

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2012: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). SB 2012 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "and"

Page 1, line 2, after "exemption" insert "; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program"

Page 1, replace line 24 with:

"Salaries and wages	$41,389,716	$8,956,495	$50,346,211"

Page 2, replace lines 3 through 7 with:

"Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	326,293,701	1,626,936,024
Total all funds	$1,870,492,778	$384,645,857	$2,255,138,635
Less estimated income	1,381,801,240	136,289,446	1,518,090,686
Total general fund	$488,691,538	$248,356,411	$737,047,949"

Page 2, replace line 20 with:

"State hospital	65,641,609	7,993,431	73,635,040"

Page 2, replace line 22 with:

"Total all funds	$264,143,530	$26,033,115	$290,176,645"

Page 2, replace line 24 with:

"Total general fund	$131,355,655	$33,179,288	$164,534,943"

Page 2, replace lines 29 through 31 with:

"Grand total general fund	$646,349,516	$286,754,838	$933,104,354
Grand total special funds	1,549,066,932	142,203,868	1,691,270,800
Grand total all funds	$2,195,416,448	$428,958,706	$2,624,375,154"

Page 3, replace lines 12 and 13 with:

"State hospital capital projects	0	1,961,840
Total all funds	$92,329,503	$2,481,015"

Page 3, replace line 15 with:

"Total general fund	$4,296,298	$1,961,840"

Page 4, after line 7, insert:

"**SECTION 6. OFFICE SPACE LEASE LIMITATION.** The department of human services may not expend more than twelve dollars and fifty cents per square foot per year for leasing office space in the prairie hills plaza in Bismarck for the biennium beginning July 1, 2011, and ending June 30, 2013.

SECTION 7. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES SERVICE PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $11,364,049, of which $5,021,489 is from the general fund and $6,342,560 is from federal funds, for providing supplemental payments to developmental disabilities service providers to allow for a salary and benefit increase for employees beginning July 1, 2011.

SECTION 8. LEGISLATIVE INTENT - FULL-TIME EQUIVALENT POSITIONS. It is the intent of the sixty-second legislative assembly that the department of human services only fill the seven new full-time equivalent positions authorized by the legislative assembly for the 2011-13 biennium relating to implementing federal health care reform after receiving applicable rules from the federal department of health and human services.

SECTION 9. AMENDMENT. Section 50-29-04 of the North Dakota Century Code is amended and reenacted as follows:

50-29-04. Plan requirements.

The plan:

1. Must be provided through private contracts with insurance carriers;
2. Must allow conversion to another health insurance policy;
3. Must be based on an actuarial equivalent of a benchmark plan;
4. Must incorporate every state-required waiver approved by the federal government;
5. Must include community-based eligibility outreach services; and
6. Must provide:
   a. A net income eligibility limit of one hundred ~~sixty~~seventy-five percent of the poverty line;
   b. A copayment requirement for each pharmaceutical prescription and for each emergency room visit;
   c. A deductible for each inpatient hospital visit;
   d. Coverage for:
      (1) Inpatient hospital, medical, and surgical services;
      (2) Outpatient hospital and medical services;
      (3) Psychiatric and substance abuse services;
      (4) Prescription medications;
      (5) Preventive screening services;
      (6) Preventive dental and vision services; and

(7) Prenatal services; and

e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Senate Action

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
DHS - Program/Policy			
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
DHS - State Hospital			
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
DHS - Developmental Center			
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
DHS - Northwest HSC			
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
DHS - North Central HSC			
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC			
Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
DHS - Northeast HSC			
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
DHS - Southeast HSC			
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
DHS - South Central HSC			
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152

General fund	$9,343,547	$0	$9,343,547
DHS - West Central HSC			
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
DHS - Badlands HSC			
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
Bill total			
Total all funds	$2,611,024,908	$13,350,246	$2,624,375,154
Less estimated income	1,683,661,250	7,609,550	1,691,270,800
General fund	$927,363,658	$5,740,696	$933,104,354

Senate Bill No. 2012 - DHS - Management - Senate Action

Other changes affecting management programs or multiple programs of the department:
A section of legislative intent is added regarding office space leases.

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50

1

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	374.50	$731,469,093	$1,510,481,136	$2,241,950,229
Program and Policy - Senate changes:				
Economic Assistance Policy Program				
No changes			$0	
Child Support Program				
No changes			0	
Medical Services				

Program Add funding relating to increase in eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		567,367	1,266,990	1,834,357
Long-Term Care Program Add funding for a supplemental payment to developmental disabilities providers to allow for a 50-cent salary and benefit increase for employees beginning July 1, 2011		5,021,489	6,342,560	11,364,049
Aging Services Program Remove funding added in the executive budget for a grant to the Silver Haired Legislative Assembly		(10,000)	0	(10,000)
Children and Family Services Program No changes			0	
Mental Health and Substance Abuse Program No changes			0	
Developmental Disabilities Council No changes			0	
Developmental Disabilities Division No changes			0	
Vocational Rehabilitation No changes			0	
Total Senate changes - Program and Policy	0.00	$5,578,856	$7,609,550	$13,188,406
Senate version - Program and policy subdivision	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
Other changes affecting program and policy				

programs:
Adds a section of legislative intent that the 7 new FTE positions included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Senate Bill No. 2012 - DHS - State Hospital - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51

1

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	467.51	$53,326,797	$20,146,403	$73,473,200
State Hospital - Senate changes:				
Add funding for extraordinary repairs to provide a total of $1,961,840 from the general fund		$161,840	$0	$161,840
Total Senate changes - State Hospital	0.00	$161,840	$0	$161,840
Senate version - State Hospital	467.51	$53,488,637	$20,146,403	$73,635,040

2011 HOUSE APPROPRIATIONS

SB 2012

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Committee
Roughrider Room, State Capitol

SB 2012
3/2/11
14861

☐ Conference Committee

Committee Clerk Signature Meredith Trachtt

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; and relating to eligibility for the children's health insurance program.

Minutes: You may make reference to "attached testimony."

Chairman Delzer: We'll start SB 2012.

Carol Olson, Executive Director, North Dakota Department of Human Services: See attachment 1. I would like to leave you with a few thoughts before I end my prepared remarks. The Department of Human Services is a payer of health care providers. Medicaid is healthcare. It is an entitlement program. If they come, we serve. 62% of our budget is Medicaid. 63% of our general fund increase is a result of the decrease in the FMAP.

Chairman Delzer: On the MMIS, are you going to run a parallel system for awhile?

Olson: We are still running the legacy system, as we have been up until now, and we will continue to run it right now. June 1, 2012, would be the go live date, when we would run the new MMIS system. We will do months of testing before we do go live, so that when we go live we feel that we are ready to do so. We will not be running the legacy system as we go live.

Chairman Delzer: You'll only do a one month test?

Olson: No, it will be a six month test before June 1.

Chairman Delzer: So they should be in here before the end of 2011 with the finished program.

Olson: We're hoping that's the way it goes.

Chairman Delzer: I have a question about your testimony, page 3, and what you are saying about beds not being Medicaid eligible. If the PPACA (Patient Protection and

Affordable Care Act) goes forward, and in 2014 we go to 150%, of those 4900 cases you are talking about, how many would fit into that, do you know?

Olson: I'm not sure, we have a number of different levels of eligibility.

Maggie Anderson, Department of Human Services: Some of those 4900 beds mentioned in Olson's testimony will qualify with the expansion. Adults have different eligibility levels, but we will need to go to 133% plus a 5% disregard, so essentially 138% of poverty. This will be an expansion of some of the groups today, as well as the addition of a whole new group, often called the childless adults, those who have no children. If they are not otherwise disabled, they are not eligible for Medicaid today, and they would become eligible under the expansion in PPACA.

Chairman Delzer: How many of these 4900, do you have any kind of guess?

Anderson: I don't have that at this time. We continue to work on the details of the expansion.

Chairman Delzer: The date is January 1, 2014?

Anderson: Correct.

Chairman Delzer: Questions by the committee?

Representative Williams: I'm concerned with the increase in general fund, even though I understand it. Is this FMAP money going to continue to shrink?

Olson: It's a possibility it could continue to go down, but by federal law it cannot go lower than 50%. Right now we're basing our budget on 55.40%. Should the per capita personal income rise, the federal participation rate could go down another 5.4%.

Representative Williams: What is the highest we've gotten, since its inception?

Olson: I believe in 1997, when I came over to the department, we were somewhere around 70%. We've been over 70% federal, leaving 30% for the state.

Chairman Delzer: The highest I remember is 73%.

Representative Kaldor: On page 2, the cost in caseload increases, since the FMAP percentage is going down since our per capita income is going up, what's driving that caseload increase? I see nursing home care is one factor, are there others?

Olson: Healthcare costs. The increase in nursing homes account for about $5.6 million, $12.2 million is in the traditional Medicaid grants. That's where your basic health care costs are going up, your inpatient and outpatient care. Going to the doctor today costs more than two, four years ago. Your prescription medications cost you more, and there are new, more expensive medications on the market. Everything costs more.

Chairman Delzer: Further questions? Thank you.

Deb McDermott, Assistant Director of Finance, North Dakota Department of Human Services: I am here today to present testimony on behalf of Brenda Weisz, see attachment 2.

Chairman Delzer: The Senate didn't change that (the unexpended $12.8 million, page 2), make you turn it back and give you general funds for that?

McDermott: No, they left it the way it was. Testimony resumed on page 2.

Chairman Delzer: Did the Senate leave those seven FTEs in there (page 5)?

McDermott: Yes they did. There is language, which I'll discuss later, that we are not to fill those positions unless health care reform passes.

Representative Skarphol: How do you get seven FTEs with $200,000?

McDermott: This is the general fund share.

Chairman Delzer: Is it for the full biennium, or just part?

McDermott: Those positions are phased in. I will go into more detail later in the testimony. Testimony resumed on page 5.

Chairman Delzer: Where were the bond payments at (page 6)?

McDermott: At the Developmental Center, and I believe there are some at the state hospital that were still remaining, also.

Chairman Delzer: They are all done now?

McDermott: Yes. Testimony resumed on page 6.

Chairman Delzer: How many patients do you currently have at the Developmental Center?

McDermott: 107, but we anticipate being at 95 by June 30, 2011.

Representative Skarphol: How many vacant FTE positions do you have, and what is your turnover rate?

McDermott: I don't have that information down here.

Olson: Our turnover rate in 2010 was 11.45%; I don't know our vacancy rate.

Representative Skarphol: How does that turnover rate compare to previous years?

Olson: We're pretty stable. We have our hard to fill positions, like addiction counselors, psychologists, psychiatrists, and some nurse positions, so those can remain on the books for quite some time. Normally we're pretty good.

McDermott: Resumed testimony on page 7.

Chairman Delzer: On the DD, the $.50 per hour, what is the 3 and 3 equal to?

McDermott: I will have to get that information.

Chairman Delzer: And the fifty cents, does that also do the 33 or 37% for benefits?

McDermott: No, it is just fifty cents.

Chairman Delzer: It's just fifty cents and nothing for benefits.

McDermott: The only thing included within that is the 8% FICA share, but nothing else related to benefits. Testimony resumed on attachment D, and concluded.

Chairman Delzer: Your usage rate on Medicaid, your quarterly report shows around 46,000; does it go up during the winter and down during the summer? There are 62,000 that are eligible, and you have about 46,000 using it.

McDermott: As far as the recipients, that is based upon when the claims get processed through the system.

Chairman Delzer: Questions by the committee?

Representative Wieland: Under the long term care continuum, the foster care for the elderly, which part of that does it fall under?

McDermott: Under home and community based services

Representative Martinson: Where did that reduction in rent payment come from in the Senate?

McDermott: I am not sure of the basis for that, I believe it came from Senator Warner.

Representative Skarphol: Could you briefly talk about your information technology costs at $2.6 million, and what we should anticipate happening when the new MMIS system is in place. Will there be reduced costs associated with that, or should we expect stable cost?

McDermott: I will have our IT director address that.

Chairman Delzer: Also, I see you're adding some FTEs there, going from temporary to full time. Shouldn't the new system take less staff?

Jennifer Witham, Director of Information Technology Services, Department of Human Services: We are going to see an increase in the cost of running the MMIS, it is more expensive in terms of our ITD costs, in hardware and software, than it is to run on the mainframe. I will be testifying tomorrow and can give you more detail at that time.

Representative Skarphol: Whenever we do IT projects, we'd like to hope we're reducing costs or holding them stable, not see them increase. What benefit, other than replacing an antiquated system, should we be anticipating getting out of this new system? Will it provide cost savings in other ways?

Witham: Yes, it will give us cost savings, in efficiencies at least, in other ways. The new system does allow for real time adjudication, for web-based access for providers. If they submit their claims today, we run the adjudication of the claims on a weekly basis. The providers don't have any insight as to whether or not the claims they submit will actually pay or not pay. With the new system, they can submit, they can look the next day or within a few hours, and verify if the claims are going to pay; if there are any errors with the claim so they are denied, they can resubmit the claims. It should be a tremendous increase in productivity for the providers, in terms of increasing their cash flow. There are other opportunities that medical services staff will see in efficiencies. Part of the reason the current mainframe-based system is so inexpensive to run is because it is all on a large monolithic server, which is shared across other state agencies. As you have noted, other agencies are moving off the mainframe, and some of that shared cost is then being transferred into individual server-based systems, which this new system is. Because of the software and hardware licensing, there is an anticipated incremental increase in those costs to run the system.

Representative Skarphol: We're going to spend $60+ million on this project. I'm satisfied it needs to be done to replace an antiquated system. For the benefit of future projects of this magnitude, I think it behooves you to provide us with some objective documentation of the benefits of having the new system. To the providers, fine, I can appreciate that, but there should be some benefits that we can realize on the state level as well, be it savings in FTE time, or less errors that cost us money; there must be some easily documented benefits you can show us.

Olson: Regarding your question about the four temporary FTEs that would like to move to full time status, when the HIPAA transactions were brought into our legacy mainframe system that is so antiquated, it really messed us up with our providers. We got into a situation with a couple of our larger hospitals, where we had to do some advance payments because they got into cash flow problems because we had so many claims in suspense. We brought on some temporary staff to help us work those claims. They've been temps for four years. We're going to keep them there, because we had upwards of 100,000 claims, which made everybody nervous. We made it a priority to get those suspended claims down, hired the temps, and allowed regular employee overtime if they so chose. As a result, we have managed to keep our claims in suspense down in the low 20,000's, and we plan to keep it in that area as we transition into the new system for awhile even after we go live to make sure we don't get into another mess. Perhaps as we transition some of our regular staff may resign or retire, and we would like to offer an opportunity for them to fill in some of those slots. Some of them have moved into cross-training as coders, so when we

get jammed up in our claims, we have a safety net. They have become very valuable to the department in this area. We really chose this time because we have decreased our FTE number at the Developmental Center, it seemed like a good time to move them into full time.

Chairman Delzer: Isn't that what your new MMIS program is supposed to take care of, the claims in suspense?

Olson: Yes, ideally that is what it's supposed to do.

Chairman Delzer: Further questions by the committee? Thank you. With that we'll stand adjourned.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 3, 2011
14908

☐ Conference Committee

Committee Clerk Signature Julia Zeigler

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (section overview on Department of Human Services (DHS) budget).

Chairman Pollert: any questions from yesterday's testimony? (attachment **ONE**)
Representative Nelson: Indicated in the testimony was $800,000 in the Community health trust fund for Women's Way programs. Can you provide clarification, as I thought this was all Dept of Health?
Debra McDermott: 3 biennia ago, they had us start paying for the services for the individuals that screened eligible for the Women's Way at the Health Dept and at that time, the matching money was from the community health care trust fund.
Representative Nelson: this is for procedures that were done and paid with Medicaid rates?
Debra McDermott: It was the enhanced FMAP rate that we were able to get to provide those services to those eligible individuals. At that first biennium, there were no general funds that were put into program. It was all the matching money came from the community health care trust fund. It was that way until last biennium and we were limited to the funds we could use. This biennium, we were told that there were no funds available in the community health care trust fund for our program.
Representative Nelson: that appropriation went from the community health care trust fund to the grant line item?
Debra McDermott: yes, we spend money out of the community health care trust fund.
Representative Nelson: that goes to the medical services grant line item; that's where you are budgeting this time?
Debra McDermott: Correct. The services are still being provided but they'll be matched with general funds instead of community healthcare trust fund dollars.

Debra McDermott, DHS, provided testimony (replacing Brenda Weisz (Chief Financial Officer for DHS) who was originally scheduled) in support of SB 2012 which illustrates an overview of the Administration/ Support area and is labeled as attachment **TWO**. Committee members interjected with questions throughout testimony and questions and answers are indicated as follows.

Chairman Pollert: you'll have the 09-11 executive budget. Will you also have how much you've expended through the current biennium?
Debra McDermott: Yes, we'll have 09-11 budget schedules, first time expenditures and the changes that are needed to get to get to the 11-13 budget.

Chairman Pollert: in your general overview (attachment **ONE**), you spoke of FTE changes with an overall reduction of about 20 FTE. Can you provide a schedule of all the FTE schedules and changes?
Debra McDermott: Yes

Representative Nelson: can you give me an explanation about the underfunding of salaries? did we change that last session or was that just a calculation change that became necessary because of internal operations?
Debra McDermott: During the last session our salary line was underfunded by $1.4M in general funds and we allocated that back out to the divisions across the dept based upon the funding of their general funds contained in each one of their salary line item. This was the amount that was the attributable to the admin/support division; the $91,000. Due to the turnover within the dept, we were not able to generate those dollars to cover that underfunding.
Representative Nelson: was this something that you didn't see? Was this something that we changed in our consideration of the budget?
Debra McDermott: Yes, the basis for that was the vacancy report. We ended up with a $1.4M underfunding.

Chairman Pollert: was that 40 FTEs in consideration of the 70 vacancies that were in there?
Debra McDermott: The vacancy report is positions vacant as of Jan 1 and those 70 positions do not include the 40 that were underfunded.

Representative Wieland: is that a onetime spending as far as the increase goes? The $1.4M?
Debra McDermott: Because we are saying we need the $91,000 in our budget, it would not be ongoing. Because I need that money back in my budget to actually fund my pay plan. Some of the divisions that you will see, they were able to recoup those funds because of some highly paid long term employees that had left so they are not asking for those additional funds back to fund their pay plan because they hired individuals that wouldn't have been paid the same salaries of those that had left.

Chairman Pollert: it would have to be an ongoing expenditure if the employees would stay stable or in other words, the same employees stay.
Debra McDermott: Yes, that is true.

Representative Kreidt: Wasn't there equity money that went back into the Dept to cover the underfunding?
Debra McDermott: there were guidelines given by HMRS that the depts were to follow in order to provide those funds to the individuals within the dept that met certain criteria.

Chairman Pollert: It was underfunded, but you still would have paid for it anyway because there is turn back ($12M). It still got paid out. Nobody lost their jobs. In other words, if you have an underfunding, it still got funded. There was $12M turn back. The salaries still got paid. It will get added to the base line is what underfunding is doing, right?
Debra McDermott: Correct. When we build our budget, we have to fund out the pay plan for the individuals that are there and that's built separately and independently of any of the operating expenditures or grants.

Representative Nelson: as we look at this budget and the salaries, that's a floating target because of what you explained as far as who's going in and who's coming out, that every dept is going to have change. Is that commonplace? Do we oftentimes do this? What's the track record?
Debra McDermott: You have underfunded our pay plan before. When we build the institutional budget, we account for our turnover ratio in those budgets and actually underfund our pay plan to Office of Management and Budget, but because our turnover ratio is not that large, we don't build the underfunding into that area of our budget.
Representative Nelson: you can't do that in the dept's budget, but you can in the institutional?
Debra McDermott: Because it's a 24/7 facility and the turnover ratio they have, we do account for in building our budget.
Representative Nelson: do you go through the employees and look at that? How do you arrive at that underfunded number?
Debra McDermott: I am not sure, but I can get that to you. We underfunded in our Human Service Centers as well.

Chairman Pollert: leasing of office space senate amendment will that be in section
Debra McDermott: That will be VR program as well as our Aging Division.
Chairman Pollert: We need to know why the amendment was brought forward. We'll get a leasing schedule from you.
Debra McDermott: Senator Warner had issues with the rent we were paying there.
Chairman Pollert: when we get to that point, can you provide the leasing schedule? We need to figure out the reason for the amendment and see if leases are equal.

Representative Wieland: out of the 74.60 people in this unit, how many separate buildings are included in that unit?
Debra McDermott: The majority of the staff are in the capitol building. There is one in prairie hills plaza, another in Century center and several staff in collections for the human service centers in centers across the state. This is a centralized cost so all the capitol building rent is paid within this budget.

Representative Kreidt: Regarding the increase for office of administrative hearings; can you give us a report showing the breakdown of the hearings? How many are related to DHS and a breakdown within DHS?

Debra McDermott: Yes, we can get that to you.

Representative Nelson: as I look at the professional fees line item, the office of administrative hearings line item concerned me as well. It might be helpful to see how the utilization of services for the attorney general's office has increased. The other concerning issue is the Work Force Safety, the dollar per square foot thing; what's that all about?
Debra McDermott: We rent space in the Century Center from Work Force Safety and it's located on Century Ave right across from the cemetery, behind Space Aliens (east of Space Aliens).
Representative Nelson: they are just assessing another dollar per square foot across the board? I'm assuming this is more than just state agencies that are paying this and that all their clients are being assessed that additional dollar. Correct?
Debra McDermott: Yes, those are basically the rental rate increase that was determined by Workforce Safety who owned that building and what it cost to maintain that building so that is passed onto the other state agencies that are in there.

Chairman Pollert: Senate proposed an amendment to cap rent at Prairie Hills at $12.50. However, there is a rent increase for the Century Center to $14.50. Thus, we should be telling Workforce Safety and Insurance (WSI) to drop to $12.50.
Representative Nelson: that's where I was getting at. How many instances do you rent space for over $12.50 per square foot?
Debra McDermott: There are several of them that are over $12.50.
Chairman Pollert requested a schedule of rent.

Jenny Witham, Director of Information Technology Services of DHS, presented testimony, labeled as attachment **THREE,** which illustrates an overview of Information Technology Services Division for DHS.

Chairman Pollert: wouldn't you have been doing that the last biennium or two?
Jenny Witham: This is in regards to the ARRA funding that took place last year and the emphasis of the High Tech Act to implement health information exchanges across all states. Sheldon Wolf in the Information Technology Dept is the health information technology coordinator for the state. Medicaid is a large partner in the implementation of that. Medicaid and other payers will be participating.

Representative Nelson: when you move an FTE internally, that shows up as an increase in that cost center, but it would be a decrease in where that person came from.
Jenny Witham: Yes

Representative Wieland: where will that show up; in which dept?
Jenny Witham: The Developmental Center will reflect the decrease in need. The increase funding that is needed for the benefits only for these three data entry FTEs is $25,000 in general funds and $82,000 in total funds.

Chairman Pollert: where is that funding come from for the Health Information Technology Coordinator?

Jenny Witham: That funding is the general fund match that is being requested in this budget. The federal match is coming from CMS at a 90/10 match. The one position is $214,000 of which $21,000 is general funds.

Representative Wieland: you talk about conversion of 3 data entry staff and then you're talking about an increased need in providing outreach and information (5 people).
Jenny Witham: The outreach for the providers was an internal move within the Department during this biennium so that is not included in the total of the 4 FTEs that is being requested. During this current biennium, we included the transfer of FTE for the provider outreach.
Representative Wieland: Where did the transfer of that FTE for the provider outreach come from?
Jenny Witham: That came from the Developmental Center.

Representative Nelson: the 3 data entry positions, when they become full time FTEs, they come in at the same pay grade that they are currently at. Do they qualify for higher pay grades sooner now as an FTE? What would be the natural progression as far as their vertical movement on the pay scale?
Jenny Witham: There are always opportunities for upward mobility, especially in the medical services division. Currently they deal with the scanning and the entry of the medical claims. As we put in a new MMIS, I understand there is going to be increased needs with additional scanning. We're actually going to be including all correspondents to be available online which we don't have today. There is going to be needs for paper handling. As far as upward mobility, it would depend on each person's qualifications?
Representative Nelson: it's the same as it is today?
Jenny Witham: Yes, it's the same as it is today. This is really requesting benefits for these employees that have been long term temporary employees.

Chairman Pollert: does MMIS come online in June/July 2012. Will this put you at the FTE count you feel you need for implementation, etc?
Jenny Witham: Yes, it does.

Jenny Witham resumed testimony.

Chairman Pollert: would you have a simple form of your IT rates including percentage increases?
Jenny Witham: I can provide that in my detailed testimony.

Representative Nelson: What we saw in other budgets is that the change in ITD from personal connections was the change and you are a labor intense unit. Is the majority of the increase because of the conversion that they made in how they bill?
Jenny Witham: That is not a big portion of this. That is the technology fee. They converted from device counts to incorporating additional services into an overall technology fee. That shifted some of our other costs into a single cost. That impact took place this biennium. We went from a device count to a technology fee in the 09-11 biennium. That stayed relatively static for us going forward into the 11-13 budget. The primary changes for us here are labor costs and CPU costs. We also have some utilization increases that would not be related to rates which I can also break out in that schedule for you.

Representative Nelson: what kind of role does ITD play when MMIS does come online?
Jenny Witham: They'll play a very large role. After we go online, for the first year, we'll still be in the implementation. For the second year, we'll be doing a great deal of knowledge transfer between ACS and ITD. It is our intent to be a turnkey state in which we would run and manage the MMIS internally within the state. That is going to take some transition time.
Representative Nelson: is that cost projection in these numbers?
Jenny Witham: Yes and I'll break that out in the schedules.

Jenny Witham resumed testimony.

Representative Wieland: When was MMIS originally suppose to be completed?
Jenny Witham: In July 2009.

Tove Mandigo, Economic Assistance Policy Division Director with DHS, presented testimony labeled as attachment **FOUR** which illustrates an overview of the Economic Assistance Policy Division.

Chairman Pollert: in the first half, we were pulling the funding with anything that universal healthcare until next Nov until we go into special session.
Tove Mandigo: Yes. We just wanted you to know that this was build here for that one reason. It's for systems support and these are the people who work with the programming and make sure the programming works with the systems. They would work with the MMIS people on the eligibility to make sure the eligibility works with that exchange.
Chairman Pollert requested a schedule for TANF (what it was in 09-11 and what it's going to go for).

Tove Mandigo resumed testimony.

Representative Kaldor: the human services interim committee did some investigation on what you are talking about. There are some states that allow for 4 year college programs for TANF recipients because of the reason you are talking about; higher likelihood of increased wage. Because we are getting a reduced caseload, this affords us the opportunity to test that?
Tove Mandigo: Yes. The reason is because our work participation rate is so high. Because they aren't going to meet the work fee federally required rules for the work participation rate, we won't be able to count them. The work participation rate will go down, but that won't hurt us at all because it has to go down below 50% for us to be hurt. We are sitting at 80-90% so we can do some of these things and use the federal money to be able to afford this kind of thing. Additionally, we have many TANF clients that don't look farther than the day they walk in for services, so with our TANF and Beyond program, we are looking at helping the clients look farther out into the future, like what happens in 6 month, a year and helping them figure out how to change their lifestyle so they don't remain on TANF for the rest of their life. The whole idea is to get our TANF clients self-sufficient.
Representative Kaldor: what does work participation means? What is the work participation rate defined as?
Tove Mandigo: Work participation rate is measured by the federal govt and measures accountability on things these individuals do and one of those things is that they have to work. thus the minute they go to school for something that isn't acceptable (like going to

school for 2 years – going for 1 year is acceptable), we wouldn't be able to count them in that work participation rate.

Tove Mandigo resumed testimony.

Chairman Pollert: what kind of fund do you use? Accrual fund or a reserve fund, so that money stays available for later time periods?
Tove Mandigo: We obligate money to the providers that we would be paying the money to anyway, for the future years and they just draw down on that obligated money.

Representative Nelson: as we go forward in some of the other programs, like SNAP or TANF, that same situation looks like it's appearing with federal money. Is some of that return to the federal govt or does it all go forward for future needs?
Tove Mandigo: LIHEAP is the only one that's like that. TANF is a block grant. For most of the other programs, it's a spend down, like Medicaid. It's not a block grant, so you don't have the money. You have to actually use the money.
Representative Nelson: in the case of a block grant, if the utilization isn't where you believe it will be, what happens to that money?
Tove Mandigo: We can roll that money over for a period of five years and then you go through a new reauthorization of the TANF block grant. It's around $26M that we get now and we don't know what it's going to be. The TANF reauthorization is coming up now and right now they are working on a 3 month period where they are giving us money in advance, but they haven't worked it all through. We can roll it forward if need be.

Chairman Pollert: Is this $30M (SNAP benefits) an increase in state need or is it like LIHEAP?
Tove Mandigo: it's what we draw down, basically. This is what they have allocated to us and if we use that money, then we use it; otherwise we don't get it.

James Fleming, Director of the Child Support Enforcement Division of DHS, presented testimony, labeled as attachment **FIVE**, illustrating an overview of the child support enforcement (CSE) program for DHS. Committee interjected questions throughout testimony and questions and answers are as follows.

Chairman Pollert informed DHS that the committee would like a schedule of funding that DHS is asking for in response to federal decreases.

Maggie Anderson, Director Medical Services for DHS, presented testimony, labeled as attachment **SIX**, illustrating an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division.

Chairman Pollert: in regards to attachment C in attachment **SIX,** would you be able to give us information as far as the trend in Montana or SD for instance? Is it similar to ND?
Maggie Anderson: We ran an analysis since July 2008 and our total enrollment was about 51,000. Now it's 63,584 (in January it went up). Thus there was a 12,000 increase; of which 9000 were children. Since July 2008, there have been two rounds of outreach grants for

children's insurance. When a family applies we always test for Medicaid eligibility and if a child doesn't qualify for Medicaid, the child is put on CHIPS with continuous eligibility.
Chairman Pollert: in looking at the total population of the state versus what you have on your charts, are there simple figures we can look at for comparison. Didn't we do $300,000 in outreach last session and this session it's $600,000?
Maggie Anderson: It's a hold even amount in our budget and it was the $650,000.
Chairman Pollert: with healthcare reform, there's something about gross and we're on net...you know where I am going? Can you give us a lesson on that as well?
Maggie Anderson: I can do that.

Chairman Pollert: last biennium, you gave us a nice chart as far as where 160 correlated to the number of people eligible and then you had what 170 did and 175. Could you get 160, 165, 170, 175, perhaps more?
Maggie Anderson: you would like every 5% up to 200%?
Chairman Pollert: Yes.

Chairman Pollert: is there a correlation as far as how much for our bang for our buck came from the $650,000 of outreach versus going to 160 last biennium? Weren't we at 150 before and we went to 160?
Maggie Anderson: When the program started, it was at 140. In Oct 2008, it went to 150. In July 2009 it went to 160. Corresponding to that, the legislature provided additional funding for outreach. We could tell you about all of the outreach events. With the increase in CHIP and the Medicaid enrollment, that the outreach is having an impact because families are coming forward and applying for benefits. How much is related to outreach versus families finding themselves in a situation where their children don't have coverage and they know about it and come forward; we would need to talk about exactly what you are looking for.
Chairman Pollert: I am looking for a 1-2 pg synopsis to illustrate the 09-11 biennium and with the outreach, we went up this many.
Maggie Anderson: I can tell you that number. From August 2009 to November 2010, an additional 2,888 children had enrolled (between Medicaid and CHIP).
Chairman Pollert: how many children were added when we went from 140 to 160?
Maggie Anderson: yes, I can get you that figure.

Chairman Pollert: last session, you gave us what the inflationary increases were for the past 5 biennia and you also had on that same form what the CPI was. Could you provide that to us again?
Maggie Anderson: yes

Representative Kaldor: regarding the estate recovery, are you talking about the cost to recover from an estate? That's the part that we will no longer be able to recover?
Maggie Anderson: Because Medicaid pays premiums on behalf of these individuals, when the individual dies, their estate is subject estate recovery. Let's say, over their lifetime, we paid out $7000 or premiums, we would no longer be able to go after that $7000 as part of our estate recovery efforts.

Chairman Pollert closed hearing and informed committee that hearing would resume on SB 2012 at 1:30 pm today.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 3, 2011
14913
14929

☐ Conference Committee

Committee Clerk Signature Julia Jeffe

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert reopened hearing on SB 2012, following afternoon recess.

Maggie Anderson, Director Medical Services for DHS, continued presenting testimony (starting at the bottom of pg 3) that was started this morning and is labeled as attachment **ONE.** The testimony illustrates an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Nelson: the temp staff has been there for 4 yrs. Are they receiving benefits for this tenure?
Maggie Anderson: They don't receive fringe benefits such as medical benefits, medical leave, sick leave, certain retirement benefits, etc. We do pay the FICA for these employees.

Representative Wieland: how many hours do you they work a week or a month to be classified as a temp?
Maggie Anderson: 40 plus hours a week so that is the reason the position would be moved to a full time FTE. Medical services has other positions that aren't full time as the need isn't there thus there are positions that are part time temp like 20 hrs a week.
Representative Wieland: you spoke of 5 FTE in connection with health care and this one who is a conversion from a temp to a full time FTE and another transfer within dept. Is that like a promotion? If it's not, do you have to fill another position?
Maggie Anderson: The 5 FTE for healthcare reform and the one temp to full time is included as an increase from 09-11 to 11-13. The other position was in children and family services and was transferred to the medical services division as a deputy officer there. This position was formerly vacant. That one FTE is included in the 67.5 for 09-11 budget.

Representative Wieland: how many vacant FTEs do you have now?
Maggie Anderson: In the medical services division, we have one vacant FTE and in process of doing interviews for that position.

Representative Nelson: Jenny (information technology) had mentioned about 4 temp positions that were requested to be converted to full time. I thought that was in claims.
Maggie Anderson: You are correct. There are two different types of claims. (recording inaudible for a few seconds). The work that the staff in the medical services division completes, the work that the staff in IT completes is actually the upfront scanning of the paper claims and documents that come into the system and keying of claims. For example, qualified service providers, transportation providers and other providers still submit a lot of paper claims to the office and those all need to be manually scanned into the computer and in a few types of provider situations, they need to be keyed into the computer. That's the work that's done in Jenny's shop (data entry, claims processing,
Representative Nelson: does that include the coding from some of the medical facilities as well?
Maggie Anderson: the actual coding review from our staff is done with the medical services and that is part of our medical utilization review team that does the coding review.
Representative Nelson: I've had a number of QSPs that have talked to me about the length of time that it takes for payment sometimes for their services. Is some of that because of the unsophistication in how they present their work or are you understaffed in that area as well?
Maggie Anderson: the dept prioritizes the processing of qualified service provider claims. We know how important that cash flow is to the providers and we do that. The day of check write is Monday, and typically qualified service providers get their bills in for the first check write of the month. We make sure that we don't start check write that afternoon until the entire batch that we receive (by noon that day) get into the system. Thus, unless there is a computer system problem, that's our goal. Certainly some of those will have errors. On paper claims it's not uncommon for something to be outside of a box and the system not pick it up. If it goes through to pay, they would actually receive their payment, the Tuesday morning following the first check write of the month. If there is an error, then it would need to be worked that next week and it be processed. There are situations that sometimes have to do with recipient eligibility or liability that may deter a claim longer than that. I can tell you that most of them are very timely about being processed. The other thing that the Home and Community based services staff worked on over the last couple of years is actually developing an online claims submission form for the qualified service providers. The individuals who have done that find that there are fewer errors that just happen on the claim and the turnaround time with the payment is improved.

Representative Kreidt: is there an instance you don't pay the FICA? When you mentioned the temp benefits, it seemed like you meant you pay FICA as a special benefit, however that is required by law.
Maggie Anderson: You are right. We just pay the employer share. I mentioned the FICA piece to clarify Representative Wieland's question.

Chairman Pollert: if the repeal happens and they give the flexibility to the states, does that change your plans at all?

Maggie Anderson: The FTE that were requested is based on what we know about healthcare currently. If Medicaid expansion would go away and the legislature would decide not to expand, the FTE would likely not be necessary. It depends on the flexibility and how ND would develop and craft its program. It would be difficult to say until we know more.
Chairman Pollert stated committee is expecting to receive the OAR request.

Chairman Pollert: you didn't budget for the beginning of the 11-13 biennium?
Maggie Anderson: That is correct. The only one that would be from the beginning would be the eligibility policy position.

Representative Kreidt: with the new healthcare law and the number of new individuals expected to come online, have you made any type of estimate of what type of a number you are looking at?
Maggie Anderson: We calculated very preliminary estimates based on what we know at the time. We're estimating that the Medicaid enrollment could increase by as much as 50% based on the expansion.

Representative Nelson: when we had a joint committee hearing with the other subsection of Appropriations and IBL committee regarding the PPACA legislation, Carol did testify and I thought the number she used was about $15M to implement that legislation. Does that include the 5 FTE? I am referring to HB 1126 – the Health Insurance Exchange bill.
Maggie Anderson: That estimate is solely for the Medicaid eligibility system portion of what would need to be attached to the health insurance exchange. That is separate from anything here.

Chairman Pollert: what do you mean by primarily funded?
Maggie Anderson: There would be some dollars in there (we can give you the breakout) that I would estimate about 90% federal.
Chairman Pollert: we can get that more with the detail.

Chairman Pollert: there is no bill out there in regards to children's insurance increase?
Maggie Anderson: There were 3 bills introduced in the Senate, however all three were defeated.

Chairman Pollert: you'll be getting us figures for 1 and 1, 1.5 and 1.5, 2 and 2, 2.5 and 2.5, and 3 and 3?
Maggie Anderson: yes

Chairman Pollert: Can you include all the breakdowns for the costs of inpatient, outpatient, utilization numbers, others costs, etc
Maggie Anderson: Yes

Vice Chairman Bellew: can we have the figures on what the rebasing cost is during the detailing?
Maggie Anderson: yes

Chairman Pollert: when we get the report with the rebasing, should have physician services been higher? Didn't we increase physicians from 25% to 75% in conference committee?
Maggie Anderson: The rebasing amount costs would be included in the 2473 because at the point when the legislature provided the rebasing and then the second year (the 6%), that's included in that 2473 because that's what we had in our budget and on average what we were expecting to pay for services. As we went to build the budget, the mix of services that were being claimed for the Medicaid clients by physician changed and it just happened to go down. In essence, the rebasing money is still in the 1963 as is the second 6%.

Chairman Pollert: that is dollars over and above what will be coming to the big 6 through health reform?
Maggie Anderson: Are you talking about the Frontier amendment?
Chairman Pollert: Yes
Maggie Anderson: yes, my understanding of that is to address health care costs and some disparities in recognizing salaries and things like that where the electronic health record money is specific...they have to prove that they are adopting meaningful use of electronic health records in order to access the Medicaid dollars.
Chairman Pollert: when is the frontier amendment supposed to take effect?
Maggie Anderson: I believe it already has.

Job Recorder Number: 14929

Maggie Anderson, Director Medical Services for DHS, transitioned to presenting testimony, labeled as attachment **TWO,** which illustrates an overview of the Long-Term Care Continuum budget.

Representative Wieland: Can you explain the adult family foster care point split?
Maggie Anderson: We have a monthly rate worksheet where we determine what the client's needs are and assign points and dollar value to go with it. When we had the point split, the points for laundry, housekeeping, and shopping were split among the number of individuals in the home. In the executive budget last time, we recognized there is just as much effort that goes into those particular services so we removed that point split and in that same situation, the adult family foster care rate for that provider would not be reduced for each one of those. They would receive the full rate for laundry, housekeeping, and shopping.
Representative Wieland: are those federal dollars? State dollars?
Maggie Anderson: There can be private pay individuals in adult foster care. If the person is Medicaid eligible, the cost would be at the FMAP rate. The room and board needs to be paid by the client, not by Medicaid.

Representative Kreidt: does the facility notify you? How does it work? Is it a paper trail? Is it a quick turnaround?
Maggie Anderson: They would submit a new assessment and then, that would kick into the payment system so through the same electronic process.

Chairman Pollert: so, you didn't use the loan of the $8.5 because of available funds, but you are putting the 8.5 into the budget because you indirectly needed that to do your cost?

Debra McDermott: we started out with 09-11 appropriation. If we wouldn't have gotten the additional ARRA money for the extended time period, we basically would have to use part of the Bank of ND loan. Because we were able to draw down those additional ARRA funds, we didn't so what we're saying is to continue the budget, we would need to replace the bank of ND loans with general funds.
Chairman Pollert: you did that the last biennium as well? In 07 we first did the bank of ND backup on the DD, but you didn't use the money, but you used it to have your costs.
Debra McDermott: That's correct.
Chairman Pollert: I can your thought process now, but I'm sure I understand the thought process back in 07.

Chairman Pollert: when I see this chart, the figures stand out. The number of beds in nursing homes has dropped as well as the number of days of occupancy has dropped?
Maggie Anderson: Since 1991?
Chairman Pollert: The last 4-8 years. We have dropped utilization rates down. When we increased salaries in all the units, we are going to have this type of expenditures. The number of days of occupancy has dropped, right?
Maggie Anderson: I would need to coordinate with the Long Term Association and get those figures back to you.

Representative Kreidt: in regards to the new construction, are all the beds pretty well online and up or are we going to see some additional beds that are going to be coming forward? Where are we at with that?
Maggie Anderson: the four facilities, the two in Bismarck, the one in Fargo, and the one in West Fargo, are operational. The ones in Fargo/West Fargo are nearly at 97-98% occupancy and the Bismarck ones are not that high, but they are continuously adding clients each month. We are monitoring that closely and communicating with Long Term Care Association so we can stay on top of that occupancy.

Representative Metcalf: You stated that Fargo and West Fargo are about 90% occupancy. How about the rest of the nursing homes in that area? Are they dropping?
Maggie Anderson: The other facilities in the Fargo area (with the exception of one) all still remain over 90% and as of Dec 1, that one facility is at 82% occupancy and that may have changed since Dec 1.
Representative Metcalf: how many rooms were added in that area?
Maggie Anderson: The facility in West Fargo is licensed for 64 beds. The facility in Fargo is licensed for 78 beds. There are two facilities in Bismarck and these facilities are licensed for 48 beds and 72 beds. These are all the new beds.

Chairman Pollert: did we ask for a report, like the costs per day of the nursing home facilities?
Maggie Anderson: The high and low rate for that facility?
Chairman Pollert: Yes, could we get that again? That would include the Veterans' Home (I recognize there are variables in the Vets Home such as revenue coming in due to the new facility). We passed the property assets limit around $300,000 last session. Do we have a figure of what's that's going to cost us this biennium? 09-11 and 11-13?
Maggie Anderson: I can get that.
Chairman Pollert: HB 1325 is what we passed in the first half. Is that contained in this?

Maggie Anderson: No, those dollars are separate and not contained in 2012.

Chairman Pollert requested a schedule on IGT.

Chairman Pollert: if we go across the line on nursing homes, you add all the 425, so you are putting the 12.8 into the nursing home portion and then coming out with 459123.
Maggie Anderson: that's correct, but the actual expected expenditures in that area would be closer to 472. It's just that we are able to carry over the 12.8.
Chairman Pollert: there's a few of us on the House side that don't want to get into having turn back. If we need to put it in, we should put it in as a general fund instead of having an agency.
Debra McDermott: If you do choose to make that amendment we would need language added in to make sure we have proof to the federal govt that we haven't put those extra ARRA dollars into a rainy day fund. That language was added in our bill last time.

Representative Kreidt: with the increase there, are we also seeing a conversion of skill beds to basic care beds?
Maggie Anderson: We can get that number for you.

Tina Bay, Director of the Developmental Disabilities Division with DHS, presented testimony, labeled as attachment **THREE**, which illustrates an overview of the Long Term Care Developmental Disability Grants Budget for DHS.

Chairman Pollert: the Senate put in a .50 raise for staff who works with the DD population, but they didn't look at staff with the nursing facilities, correct?
Tina Bay: Yes, just our dept.
Chairman Pollert: I am going to want education on this, such as more detail about the 37of the wage that is benefits and is the .50 going to benefits?

Andrea Pena, Executive Director of the State Council on Developmental Disabilities, presented testimony, labeled as attachment **FOUR**, which illustrates an overview of the Council's budget request.

Jan Engan, Director of the Aging Services Division with DHS, presented testimony, labeled as attachment **FIVE,** which illustrates an overview of the Division's budget for DHS.

Chairman Pollert: this is just in one region, Morton county, right? Has the ADRC expanded services to other areas?
Jan Engan: It began in Burleigh county about a year ago and has since then expanded to Morton, Kidder, Emmons and Oliver counties and all of Region II has transitioned so that's about 2 ½ regions with ADRC.
Chairman Pollert: there's basically 2 contacts a day by the ADRCs in these ADRCs.
Jan Engan: Part of that is start up time, so as you are starting up, you'll work with a client and it's increased. To give an example, in January, they had 160 contacts alone, thus contacts are increasing as information gets out there about the services.

Chairman Pollert: the $300,000 general funds plus the $226,000 federal funds, is that increased food costs or what is that increase attributed to?

Jan Engan: It's attributed to a number of factors. There has been an increase in raw food costs over the years. The nutrition providers in the state of ND have committed to serving an individual walking through the door requesting a meal (they have to qualify- federally determined). Through the dollars that we get through federal funds, we do not have sufficient funds to pay directly for all of those meals, so the provider network then has to go out into the community and raise additional funds so by leveraging additional dollars, they are able to serve everybody. We are being told that it is becoming more difficult at the local level to raise funds. There are shortages of funds out there so this would help to offset some of those costs or folks would be put on a waiting list.
Chairman Pollert: we can get into that when we do the detailing.

Representative Nelson: is this one area where the federal funds are decreasing?
Jan Engan: It is flat. Traditionally, federal funding for Older Americans Act program has been flat. At this point in time, the money we have in contract is at the 2010 level because we haven't received the 2011 level. We are looking at 2010 funding though as we expecting 2011 to stay at this rate.
Representative Nelson: so we can continue to see these nutrition programs and the meals be taking its toll on the local agencies. It seems like there's going to have to be a day of reckoning with that.
Jan Engan: I agree. We have problems that we have to address with the increase in the older adults in our state which is shown in the demographics I have provided.

Representative Nelson: in the nutrition program there was some ARRA funding that is going away. What were you able to use that for?
Jan Engan: the ARRA funds did assist in purchasing meals and that money went away when the state dollars started to kick in. They were continued to be able to provide services at the level they were providing before the ARRA came in.
Representative Nelson: it didn't enhance the payments...
Jan Engan: at a higher rate? No.

Carol Olson: there was an idea that the Senate had about congregate meals and the costs and them going up. We realize the facilities set out a basket for individuals who receive the meals to put money in if they so choose and can afford it. The idea was to post the cost of the meal that they are serving at that time and perhaps it would influence the daily money that is dropped in the basket for those who could afford it. We thought it was a great idea and we believe we are going to follow through on that. Perhaps that is one of the solutions that will help offset some of the costs.

Chairman Pollert: I have another question. I have heard that home and community based services are increasing, yet when I look at the charts, it doesn't show that. Can you explain this? It looks like long term care is increasing with utilization, but home and community based services, which we've been trying to go to, aren't increasing that much at all.
Maggie Anderson: it is a combination of things. You'll noticed the significant decrease in the SPED utilizations so it shows this negative, although we are still seeing some increase in SPED, we're just seeing less of an increase than we thought. Thus as we went to build the 11-13 budget, it comes in as a negative. Certainly SPED is one of the large areas of home and community based services. Even with the cost and utilization changes, we're still looking at about $14M. That's 95% general/5% County. We are seeing growth in the home

and community based services waiver. Our average cost per month in this area is $1,215 and in nursing homes, the average cost per day is $187 so it's hard to compare. You will see an increase in the PACE program which is a home and community base service program that is in the Bismarck and Dickinson area and their numbers have increased. We are making efforts to assist those individuals who would like to move from an institutional setting to a home and community based setting and I think over time you will see those numbers impacted as well. We are still estimating to serve 1350 clients per month.
Chairman Pollert: is assisted living growing in the state?
Maggie Anderson: Yes, I believe it is, however you won't see that reflected in the Medicaid program because we don't pay for room and board.

Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 4, 2011
14968

☐ Conference Committee

Committee Clerk Signature Julie Meiselbach

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert announced that amendment .02002 introduced by Senator Mathern did not pass in the Senate, thus can be taken out of bill book. He also announced that public testimony for SB 2012 will be on Tuesday March 8 in the Brynhild Haugland room starting at 8:30 am. The testimony will go in the order of how the overview was done. Chairman Pollert opened hearing on SB 2012 (section overview on Department of Human Services (DHS) budget).

Tara Lea Muhlhauser: , Director of Children and Family Services (CFS) in DHS, presented testimony, labeled as attachment **ONE**, which illustrates an overview of Division of Children and Family Services for DHS. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Vice Chairman Bellew requested that DHS provide the county shares of the foster care payments when committee does detailing.

Chairman Pollert: You are speaking about a new pilot program. Are those federal dollars?
Tara Lea Muhlhauser: Those are dollars ($100,000) we were provided in the last legislative session.
Chairman Pollert: was that Pennsylvania something or other?
Tara Lea Muhlhauser: Yes, it was part of the Allegheny County initiative that came through the Family Impact initiative last year. It was $100,000 that you gave us to begin that pilot.
Chairman Pollert: we put some into extension under Families and the rest went through here.
Tara Lea Muhlhauser: Parent resource centers fell under the NDSU budget and they were part of that initiative.

Chairman Pollert: In the Commerce Dept there is $4M for childcare grants. Is that related to what you are doing here?
Tara Lea Muhlhauser: Yes it is. We have developed a nice working relationship with commerce. 2 years ago, commerce had dollars in their budget to give childcare incentive grants. We worked with two rounds of grants with them. There are dollars in the commerce budget for recruitment and to speak to retention and training issues for childcare providers.
Chairman Pollert: the dollars were raised from the previous biennium like $3.someM and now it's $4.someM. We can talk about that more when we get to the detail.
Tara Lea Muhlhauser: There is a reference to that when I get there. There were ARRA funds. They have been negotiating in that process of taking a look at that ARRA amount dollar and trying to figure out where they wanted to put additional dollars in back of the ARRA funds.
Chairman Pollert: you mentioned guardianship. Did we remove that funding for adult foster care services in HB 1199? Where would that show up in this budget?
Tara Lea Muhlhauser: No, that would not show up in the CFS budget. That would be in the Aging budget.
Chairman Pollert: we'll talk about it when we get to the detail.

Chairman Pollert: are you saying the amendment in commerce dept is taking the place of ARRA funding of 4.5?
Tara Lea Muhlhauser: No, this was an ARRA funded childcare enhancement and incentive service called QRIS. It's not a replacement, but it's been talked about as being an effective early childcare service that was funded with ARRA money. One of my program administrators that has been working with commerce and tracking that bill, but we haven't been involved in any of the dollars amounts that are going into that discussion.

Representative Wieland: Is the $1.7M increase for county administration reimbursement above and beyond SWAP? The county are suppose to retain the administration costs, so they're getting reimbursed now for administrative costs?
Debra McDermott: We reimburse for the county for administrative expenditures for foster care services and basically everything in the social services area. The SWAP legislation which is the part we don't reimburse for was in the economic assistance area. This increase has to do with the random moment time studies we do at the county level and their expenditures and then how much federal funds we can draw down and then reimburse them.

Chairman Pollert: I am perplexed as to the reason the salaries and wages drop when we are doing insurance increase and the 3 and 3 or whatever the Senate did.
Tara Lea Muhlhauser: We had a number of retirees and the new hires were brought in a lower rate. We'll provide more information in the detail.

JoAnne Hoesel, Division Director from DHS, presented testimony, labeled as attachment **TWO**, which illustrates an overview of Division of Mental Health and Substance Abuse Services. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Wieland: Can we get this data (pg 7-Alcohol Consequences, attachment TWO) from previous biennia to do a comparison with these same statistics? Can we get information from 2, 4, 6 yrs ago?
JoAnne Hoesel: Yes, we do have that information. We have epidemiologists across the state that compile this time of data. We have we have a profile that we do on a annual basis and we can get that to you.

Representative Metcalf: what is being done in the schools as far as alcohol prevention and this particular program?
JoAnne Hoesel: Yes, DPI has a lead in that area. We coordinate with DPI and local school systems to look at how to get that message to the kids. We have a targeted curriculum to provide. We are also trying to implement what's called curriculum weaving. Teachers have a lot to teach in their curriculum thus this program allows teachers to address underage drinking. For instance, while explaining the topics, teachers can weave in examples and information related to alcohol abuse. Law enforcement has initiatives to address these issues as well in the school system.
Representative Metcalf: DHS has the ultimate responsible to address these issues. Kids are receptive to like bulletin board posts. Are we making efforts to get things like that out to the schools?
JoAnne Hoesel: We are getting information out in this way. Our state team has a campaign where tool kits are mailed to the schools for each kid to get a kit. Information is included in these kits. There has been positive feedback as a result.
Representative Metcalf: this is where we are going to stop the use of alcohol, at the youth age as once an individual gets entrenched in alcohol abuse, especially at a young age; it is that much harder for this trend to be reversed.
JoAnne Hoesel: No, it won't be a quick fix, but we have strategies that we will be able to report a positive impact from.

Representative Nelson: When we did the ND Dept of Health (DOH), they stated that they do this type of work as well, such as tobacco cessation and HB 1202 (healthy eating program in school). What type of collaboration is taking place between DPI, DOH, DOT, etc?
JoAnne Hoesel: To clarify, we don't work with good eating choices. Our focus is on substance abuse prevention. We work with DOH on tobacco prevention. We also work with DOT related to accidents (related to substance usage) reduction and the DPI. We all have a place with a different focus and the governor's prevention and advisory council on Drugs and Alcohol gives direction on this. We have formed a unified brand from the council which is called The Not Our Kids initiative. Each of those agencies has agreed to use that terminology and that brand whenever they can. We are going to implement a website (this spring) that is a hub. This will have the connection with all the agencies in the state that have a piece in prevention.
Representative Nelson: I'd be interested in looking at how it all fits together in that comprehensive plan.
JoAnne Hoesel: We can get that for you.

Representative Wieland: To what extent are alcohol prevention services being provided at college and universities?

JoAnne Hoesel: We have a representative from higher education on the Governor's Prevention and Advisory Council. We also know what everybody is doing. At the administrative level, our prevention administrator works with their prevention administrators. In the communities, we coordinate with higher ed. In fact higher ed has a grant right now where our staff are coordinating with them to put together late night activities for youth under 21 in the college world, that are still part of the community.
Representative Wieland: Last fall, I attended a breakfast at ND State University and one of the reasons that students give for drinking is that they are bored. When I went to college, there was too much to do like classes, studying, working, so there wasn't time to be bored. Are we making college life too easy? Should we be looking at this issue with a different approach?
JoAnne Hoesel: One important strategy is to look what individuals can do instead of using alcohol; not necessarily looking at the negative. We are also working on getting parents more involved.

Representative Nelson: you had a contract with some of the services for the 6 new FTE that you are proposing in this budget. Was there 6 individuals that were contracted?
JoAnne Hoesel: We had 8 contracts (8 individuals around the state). We had moved from 6 contracts to 1 contract. Now we have 6, but we are remaining to have contracts with the 4 tribal areas because that seems to be working well for them.
Representative Nelson: the tribes were included in the contract of the last biennia. You had 4 working outside of tribal govt?
JoAnne Hoesel: We had 8. One in each region and then one in each tribal area, thus there were 12. We were paying for this through contract and we have now moved some into salary and some into operating and we remain having funds in the grant line area to continue contracts with the tribal areas.
Representative Nelson: the contract situation was 100% federally funded and now with the 6 proposed FTE, that will be a general fund expenditure?
JoAnne Hoesel: it continues to be all federal funded. We are just using money differently. Instead of contract, we are moving them into the statewide team.
Chairman Pollert: that will be continual federal funds?
JoAnne Hoesel: this is our substance abuse and prevention treatment block grant. We are required to use 20% of that on prevention and that is what is being use for this. This is an ongoing, noncompetitive grant that each state receives.

Representative Nelson: in the previous division testimony, many of divisions are going to web based meeting. Thus the travel expenses are going down, however yours is going up. Can you explain why you aren't able to utilize these types of services more?
JoAnne Hoesel: there are two things that are driving that. We have two of the prevention staff located out of Bismarck, in Williston and Minot. We are providing direct service support to communities so they travel to Mohall, Carrington, etc. They traveled before, but we paid it in a contract, and now it's showing up in this area. When we do training, we absolutely do conference calls and we do polycom when we can. A lot of this is working with communities so there will continue to be a need to have face to face to allow for rapport to build and are supportive in a way that is meaningful to communities.
Representative Nelson: travel time is pretty dead time. It seems like that it is a trend that is growing.

JoAnne Hoesel: We would have had a decrease had we not moved this out of contract. It was being paid through a contract. We also have web cards so that one person drives, the other one is on the internet doing their work.

Representative Wieland: You mentioned ASD. I have read that the Autism birth rate is 1 in 110 and about 4 yrs ago, it was 1 in 140. Is that right?
JoAnne Hoesel: Yes, that's true. I've heard a 1 in 95 more recently.

Representative Nelson: in the grant line, you show that 86.6% is federal funds. Is the general fund share of that spread pretty evenly across the grant lines or is there some grants that are more heavily...can you give us a breakout of where that general fund spending is concentrated?
JoAnne Hoesel: we certainly can do that. We have a number of grants in this division that are 100% with no match required. We do have some that require a maintenance of effort which is different from a match.

Chairman Pollert: how is SB 2163 related to the million dollar grant on TBI?
JoAnne Hoesel: 2163 would be a continuation of what was funded in the 09-11 session where we currently have direct. TBI is an implementation grant. There is a different focus on what that money can be used for. It would be adding $110,000 for services similar to what the head injury association is doing now and that's currently funded in this budget, but on the eastern side of the state.

Chairman Pollert: on pg 5 (graph), when I add up the total number of the amount of drug use and meth use and then add up in 2006 and then add up in 2009, that is a reduction of 224. If I was a pure numbers person, wouldn't I say that there be less money going to these types of programs as compared to if you have more of an alcohol abuse problem?
JoAnne Hoesel: I would have to respectfully say the opposite in that it should not be reduced. You are looking at a snapshot of two drugs. You are thinking that those are somehow isolated out of the whole universe of people receiving treatment and that is not the case. When a person comes in to a human service center for treatment, we don't isolate them by drug of choice and then treat them separately. They are assigned and assessed for level of care. The process of treatment tends to be the same process for all drugs of abuse.
Chairman Pollert: can we get numbers of clients served in your section?
JoAnne Hoesel: Those numbers will show up in the human service centers.

Tine Bay, Director of the Developmental Disabilities Division with DHS, presented testimony, labeled as attachment **THREE**, which illustrates an overview of Division of Developmental Disabilities Division with DHS. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Nelson: You've had the right tracks screening program prior to the ARRA funding that funded part of that. You talk about the ARRA funding being used to provide that data base. Is that all your ARRA did and what are you getting out of that data base that you didn't have before?

Tine Bay: We have not completed the data base at this point. There isn't just one central location that people can go out in the regions to monitor the right track contracts. We are looking at a little bit more tied together.
Representative Nelson: what did you do with that information prior to this data base (the 7700 contracts) or what are you doing with it now, as the data base isn't available? As a legislator, parent, health care provider, etc., how can I muddle through that knowledge?
Tine Bay: I can get that for you.

Representative Kreidt: on the change in the reimbursement system, is that taking place?
Tine Bay: SB 2043 is a result of that change. It was passed through the Senate.
Representative Kreidt: Last session it came out of 1556 and then it was studied and the recommendation is that we go ahead with the respective system so nothing has happened.
Tine Bay: There was a study conducted and we made a recommendation to move to a prospective system using the supports intensity scale. That's what SB 2043 is. In that bill, it describes the phasing in of how we are going to do a two year plan.

Chairman Pollert: are the dollars to implement what you talked about in this budget (SB 2012)?
Tine Bay: There's a fiscal note attached to SB 2043, however the dollars were not moved through in the Senate.
Chairman Pollert: They pulled out and didn't fund it.
Tine Bay: Yes.

Russell Cusack, Vocational Rehabilitation Director with DHS, presented testimony, labeled as attachment **FOUR**, which illustrates an overview of programs and services that make up the budget request for the Vocational Rehabilitation (VR) Division for DHS. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Wieland: Regarding travel to required federal meetings; the federal govt doesn't use interactive TV versus doing required meetings to attend someplace? Another question is what is the blind vendor program?
Russell Cusack: The blind vendor program is a program that's called the Randolph-Sheppard Act, a federal program. The state of ND DHS is the state licensing agency. We have contracts in Fargo and in Bismarck to operate the snack bars at the federal buildings. We play individuals that are legally blind in those snack bars to operate their own businesses. In terms of the other question, the federal govt is not as savvy as the state of ND as far as using polycomp systems for different meetings that are required. Our funding source (United States of America Dept of Education Rehab Service Administration) is changing the monitoring method that they're going to use in terms of looking at state agencies and so they require the state agency representatives to come back and give input on that state monitoring protocol and to be up to snuff as far as knowing the information about the monitoring. During the detail, there will be an opportunity to provide more information about the travel.

Representative Nelson: Regarding the IPAT (Interagency Program Assistive Technology) program; what's the status of the needs across the state for this program?

Russell Cusack: There's a great need in ND for assistive technology, not only info, but also training. Being that ND is a rural, there is more difficulty in getting the training out to those who need it, i.e. youth and there are always struggles in providing that ongoing training.
Representative Nelson: is the IPAT federal funded? What kind of state contribution is there?
Russell Cusack: Federal grant (non competitive) for assistive tech and a state match
Representative Nelson: We are using the match to leverage those dollars in the best way possible?
Russell Cusack: Yes, we are

Chairman Pollert: In the last session, didn't $100,000 go to some project in Arthur? Is there is money in this budget for that?
Maggie Anderson: It was the community of care project that was funded in the medical services division. We have a contract with the community of care and can provide their report that we had them do prior to session that outlined all of the activities that they have done. That money is contained in the 11-13 budget proposal as well. They have been testing various methods of outreach and providing services to individuals in the community as a way to establish in hopes of replicating that model in other areas, specifically for home and community based services and the community taking ownership of assisting individuals in their community with home and community based services.
Chairman Pollert: it's a combination of an ADRC social services type program?
Maggie Anderson: It is a single point of entry for that community. Individuals in the community work through the community of care to access services, whether they be Medicaid clients or private pay and they provide networks of people to assist individuals in their home; sometimes they are paid, sometimes it's volunteer work. It is intended to create a model that could be replicated. It doesn't provide all of the outreach and detailed options counseling that, for example, the ADRC does, but it's similar.
Chairman Pollert: that was a general fund appropriation where the ADRC you found federal funding for?
Maggie Anderson: Community Care is a general fund and ADRC is a federal grant.
Chairman Pollert: We didn't appropriate that and it came up after the session was done?
Maggie Anderson: Yes, that's correct.

Nancy McKenzie, Director of the Human Service Centers (HSCs) with DHS, presented testimony, labeled as attachment **FIVE**, which illustrates an overview of the budget and program trends in the regional centers. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Nelson: where are you utilizing the tele-medicine services and what are you doing in those areas?
Nancy McKenzie: We have a tele-psychiatrist in Dickinson. In Dickinson, we have one doctor on site and our psychiatrist is through tele service. Due to poor roads impacting travel, in Devils Lake, we have tele services that do title 19 Medicaid evaluations and medical reviews. Through Northeast Human Service Center, there are tele- therapy services that serve Northwood. We've used the tele services to share our physicians. We've done the title 19 reviews with Minot and Devils Lake when needed. It is growing and expanding.

Chairman Pollert: would those individuals been served at the Robinson Recovery Center?
Nancy McKenzie: Yes, some of them could, but there is a high demand for these services and not enough beds.
Chairman Pollert: with the increase in the beds you are speaking of in a locked facility (15 beds), would there be a reduction in 15 beds in the State Hospital?
Nancy McKenzie: Yes, that's what the plan is.

Representative Nelson: how much is the cost of that ITD unit?
Nancy McKenzie: we can get that to you.

Chairman Pollert: When we did the DOCR budget, there was discussion about vacancies for psychology and psychiatrists and DOCR spoke of utilizing nurse practitioners to reduce costs. Are you doing something like this?
Nancy McKenzie: Yes, we are. We have advanced clinical practice nurses. There are supervisory requirements with psychiatrists. We can provide this to you when we do the detail.
Chairman Pollert: if you have a vacancy, are you using interactive video to help cover this?
Nancy McKenzie: Yes we do this to help share our staff across regions.

Chairman Pollert: Why is it the state's responsibility for Fargo to have a Cooper House as other towns like Minot, Bismarck, etc. have this same issue? Won't these towns be asking for Cooper House as well?
Nancy McKenzie: Being able to have the housing piece in place translates to less detox time, less hospital times, etc. By serving this need in Fargo area, we are serving our people (the individuals who utilize human service centers).
Chairman Pollert: My question is rather it's a local issue or a state issue?
Nancy McKenzie: we'll discuss that further in the detail

Chairman Pollert: What is the total amount for the psych inpatient?
Nancy McKenzie: $3.4M is the increase. The previous amount in budgets between 5 different human service centers for their contracts was $829,243. Thus, the total is $4,260,260.

Representative Wieland: does the state do any funding to Centre, Inc?
Nancy McKenzie: A small amount of contracting via Southeast with Centre. That's not so much for their detox program as some short term beds stabilization. Not as much as we use to in the past. Their population base has shifted more to corrections base, state and federal prisoners, and there was some issues with mix of clients, so occasionally we will contract for some bed days with them.
Representative Wieland: that's the Fargo detox. If their detox is down, they made a switch to do other things in their facility.
Nancy McKenzie: I can get that information to you during the detail.
Representative Wieland: the building at SEHSC is owned by the state. Is that paid for or is there still a bond payment left?
Nancy McKenzie: It is completed.

Representative Nelson: the $498,000 is more than just to provide an extra security person, right? What other services are included in this amount?
Nancy McKenzie: That amount is for two people, but those are 24/7 needs.
Representative Nelson: Is the one person included in the budget or was that onetime funding?
Nancy McKenzie: One is in the budget. It could be 2 or 3 people doing 12 or 8 hours shifts, respectively.

Chairman Pollert: how many full FTE does it take to run a 24 hr shift?
Nancy McKenzie: Alex will answer that when he does the next section.

Alex Schweitzer, Superintendent of the ND State Hospital and ND Developmental Center (One Center) with DHS, presented testimony, labeled as attachment **SIX**, which illustrates an overview of the One Center. Committee members interjected with questions throughout testimony and questions and answers are as follows.

Representative Metcalf: what has the recidivism rate been for the sex offenders in your program?
Alex Schweitzer: We have discharged 17 patients. 2 have returned to prison on a non sex related offenses. One in ND and the other in CA. Thus there has been no recidivism.
Representative Metcalf: you are having admissions of 17 per year? It appears you're holding the same.
Alex Schweitzer: There's been 81 individuals enter the program since 1997 which is when the program started. We admit many individuals for evaluations and once these are complete, the treatment recommendation may not be into that program, even though the states attorney may have indicated that an individual would be appropriate for the program. We may find their needs can be addressed more appropriately through different avenues. We are doing more paper reviews and we are more sophisticated in evaluating and treating these individuals.
Representative Metcalf: how many are still there since the beginning?
Alex Schweitzer: Currently we have 59 in the program. 17 have been discharged and 5 went to prison (potentially to return to the program) for offenses committed while at the hospital; most of which have been on the staff. There are certain things we do not tolerate such as aggression and bring in states attorney to prosecute.

Representative Nelson: From the DOCR budget, with the new prison construction, there's a pharmacy that's associated with that and that's going to service the JRCC on your campus. Wouldn't it be more efficient for you to do this as you are providing tele-pharmacy services?
Alex Schweitzer: We did provide the services for the JRCC from the beginning. In the last couple of years, they decided not to use us. We have the time to do that. You'll have to ask them why that is. We were providing that service and they decided to bring it in house.

Representative Wieland: pg 5 of the overview of the budget changes, behind the general funds, you have the Senate changes of $161,840. However, under the total, you don't show that 161,840. Is it already built in there and where would it be?

Alex Schweitzer: It's built in the general funds, goes to the House in the last column. If you look at the 11-13 budget, general funds 42,061,882 and you add the 161,840 you get 42,233,722 and then it's totaled down to 62,370,125.
Representative Wieland: it should show that. In the 2157947 figure back on the increase/decrease or should that be added in and actually increase the total?
Alex Schweitzer: It should be added in, in the increase. That was a mistake.

Representative Nelson: What is the 11-13 underfund of $900,000 made up of?
Alex Schweitzer: It's our estimate of turnover and the time to fill positions in terms of roll up dollars
Chairman Pollert: we'll have Office of Management and Budget going through it with us when we do the detail
Representative Nelson: in this equation, you are thinking that they thought there would be more transition...more people going out of the system than actually will.
Alex Schweitzer: It's our best guess and we provide that as an underfund.

Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 7, 2011
15057

☐ Conference Committee

Committee Clerk Signature Meredith Trachsel

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Chairman Pollert opened hearing on SB 2012 for detailing of the budget of Department of Human Services (DHS) budget. He requested OAR sheet. DHS confirmed they would provide this.

Debra McDermott provided information the committee had requested during overview of budget, starting with DHS Office Space Rent (2011-13 biennium compared to 2009-11 biennium). This information is labeled as attachment **ONE**.

Representative Nelson: The one issue that came up is the Prairie Hills Plaza and the amendment that was offered in the Senate. Are you comfortable with this proposal? You knew what was happening with the rents going into the lease?

Debra McDermott: Yes, that is true.

Chairman Pollert: Main office place, West Central, is that the same place?

Debra McDermott: They are also located in the Prairie Hills Plaza.

Chairman Pollert: Vocational rehab, is that something a little different?

Debra McDermott: They are also located within the Prairie Hills Plaza; it's in a different section and they had to do some remodeling in that area so we could have adequate office space.

Chairman Pollert: Do you have any place in Bismarck? The only other option is if you moved. Do you have anything that is as big a size as Prairie Hills is in Bismarck?

Debra McDermott: We do contact facilities management from time to time and see what they are aware of, as far as space throughout the Bismarck area, and what the rental prices are. We do work with them if there is a lease that is expiring and if we do need additional office space. I'm not aware of anything right now that is set up that we could move into.

Chairman Pollert: We'll be getting a list as well to double check what we're doing.

Representative Kaldor: Do we have an inflation clause in the contract that guarantees a rent increase each year?

Debra McDermott: Yes, in some of the lease agreements, there are inflationary increases that are built in each year. There is also language in there that says 'subject to appropriation,' as do all of our contracts which cross different bienniums.

Representative Kaldor: What is the basis we use for the inflation?

Debra McDermott: Each one is negotiated individually, and the inflators are usually put within the lease agreement.

Chairman Pollert: Office of Management and Budget (OMB), statewide, you guys are involved in that process as far as what lease agreements get done? Do you have guidelines you work through?

Joe Morrissette, OMB: It's up to each agency, there's not any oversight on the part of OMB. As part of an interim study process, OMB did compile information on rental rates and spaces leased by agencies around the state.

Representative Nelson: The amendment added by the Senate put a $12.50 maximum at Prairie Hills. If the landlord says they won't accept that, what would occur? Do you have a contingency plan if you were kicked out of there?

Debra McDermott: We do not have a plan. It is such a large office space, I'm not sure where we would be able to move in Bismarck-Mandan.

Representative Nelson: You are really trusting us then.

Debra McDermott: Yes I am, and I have full confidence.

Chairman Pollert: If there are no further questions on that, we'll go to the next page.

Debra McDermott went over information about the Health Care Trust Fund, Status Statement, labeled as attachment **TWO**. She then went over Department of Human Services (DHS) Turnover History 2007-2010 and the DHS vacancy rate history from 2007-2010, labeled as attachment **THREE.** As an update, currently there are 48 vacant positions as of February 21, of those 76.05 that were vacant.

Chairman Pollert: You're reducing the developmental center by 40 FTEs. Those would have been phantom FTEs, then. Were they vacant? Because you've never really filled them.

Debra McDermott: They may have been filled at sometime throughout the biennium. When we look at the facility, and what the needs are, as well as bringing clients out into the community, that's the FTEs we feel are no longer needed in 11-13.

Chairman Pollert: Going from 95 to 67 (clients), that is where your 40 is coming from.

Debra McDermott: I'd have to look at the FTEs from last biennium, but some the FTEs from this biennium would have been filled.

Debra McDermott provided and presented testimony on the detail of the Administration /Support section of DHS, labeled as attachment **FOUR**. Committee members interjected with questions throughout testimony with questions and answers illustrated as follows. She utilized attachment **FIVE** (information from previous testimony, overview of budget) in conjunction with attachment **FOUR** to explain the detailing of the budget.

Chairman Pollert: Did the Senate go to 4 and 1 for salaries?

Roxanne Woeste, Legislative Council: In the OMB bill where there is section of intent regarding state employee salaries, the Senate did change that from a 3 and 3 to a 4 and 1. The dollars that equate to those two scenarios are very similar, so there are no adjustments to agency budgets.

Chairman Pollert: Under the salary and benefit increase, that is the 3 and the 3 and the insurance increases is what is in that item.

Debra McDermott: The salary increase, or account code 599110, that's the 3 and 3. The next one down from that is the fringe benefit, FICA and retirement of 9.26%. Next is health insurance, which is $ 60.65 per month. Next is the retirement increase, the employer's share of the 1 and 1. The last is the EAP (employee assistance program) increase.

Chairman Pollert: Would the salary roll up, the underfunding, that you talked about last week still be in these 599110 accounts?

Debra McDermott: That would be under the column 'total budget changes,' it would be included within the sum of $452,049, as well as the continuation of the second year salary increase. The next four bullets are for salaries, all of those numbers would be contained in the 'total budget changes,' including the underfunding, the second year, the lawyer, and the remaining increases and decreases.

Chairman Pollert: Why did we have to underfund, from last biennium?

Debra McDermott: It was a calculation based on the vacancy report. That was $1.4 million, and based on division needs, they were each allocated a portion of that $1.4 million underfunding.

Vice Chairman Bellew: 90% of GSA? I thought it was 65. That might just be for legislators.

Debra McDermott: For lodging, it's 90% of the GSA rate. For meals, those are going to be 65% of the GSA.

Lori Laschkewitsch, OMB: It's the meals that are 65% for instate, and the lodging is 90%. That is for everybody.

Representative Nelson: We get 65% (lodging) during session, and due to previous action we went to 65% for the monthly, and 90% for daily. When DOT sent out that decrease from $.40 to $.37 per mile, has there been any discussion about whether that is going to be adequate to fund that, with increased gas prices?

Debra McDermott: There was an error in the report. It only showed 11 months of expenditures, because of when we received the billing from DOT. There is another $11,000-$12,000 that needs to be added to that 12-month cost. Also, the way DOT gives us the billing rate is based upon a lot of things, not just gas, including how much they get their vehicles for, how much they sell them at auctions, and gas. Even though we were budgeted at 40 cents per mile, we had been paying only 29 cents. Since September that is continuing to creep up. Our rates are going to 33 cents a mile starting March 1. They continue to adjust their rates, sometimes monthly. We haven't gotten specific information yet on whether the budget guidelines are too high or too low, based on anticipated costs.

Representative Nelson: There is some cushion in there, the way it appears. Going into a new biennium, have you budgeted that closely in the past?

Debra McDermott: We always budget for what we get from the guidelines for DOT.

Representative Nelson: You just plug the number in, except for the utilization of it. Is it always this close? Did there used to be more of a cushion?

Debra McDermott: I've seen it go both ways, sometimes we get a budget guideline to follow and the DOT exceeds those rates, sometimes they go under.

Chairman Pollert: If I would look at your budget right now, $360,000 for the biennium, I'd say you are overfunded by $50-80,000. But that's if I were a suspicious person.

Debra McDermott: The other thing built into this budget is our increased usage in the motor pool. We have to do more basic care facility audits, because of the new facilities coming up across the state. It's also the hotel costs that are going up $8 a night. We are seeing increases as well in the Health Tracks area. The department is trying to work with Custer Health Unit in ensuring the children in the Standing Rock area are covered and screened, and working with the public health units to make sure we are meeting the CMS guidelines. They recommend 80% of the children are screened each year, and right now we're at 60%, so we anticipate increased mileage regarding these areas, as well. I would also like to draw your attention to the fact that a lot of things are based upon timing. If it's

printing, for example, or supplies, a lot of that is based upon when we place an order. Looking at 12 months may not be a representative sample.

Vice Chairman Bellew: Can you explain the reasoning for the 50% increase request for IT Software?

Debra McDermott: It's about timing on when we buy things. It's toner, printing ink, so it would depend on when we buy those supplies.

Vice Chairman Bellew: Has toner gone up that much?

Debra McDermott: It has, and it continues to go up. Also, for clarification, we did get guidelines from OMB for things done at Central Duplicating that there was a 3 and 3 inflation we were supposed to build in, and for all office supply-type costs there was a 2 and 2 inflation, so that was used throughout the budget process by all the divisions.

Chairman Pollert: Can you talk about professional services fees?

Debra McDermott: Let me go over the last three pages of attachment **FOUR.**

Representative Nelson: On the administrative hearings, what is the breakdown between general and federal based on?

Debra McDermott: Time studies we do and the cases they are working on. We use those statistics to draw down different types of federal funds.

Representative Nelson: Is some of it subject to FMAP, and there are other breakdowns as well?

Debra McDermott: No, nothing would be FMAP. For Medicaid admin costs, it would be 50/50 federal match.

Representative Nelson: But it doesn't always work out that way because of the mix, is what you're saying.

Debra McDermott: Correct. Some things may be 100% general funds. But we do track statistics and use those to allocate the funds out. She then went over Legal Appeals Information (DHS, 11-13 biennium), labeled as attachment **SIX.**

Chairman Pollert: What types of cases are going to the Office of Administrative Hearings (OAH)?

Debra McDermott: They do multiple things such as employee grievances, Children and Family services, sex offender cases. The attorney general is the agency that represents us when we go before the OAH. Just to note, those cases are becoming more complex and taking more time to work through due to federal regulations. Basically, as people understand the rules, they try to think of different and better ways to break them.

Chairman Pollert: Is the office of the state auditor, is that what you pay for having them come in and audit certain divisions?

Debra McDermott: We get charged for a single audit, which is a statewide federal audit, and we paid around $240,000 for that, regarding compliance with federal regulations; there is also the agency audit, where they come in and do compliance with LAFRC, basically for compliance with state laws and our appropriation.

Vice Chairman Bellew: It says that appeals that go to OAH are also referred to the AG's office. Is there a lot of duplication of effort there?

Debra McDermott: The attorney general's office represents us, they are our legal representation when we go to OAH.

Representative Wieland: Under repairs, are you talking about machine repairs?

Debra McDermott: In the repairs budget account code, it is maintenance costs such as meter machines maintenance, copy costs, etc. Essentially, it is more maintenance costs than repairs.

Jenny Witham provided and presented testimony about detailing the budget for the Information Technology Services for DHS, which is labeled as attachment **SEVEN.**

Representative Wieland: Are these four FTEs full time currently?

Jenny Witham: Yes, they are.

Representative Wieland: They came out of temporary salaries?

Jenny Witham: Yes. She explained this by referencing the detail account structure in attachment **SEVEN.**

Representative Wieland: Those four FTEs, on basic salaries, will be earning $230,000 as permanent?

Jenny Witham: That is the budget change. Gave explanation of numbers in the budget overview. For one FTE, both her salary and her fringe would be new dollars in this budget request. For the other three FTEs, the data entry FTEs, those individuals have been working for us for years. Their base salary is in the 09-11 budget as temporary salary and the only increase we are asking for those FTEs is to convert them to have benefits. There was a benefit increase of $80,000. So that $229,000 increase covers all the benefits and salaries of the four FTEs, and represents a shift of the salaries that are already in the 09-11 budget for the data entry staff, as well as the new dollars to cover the health information technology position.

Chairman Pollert: You must still have some temporary staff working in there, correct?

Jenny Witham: Yes. In the areas of data entry, we have four full-time FTEs and three temporary FTEs. I'm asking for those three temporary FTEs to become permanent salaried employees. I have additional temporary employees that work throughout the state that provide desktop service support, but we are not asking for any of those temporary employees to be changed.

Chairman Pollert: You still got $124,000 of temporary salaries.

Jenny Witham: Right.

Chairman Pollert: And that is how many?

Jenny Witham: Temp staff is 4.5 FTEs, located throughout the state, at State Hospital, SEHSC, Lake Region, and SCHSC. All of those are providing desktop support services, helping end users with using their local machines.

Representative Nelson: In most of the salary line, we spend a little over $2 state general funds for each $1 in federal funds. In the budget changes you're proposing, most of this is federal money.

Jenny Witham: The Health Information Technology position is at a 90/10 match so there's much more federal support for that position.

Representative Nelson: That one position is what skews that number and going from temp to full doesn't really affect that.

Jenny Witham: Correct.

Chairman Pollert: This is part of MMIS, correct?

Jenny Witham: Yes, the data entry staff will be supporting the Medicaid claims processing.

To clarify former questions further, **Jenny Witham** provided and went over information about FTEs (people who have been temporary employees for 4+ years), labeled as attachment **EIGHT.**

Vice Chairman Bellew: If this is funded by ARRA, what happens when those ARRA funds go away?

Jenny Witham: Not to be confusing, but these are not ARRA funds. This is actually a position whose federal match is coming from the Centers for Medicare and Medicaid Services, so it is very similar to the other positions we have in our department that work on the medical services systems. The only thing that is different about this position is that for a period of time there is incentive match, so it's moving from a regular 75/25 match to a 90/10 match. We are getting more federal funds to match this position, but it's not related to those one-time ARRA funds.

Representative Wieland: So I understand it'll be 90/10 in the next biennium, but for how long will that continue?

Jenny Witham: We're anticipating this match to occur for the six years starting in 2009, so it should completely encompass both this and the next biennium. If it's not continuing to be funded at 90/10, then they would fall back to the traditional Medicaid match of 75/25 for staff on IT projects.

Representative Nelson: As healthcare facilities implement HIT programs, how compatible is your program with the array of other HIT programs being used?

Jenny Witham: For Health Information Exchange, the mechanism in which we will receive that is the building out of the Health Information Exchange, so the term 'the exchange' is actually the infrastructure, which will be the interstate highway providers use to hook up and send information to each other. The compatibility that the Medicaid Systems program will have to receive those documents and be able to use them is something we are capable of doing.

Representative Kaldor: What is the level for the Medicaid volume criteria?

Nancy Willis, State Medicaid Health Information Technology Coordinator: 10% for hospitals and 30% for individuals.

Representative Nelson: That 10% threshold, is that to get any reimbursement, or is that to maximize the $1 million per facility for critical access hospitals?

Nancy Willis: Those are two separate pools. The PPS hospitals and the critical access hospitals both have to have a 10% minimum volume of Medicaid patients in order to meet criteria to be able to request incentives. It's the same volume for both. There will be more larger hospitals, and because there is a formula based on discharges, they will be able to get more incentive payments than the critical access hospitals.

Representative Nelson: There is a handful of critical access hospitals that would qualify as well as PPS?

Nancy Willis: Yes, that is correct.

Jenny Witham resumed presenting.

Chairman Pollert: You've got three, one and one?

Jenny Witham: Yes, the three data entry staff were discussed, those are temporary employees we are asking to move to permanent; the one health information technology coordinator position which is currently a temporary position, which we're asking to move to permanent; and the last position is, during the biennium, we did move a position to do more provider outreach and new MMIS system roll out assistance. That position is included in the 37.5 FTEs already. I am asking for four more, to bring it up to 41.5 FTEs.

Representative Wieland: In the software development area (attachment **SEVEN**, page 6), those are actual costs for the analyst, senior analyst and analyst II?

Jenny Witham: Yes, those are the dollars per hour. They are from the Information Technology Department and these costs will show up in ITD's budget as a special fund.

Chairman Pollert: Once MMIS is up will this just be a onetime cost, or an ongoing cost that increases as utilization increases?

Jenny Witham: In a way, it's a onetime lift as we move from a different information system to new one. We are running on the mainframe right now. The main frame hosting and processing costs for our MMIS are about $2.6 million; the new environment is going to be about $4.6 million. It's not a one-time charge, but it's going up as a more expensive system to run, in terms of the hardware and software. I want to mention that the mainframe costs are not staying steady. In the past, it was cost-effective as a shared environment. As people are moving off that shared environment, it would just be a cost shift back to those who are still processing on the mainframe. If we were to stay on the mainframe, we would see escalating costs as well. This is in a way a one-time shift away from our mainframe costs to server-based processing costs. This shift is prudent.

Representative Nelson: Often when we talk about utilization increase, we talk about some soft numbers and blue sky. In this case, it appears they are pretty hard numbers, you know how many people are plugged in and the services they're going to need. There isn't any guess work in this, is there?

Jenny Witham: There is no guess work in this.

Chairman Pollert: So these costs are over and above the $62.5 million for developing the MMIS?

Jenny Witham: This is the cost to continue to operate the system after implementation.

Representative Wieland: You've taken the start date for the new system, June 2012, into account?

Jenny Witham: Yes. We will still need to run the legacy MMIS for the first 11 months of the biennium. Those legacy costs are included in the information technology costs in the budget.

Chairman Pollert: In looking at 2 years from now, we've given you the FTEs, are you going to say we are in good shape?

Jenny Witham: For the medical services division, I am hoping I can say that.

Representative Nelson: I would understand the utilization increase to be pretty stagnant once you make that switch. That shouldn't grow, should it?

Jenny Witham: The reason it grows is generally new state or federal changes that need to be implemented into those programs. Most of these programs run on the mainframe, so as long as you are adding more complexity or new function, the CPU utilization is going to be the increased utilization.

Representative Nelson: But it shouldn't be significantly higher.

Jenny Witham: I wouldn't be able to speak to that unless I knew what those future changes were. I did want to separate for you the rate increase from the utilization, because I think those are two separate things.

Representative Nelson: We never see this when talk about increased enrollments in CHIP program, for example, but is it possible to put a value on what the cost to you, IT, for each individual that gets added to the program?

Jenny Witham: I don't think we've ever done that cost in that way. When we provide Fiscal Notes for changes that would be in state programs, ITD does its best to estimate not only what the implementation costs would be, but if there is going to be an ongoing cost associated with it, as well.

Chairman Pollert: What are the states that are in the red doing about MMIS? Everybody needs to switch. Do they quit funding it and wait until they get into the black, so we're just that much further ahead?

Jenny Witham: I know that other states, because of the requirements of the Medicaid program, wouldn't have that as an option.

Chairman Pollert: They still have to get it done, no matter what.

Jenny Witham: Yes. The MMIS acts like an insurance company would, and it makes payments to the providers. This system pays those claims.

Representative Wieland: If MMIS is not complete by June 2012, how will these dollars be effected? Will we still have to include them prior to the next biennium, or would there be some reduction to those costs?

Jenny Witham: We would still have to include them. We did buy all the hardware and software that is needed to run the new MMIS. The incremental increase that I was talking about, the processing in the new environment being more expensive than the current environment, we've already invested the money in those environments in order to test the software and roll it out through implementation. In the upcoming biennium, regardless of when the MMIS were to come up, we would still have these costs because those operating system environments still need to be in place.

Representative Wieland: Even if it's been delayed as long as it's been delayed now?

Jenny Witham: Yes. There are incremental components. There are not any costs in here that would go down if we were to delay the MMIS.

Chairman Pollert: What are retained funds (attachment **SEVEN**, page 3) under account 3994?

Debra McDermott: That's the swap money used in this area to fund a portion of those expenditures.

Vice Chairman Bellew: Can you go over IT equipment under $5000?

Jenny Witham: The current budget for that is $779,187. The total budget increase of $180,851 brings it to a request of $960,000. The increase represents a shift in our replacement cycle requests to move to laptops from desktop computers. With telemedicine becoming more pervasive, it allows us to go out to clients more, and having the mobility created by a laptop is a real plus.

Chairman Pollert: Do you have certain employees who have a desktop and a laptop?

Jenny Witham: No. We allow staff to have one or the other; either a laptop or a desktop. The majority of our staff have desktops. We scrutinize closely when someone requests a laptop, to make sure they actually need that mobility that a laptop provides.

Chairman Pollert: Any other questions on IT? Thank you. We have one more schedule for today.

Debra McDermott provided OAR schedules, labeled as attachment **NINE.**

Chairman Pollert closed the hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 8, 2011
15093

☐ Conference Committee

Committee Clerk Signature Julia Hjelle

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 for public testimony. Schedule for testimony is in order that the budget was presented starting with Administration/Support.

Jerry Jurena, President of the ND Hospital Association (NDHA), presented testimony in support of SB 2012 and written testimony is labeled as attachment **ONE.**

Chairman Pollert: you stated that "urban hospitals do not have the necessary staff to meet the demand in urban areas, let alone provide assistance to rural hospitals." The rebasing was a high priority for you last session, right? According to your statements, is the amount in the DHS budget going to be enough money to provide for the staff you need? I was under the impression that staff was okay, but you needed increased services?
Jerry Jurena: Yes to both. We have frequent flyers at our rural hospitals (at Rugby for instance) and there are hours spent to get them in hospitals only available in urban areas. Due to lack of staffing as part of the barrier, these hospitals are full and can't take the pt in the immediate sense. More time is spend looking around for other hospitals and in this time, pts may go AMA and then show up again in a week and the process starts over.

Paul Ronningen, State Coordinator for the Children's Defense Fund, provided and presented testimony in support of SB 2012. Written testimony is labeled as attachment **TWO.**

Representative Kreidt: in looking at across the nation with states who are at 250%; those states are all broke. In looking at our state, I would comment that we provide adequate services to our children and being able to sustain that into the future probably means more financial security than for the states at 250% and having to cut back on the services they are providing. Thus I think that, that type of comparison isn't factual in looking at the whole situation.

Paul Ronningen: across the board comparisons to other states on Children's Health Insurance Program is not apples to apples. If you are going to give me long term income tax relief, long term property tax relief, based on a gift of having established a state over an oil reserve and you are going to have long term commitments to me as a taxpayer, why can't we strip off a small percentage of those gifts to me as a rich person and enable our low income kids to have health insurance.
Representative Kreidt: hasn't the Senate raised it to 175%, so there was some increase, and the House hasn't yet discussed?
Paul Ronningen: Yes, there has been a raise for 2012 that would bring it up to 175%. Because some of our disregards, that's probably a little more than 175% and we've been all debating gross versus net and those kinds of things. However, ND is in a situation where we can do much better and we can treat the people with wealth and also those without as much wealth, more similarly.

Chairman Pollert: when you say national average, do you mean net or gross?
Paul Ronningen: I'll let the dept handle that. It's the national average of what the states list their CHIP program at. According to the research, if our 175% that Representative Kreidt cited, we can 15-20% extra to make that cross over.
Chairman Pollert: 183% is comparative to 250%
Paul Ronningen: Not at all. The 250% would be comparable to about a 230%.
Chairman Pollert: No, I mean where we are at with the 160 – that's equivalent to 180-185%, thus it's 250 versus 185 roughly.

Representative Kaldor: how many children are not eligible for Medicaid or their homes or their families cannot afford coverage?
Paul Ronningen: 13-14,000 children are without health insurance in ND. More than 1000 would be covered in going to 250%.
Representative Kaldor: the cost of coverage is less for children. Has there been analysis to give us cost data on the effect that early child coverage has on the long term? Could we reduce future medication costs as a result of early coverage?
Paul Ronningen: I do not have those studies with me, but providing health insurance coverage to individuals reduces costs overall. It increases workforce productivity, healthier workforce, better able to learn - having health insurance versus having none for cost analysis I can get this for you
Representative Kaldor: Yes, I'd be interested in that because we've discussed this several biennia and we've made adjustments to this as time goes by, but I'm always confronted with the argument that it's not going to save us money and can we quantify that. If prevention is part of the process and that does help save dollars in the future, then there is an economic benefit to cover more children.
Paul Ronningen: Yes, I can get that.

Representative Nelson: you referenced a reduction in extraction tax. I'm not aware of any reduction and extraction tax that's before this legislation session.
Paul Ronningen: There's conversation going on now about oil companies receiving tax break. Oil companies are being taxed at a certain rate and in order to make it more understandable, more equitable to other states; we are talking about a tax reduction to those companies who are drilling in western ND even though those companies are fully

engaged in the activity and it doesn't look that anytime soon that we will be stemming the interest of people making money off our oil.
Representative Nelson: is there a bill that does that?
Paul Ronningen: Perhaps not.
Representative Nelson: regarding the cost/benefit analysis, what is the short term cost to increase level to 250% of poverty?
Paul Ronningen: Those have been reflected on a few different bills earlier in the session and the costs have been reflected in the fiscal note (in house and senate).

Chairman Pollert: there are 2 bills that went through the Senate side about raising the level to 200 and 250 and the bills were defeated. An observation I have is that we get a better bang for our buck with outreach (according to past testimony) versus going to 250% because of the Dakota Medical Foundation and going out to schools.
Paul Ronningen: We look at the overall state of the economy in ND and balancing our value systems against ND values long term. We have a long history of working together with a state owned bank, state mill and elevator, the cultures we were raised in on our farm families. The gift that we've been given ought to be distributed not only to the wealthy, but to those who aren't as fortunate and in this situation, we have low income kids who could benefit greatly from health insurance coverage as would their families. These are real life situations when kids and families are maxing out due to health issues.

Representative Kaldor: we did have testimony about the program to go out and inform people that they may be eligible for Medicaid benefits. When you speak about those uninsured, are we talking about those who are between the Medicaid eligible and the 250% or are we talking about those who might be Medicaid eligible as well?
Paul Ronningen: I am referring to individuals between the 160 and the 250 level.

Jacklyn Bugbee (representing St. Alexius Medical Center) provided and presented testimony which was a letter from Gary Miller (Interim President/CEO of St. Alexius Medical Center), in support of SB 2012. Written testimony is labeled as attachment **THREE.**

Chairman Pollert: in regards to the Frontier Amendment on universal healthcare (I'll just call it that), what is the $65M going to? What does that money address from the Frontier amendment?
Jacklyn Bugbee: We are in the process of getting our claims reprocessed. That will bring up our threshold to a 1.04 for Medicaid rebasing. That will actually increase our Medicare reimbursement for services for Medicare eligible patients.
Chairman Pollert: does that address the statements in your letter?
Jacklyn Bugbee: It does. Last session we were rebased to the Medicare costs even though we are sent to a 1.04; we're still not receiving true cost and actual cost for the services that are being provided. Even with a 3% inflationary cost to the Medicare rebasing for our Medicaid patients, because our Medicare numbers are not at true actual cost, we won't be receiving true cost for Medicaid as well because of the fact the rebasing is based on the Medicare allowed cost.

Representative Kaldor: when we did rebasing, we used this Medicare step down process method for cost finding. So, that eliminates the operational costs?
Jacklyn Bugbee: Yes

Representative Kaldor: we are allowed to apply Medicaid reimbursements towards operational costs?
Jacklyn Bugbee: We are, however when we're not receiving the true actual cost on the Medicare side, we will never reach the true cost of the Medicaid side because that Medicare level is still below actual cost, even with the 3% inflationary increase.
Representative Kaldor: we basically lock in a differential?
Jacklyn Bugbee: Yes

Dianne Sheppard, Executive Director of the Arc, Upper Valley in Grand Forks and an official spokesperson for The Arc in ND, provided and presented testimony, labeled as attachment **FOUR.** As part of the attachment, for the purposes of the committee's information, Ms. Sheppard provided a study titled *Closing the ND Developmental Center: Issues, Implications, Guidelines.*

Representative Kaldor: on pg 4, you have the general fund/federal fund breakdown for OAR. Would that be an increase in general funds?
Diane Sheppard: It was an OAR in the DHS budget that was not funded
Representative Kaldor: that would leverage the $3.3M from the federal funds. Would those come from the SSI or from a different source?
Diane Sheppard: That would be a different source, but we would have to clarify that with the department.

Courtney Koebele, Director of Advocacy of the ND Medical Association, provided and presented testimony, labeled as attachment **FIVE** in support of SB 2012.

Shelly Peterson, representative of the ND Long Term Care Association, provided and presented testimony in support of SB 2012, labeled as attachment **SIX.** Along with the testimony and included as part of the attachment, for committee's information, Ms. Peterson provided a booklet of information about Long Term Care in ND.

Representative Nelson: has your association done an analysis including assisted living in the Medicaid payment structure and a comprehensive look at who would not need the services already provided?
Shelly Peterson: In the 09 biennium there was an OAR to provide rent assistance for low income in assisted living which never passed. The number one issue is individuals in assisted that are running out of money. The vast majority in assisted living are independent however there is a segment that runs out of money and with rent assistance, it would help maintain them in that environment longer. There comes a day when they become so dependent that they do need skilled services. We haven't looked at the dollar amount as it wasn't a top priority. It's just like basic care. You provide rent assistance in basic care so perhaps someday there should be rent assistance in assisted living to help the lower income population.
Representative Nelson: is one of the reasons it wasn't a top priority because the assisted living segment is generally full?
Shelly Peterson: There wasn't as many who needed rent assistance, however it could be because more are going into basic care. It is almost fully occupied; however, if you are low to moderate income, your access to it is nonexistent unless you are in New Salem, ND where the facility is very cost effective. Bethany Homes in Fargo has HUD money so they

have been able to also provide cost effective rent to the lower income population. For the most part, it is nonexistent. The department funded a rent project in Steele to test that model. Steele, which closed as a nursing facility and opened last week as a basic care facility is not moving forward with the assisted living portion because it wasn't economically feasible so that rent portion for assisted living will never be tested as a model and we were looking forward to testing that, seeing how effective a rent subsidy worked on assisted living.
Representative Nelson: the model in Fargo where the HUD project is: the cost of building the structure was subsidized so that allowed the lower rent?
Shelly Peterson: No, that is a very old building and they received a HUD grant to renovate that so since it was a grant you don't have to pay it back. That has been able to keep that rent cost effective.

Chairman Pollert: there aren't people in the nursing homes that would qualify for assisted living due to the difference in medical needs, right?
Shelly Peterson: Yes, the needs of those in a nursing home are higher and can't be scheduled around a caregiver as there needs to be a caregiver available as that person needs. In assisted living, individuals contract for specific services that are unscheduled.

Representative Kreidt: the 80 beds on your testimony (nursing home); could we suspect that those beds will never go online? Do you have any perspective that some of those will come online?
Shelly Peterson: Yes, those beds will go online at Morton county and Burleigh county where you see the plus 5. Those plus 5 are going to be converted to basic care and move to Steele; those are the MedCenter beds that are being waited to be moved over to Steele. The 48 in Cass County are highly debatable at this time because Good Sam has not made a decision as to what to do. There's not a need for them right now. There will likely be a need in the future with our aging population, but those beds will go out of service if they aren't put into service in 48 months. Some have been transferred earlier so some will go out of service in two years, so those may be leaving the system. In Grand Forks, I will have to check on that and let you know.
Representative Kreidt: we will be losing 10 skill beds due to the Morton and Burleigh County beds going to basic care. Those are the ones that came from Steele and are going back to basic care.
Shelly Peterson: Those came from West Hope when West Hope sole their beds and closed.

Representative Wieland: this last sheet you went through, listing all the nursing homes and costs and so forth, I thought we had a similar sheet last biennium and it referred to number of beds as opposed to total days. Am I remembering correctly?
Shelly Peterson: No, it was a little bit different form, but similar. I can get that if you'd like it.
Representative Wieland: yes, I'd like that.

Representative Nelson: historically, every time that we've given a wage increase to nurses, it's dropped the percentage of turnover, except this last time. What's going on?
Shelly Peterson: You gave 80% which resulted in a 30% decrease in turnover. We have new opened facilities that are putting greater strain on a limited resource. We are just not

seeing the applicants that we need to see or the interest. However, we feel that we need to at least stay competitive. We are hoping to attract from Michigan but we haven't been able to do the out of state recruitment like we had hoped for. We truly believe that even though there has been not a significant drop in turnover this time, we would have been in much worse shape if you hadn't given the wage increase.
Representative Nelson: Are there other strategies other than wages that are being considered?
Shelly Peterson: We are working with the Dakota medical foundation in looking what we can do to entice and recruit our young people to have a career in nursing such as the loan repayment program; however we aren't going to see the fruits of that program for at least a few years. We are working on providing more education about the profession. We also work with the Department of Commerce regarding this goal. Thus, we have a number of strategies we are employing.

Mitch Leupp, administrator of Mountrail Bethel Home and Mountrail County Medical Center, provided and presented testimony in support of SB 2012. Written testimony is labeled as attachment **SEVEN.**

Representative Nelson: Can you expand on why 85% of emergency care is not being paid by Indian health services? I thought they did pay, but there was just a delay in it.
Mitch Leupp: On a federal level, IHS is very underfunded. Due to EMTALA guidelines, we cannot deny for those who want it. Also, what happens is that we don't get reimbursed as the care that the individuals are seeking does not meet the ER level of service. There are significant delays as well. We haven't been paid from Minnetohe clinic in 6 months.
Representative Nelson: do most of the pts that come to your facility come after the clinic hours in New Town? Or is this a choice that the pts are making to come to your facility during hours?
Mitch Leupp: Most of those visits are after hours or on weekends. We have found that they sit in the clinic all day and did not get served there. At 4 pm or so the clinic physicians leave and these individuals come to us. We can appeal those cases, but haven't been successful in 99% of cases.

Representative Kaldor: I would assume that your proportion of Medicaid pts is low based on the economy, but when you relate the tribal pts, that probably offsets that some?
Mitch Leupp: Our total number on the hospital and clinic side in regard to Medicaid is fairly low. Part of the problem we deal with in regard to enrolled members of the Three Affiliated Tribes is that many times they do not adjudicate the claims in a timely manner. Sometimes we are out there 8, 9, 18 months, up to 2 years before they will deny the claim for us. We are then passed the timeline where we can file. We aren't getting participation from the members to go back and see if they are even qualifying for Medicaid. Once the IHS denies the claim and we go back and try to privately bill those 85% of denied claims, we are unable to do any kind of collection on the reservation or even get them to respond to questionnaires about whether they are eligible for Medicaid.
Representative Kaldor: because you are a facility that provides emergency services in addition to other things you provide, are you eligible for Impact Grants (oil impact grants)?
Mitch Leupp: Not that we are aware of. Many of the oil companies have been good on a community level to help the community and we are visiting with them about some fundraising, but not the oil impact.

Amy Kreidt, RN and the Director of Home Health Services for St. Joseph's Hospital, provided and presented testimony in support of SB 2012, labeled as attachment **EIGHT.**

Representative Kreidt: didn't we do increasing for QSPs last time?
Chairman Pollert: yes it was the same increase as the DD. CHI facilities are quitting their QSPs, however I haven't received notification about services being affected. It surprises me as to why that is.

Lynn Fundingsland, Executive Director of Fargo Housing and Redevelopment Authority, provided and presented testimony in support on SB 2012, labeled as attachment **NINE.** Included with the attachment is written testimony from **Michael Carbone**, executive director of the ND Coalition for Homeless People (NDCHP), in support of SB 2012 as well as an informational brochure about Copper House.

Scott Stenerson, Homeless Population Liaison with the Fargo Police Department, provided and presented testimony in support of SB 2012 (specifically Cooper House), labeled as attachment **TEN.** He stated that there are 42 units and is currently full. I am involved in screening and a small handful were getting services from SEHSC when they came in and now, half are getting services at SEHSC. Getting services in place at a lower level would decrease trips out to the State Hospital; another cost savings.

Representative Kaldor: originally there was request for 4 different positions your folks opened. Can you explain these positions?
Scott Stenerson: 2 were door staff and the others provided case management services within the building. Our staff was reduced to a single door staff last session. We are requesting that now, 1 would be at the door 24/7 and the second would be involved with the residents to build rapport which is necessary for success in services. This individual would find problems that are developing on the units and deal with them before the problems get to the point of involving the police.

Chairman Pollert: I am wondering if this is a local issue or whether it's a state issue. if we fund something like this for Fargo, when do we start funding the same thing for Bismarck, Minot, etc?
Scott Stenerson: 40% of the cases of the individuals in Cooper House are from other parts of the state. In 2005-2009 the detox rate tripled and many weren't from Fargo and this rate has since dropped which I attribute greatly to Cooper House. I am on the Homeless Coalition and at a quarterly meeting, a member spoke of a homeless individual in Bismarck coming to a facility which is a point of entry. This point of entry helps to get individuals access to services. The chronic homeless have often burned bridges with other agencies and homeless shelters in their area, so in this circumstance they put this individual on the bus to Fargo to get services there. When I asked her the reason, she stated that Fargo has the best services.

Representative Nelson: you spoke of a savings that has occurred in the PD. Do you have a breakdown of the payers of Cooper House? For instance, who is paying the way now from an operational standpoint? That would be helpful.

Scott Stenerson: I can't provide that, but I can tell you that there are weekly meetings at Cooper House which staff from multiple agencies that we collaborate with to include Cass County social services and SEHSC.
Chairman Pollert informed Nancy McKenzie that the committee is requesting this information from SEHSC during the detailing of the Human Service Centers.

Lieutenant Joel Vettel, Fargo Police Department: As a Fargo PD administrator, we fully support Scott and Lynn in their testimony today. As a sworn officer and a representative of the PD, Scott is closely involved in the development of Cooper House. Scott continues to be involved with Cooper House on a daily basis. He is really our boots on the ground when it comes to Cooper House and the individuals who reside there. Cooper House is currently the highest calls for service location in our city. A significant percentage of the residents at Cooper House account for the majority of our calls for service and theses individuals are the same individuals that we have a history of dealing with over and over with in our community. They are some of the most chronic offenders and are the most frequent users of our services like Centre Detox. Having these folks in one housing facility has predictfully made the facility a high call for service location. Overall, we deal with these chronic offenders much less frequently now that they are in secured housing facility. This allows officers to redirect their time and efforts and illustrates the value of Cooper House to the entire community. These folks are not just coming in from the city of Fargo. This is not just a city of Fargo issue. They come from all parts of ND to seek services in these locations where they cannot be provided for in other locals. Cooper House allows us the opportunity to get this segment of the population out of our detox centers, out of our jails and also out of the dangerous winter conditions that exist in ND. By providing a secure and safe environment for this segment of the population, we not only increase the safety and security of these folks, but also the entire community of Fargo and the entire community of ND.

Chairman Pollert: Scott talked about 600 less visits to the detox center. There are roughly 50 residents. You are there once for each individual every 12 months less visits?
Scott Stenerson: the 600 fewer detox admits in 2010 was just an overall picture to show that they have dropped by 20% and I attribute a larger portion to that because these folks are in Cooper House. For instance, some individuals go through detox 16 times a month, so if these individuals get plugged in to Cooper House, it is another cost savings. Occasionally these individuals go to detox from Cooper House but that occurs like once every 3 months compared to 5,6, plus times to detox a month when not in Cooper House.
Lieutenant Joel Vettel: We deal with these folks a lot and these are the chronic offenders. We would deal with them in our city parks, streets, people's backyards. Our calls for service in dealing with these folks (that we would deal with anyway) has reduced because the staff at the Cooper House have been able to deal with these individuals in a controlled environment and keep the issues down to a minimum.

Chairman Pollert: when SECHSC come forward for detailing, can they provide a number of employees involved in the Cooper House?

Representative Wieland: you have 49 units and how long do they stay? Do you have any statistics on recidivism?

Scott Stenerson: there are 42 units. The residents are on one year leases with the Fargo housing authority long term supported facility. The goal is to get housing first and wrap services around that. Our hope is to transition out these individuals to long term housing; however it takes awhile to establish these individuals outside of the Cooper House. For instance, there is an individual that was homeless for 15-20 years, came into us, and now we are working on getting this individual transitioned out to more permanent housing in Crookston.

Barbara Murry, Executive Director of the ND Association of Community Providers, provided and presented testimony in support of SB 2012, labeled as attachment **ELEVEN.**

Chairman Pollert: there's something about 37% besides the salary or is this through DHS?
Barbara Murry: I have think of something with 37%. We have a 33% in our benefit package. Jon Larson will address that specifically.

Representative Metcalf: I imagine (in audible – did not have microphone on)
Barbara Murry: We have a provider in Williston and one in Stanley so we experience some of those shortages.
Representative Metcalf: Does this 32% turnover include the oil patch? Are you experiencing more people that are having turnover problems out there?
Barbara Murry: That does include the provider opportunity foundation in Williston and Tri City up in Stanley. We experienced even greater difficulties a year and two years ago. In fact, our provider in Williston was giving consideration to closing one of their group homes because they just couldn't get staff to work there. They were really apprehensive about their ability to continue. While both of those providers say the labor pool continues to be very tight, with the 6% increase we got last session, it's better than it was a year ago for us.

Sandi Marshall, President of the ND Association of Community Providers (NDACP) and CEO of Development Homes, Inc, provided and presented testimony in support of SB 2012, labeled as attachment **TWELVE.**

Representative Wieland: OAR 407 is $6M federal and state funding, onetime funding over the 2 year timeframe to prepare for reducing the population at the Developmental Center - Is that basically what we are talking about here?
Sandi Marshall: Yes, we are talking about transitioning 28 individuals out from the Developmental Center into outside communities; going from the 95 to the 67 in the center. We would need the funding for the services that goes along with assisting those 28 individuals transition out of the center into the community and our community provider agencies.
Representative Wieland: that's basically what we are talking about doing, in addition to the 105 down to the 95 level.
Sandi Marshall: That is our plan to get down to 67 by the end of next biennium.
Representative Wieland: are we at the point where we should be looking at some sort of a study in preparation of totally closing the developmental center?

Sandi Marshall: We are getting closer to that point and I believe that a study would be a significant step in addressing the needs of those who remain at the center and addressing

the options for alternative service for those individuals. We understand that when the institution gets to a certain number, there may not be much utility in keeping a state institution going. That would be for others to determine. The provider community stands ready and willing to amp up to provide the community services for folks as planning proceeds at the developmental center, looking at the needs of each individual. I believe the teams there have done assessments on each individual and are continuously looking at the readiness of individuals to be matched up with opportunities that exist within the state.

Representative Nelson: I don't read OAR 407 as a onetime funding. Is the support that's going to be needed for the programs included in this OAR or is it just for the beds?
Sandi Marshall: I believe that, that funding would cover the costs of staffing and support services for the 28 individuals over the course of the next biennium. Of course those individuals would continue to live in the community after the biennium and would continue to need further support. I don't know at what timing the support or the funds could be transferred from supporting the developmental center to the community as the numbers decrease. The dept could probably answer that better.

Chairman Pollert: couldn't it be said that there are individuals at the center, which because of guardianship reasons, need an institutional type center. There is still going to be that need out there. Or are you saying that the community setting is going to be able to take care the most challenging individuals at the developmental center, say the ones who are more prone to aggression?
Sandi Marshall: Through our provider agencies around the state, we are serving some challenging individuals and consequently my discussion of the critical needs being important funding for us, for those who are most medically fragile and behaviorally challenged. There are about 10 states that have completely closed their institutions, so we know that it is possible. We know that we can build that community capacity to serve people with more specialized needs. In fact, in working with DHS with the project development team, we are looking at a different strategy for moving people out of the developmental center than we had in the past, where we had an opening and was first come, first serve. We are looking at a more specialized approach so a provider agency in Mandan, for instance, might decide that they are going to specialize services around the needs of young adults with a combination of developmental disability and criminal behaviors or chemical dependency behavior where they would focus specifically on a population. There are groupings at the developmental center that could go out into those specialized types of projects. The project that we just began focuses on young adults with autism. We recognize that with new mechanisms with building that community capacity, we can take out even more people.

Jon Larson, executive director of Enable Inc, provided and presented testimony in support of SB 2012, labeled as attachment **THIRTEEN.**

Chairman Pollert: what do you mean by that (challenge of service delivery system is rapidly rising costs of employee health insurance – DD providers are given an allowance of 33% of approved salary dollars to provide benefits to our employees)
Jon Larson: we have a rate setting system where we negotiate the number of FTEs with the dept. Each FTE is worth a value of a dollar amount based on a formula that the dept

has. Once that is totaled, we have given 33% as a benefit allowance to pay for all of our fringe benefit costs.
Chairman Pollert: if you have an employee making $30,000, 33% goes toward an employee benefit plan, that's over and above the $30,000.
Jon Larson: That is correct

Representative Nelson: can you explain the fiscal note on SB 2043 as it was introduced, the $2.5M in general funds and then the other fund mechanism in that?
Jon Larson: There would be somebody from the dept that could answer that question better than me. Last session, there was some funds allotted to study our reimbursement system. From that study came some recommendations and 2043 was one of those recommendations. That appropriation pays for a consultant to design the reimbursement system, but it also allows for costs in order to evaluate the consumers that we support to determine their level of need so that a payment system can pay according to that level of need. I believe a large portion of those dollars are to provide an assessment on each of the people that we support.

Chairman Pollert: last session, when the dollar was there, did you say it was actually $1.33 that the state would have done with the increase or would it be the other way?
Jon Larson: it would have been $1.33 and it did come with benefits
Chairman Pollert: you are asking for the 7.65 to free up the 33%?
Jon Larson: Yes. The reason we came up with the 7.65% is that there had been some misconceptions that we were being paid the 33% on top of FICA benefits. We wanted to clarify that FICA benefits are mandatory benefits included in the 33%.

Christine Hogan, lawyer with the ND Protection and Advocacy Project, provided and presented testimony in support of SB 2012, labeled as attachment **FOURTEEN.**

Chairman Pollert closed hearing on SB 2012 for the morning, to continue public testimony this afternoon, starting 15 minutes after the floor session.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 8, 2011
15128

☐ Conference Committee

Committee Clerk Signature Julia Gejfe

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division back to order to resume public testimony on SB 2012.

Tim Cox, President of Northland Healthcare Alliance, provided and presented testimony in support of SB 2012. Testimony is labeled as attachment **ONE.**

Dr. Craig Lambrecht, President and CEO of MedCenter One Bismarck, ND; a member of HPC; a member of NDHA; a member of ND Medical Association: we're in support of the 3 and 3 thus we are in support of SB 2012.

Shari Doe, Director of Burleigh County Social Services and the President and the ND Association of County Social Services Directors, provided and presented testimony in support of SB 2012, labeled as attachment **TWO.**

Chairman Pollert: can you tell us why SNAP is the fastest growing economic assistance program you administer?
Shari Doe: it has to with more people coming here in the expectation of good employment and it doesn't pan out the way they think. The eligibility requirements provide for this such as in the food stamp there is continuous eligibility. Medicaid is an ever increasing chart line in our agency as I think it is in other counties.
Chairman Pollert: the continuous eligibility makes it simpler for everybody.
Shari Doe: Yes, in the SNAP cases that's the case; they are easier to manage. That has helped us to be able to manage the increase in the other areas because we don't have to mange those cases so often.

Representative Kaldor: on the county eligible system that you are wanting rewritten, are you using a model that's being used in other states for instance or will this program have to be designed from the ground up?

Shari Doe: Information technology will have to do provide that information as they have done most computer rewrites.
Chairman Pollert: two biennia ago, there was an amendment for funding for rewrite, however since MMIS continued to be out there for so long and was thought to continue on that process it was decided not to get into another rewrite.

Tove Mandigo: I wanted to address a question that the committee asked about why SNAP is increasing when ND is doing so well. After reading numerous newspaper articles that seemed to come out on the basis about one every three days about just this, we decided to do a study to try to find out why. There is churning with the continuous eligibility on Medicaid, we found the same thing happened with SNAP and simplified reporting. In November 2006, we instituted simplified reporting. Instead of having clients have to come in every month and adjudicate whether they were eligible, they only have to come every 6 months. We took a look at this and what we found out in the research is what you saw before was a graph that went up, then it leveled off, and then at that November, it went up. It isn't that the numbers weren't there. It's just that the numbers were coming on and off and we weren't actually counting the numbers at the right time and so you'd count some of the numbers one month and they might be off that month and then you'd count some of the numbers the next month. All of our systems (other economic assistance programs) have gone down or totally leveled off. We believe that would have happened with SNAP if we hadn't gone through simplified reporting. Tomorrow, I will go into more information during the detail and show graphs.

Chairman Pollert: I also wanted to let the committee know that I spoke with Alex Schweitzer from ND State Hospital and he stated that the Center will get down to 95. We had heard information earlier that getting down to a population of 95 would be a miracle, so I just want to clarify this.

Larry Bernhardt, executive director of Catholic Charities ND (CCND), provided and presented testimony in support of SB 2012, labeled as attachment **THREE.**

Chairman Pollert: this wasn't on the OAR listing?
Larry Bernhardt: yes, it wasn't.

Representative Kaldor: this is a statewide program that is being handled by your agency and PATH?
Larry Bernhardt: Yes, we are the only agency that does special needs adoption for individuals coming out of foster care and we have staff located across the state.

Tim Hathaway, executive director of Prevent Child Abuse ND, provided and presented testimony in support of SB 2012, labeled as attachment **FOUR.**

Susan Rae Helgeland, executive director of Mental Health America of ND (MHAND), provided and presented testimony in support of SB 2012, labeled as attachment **FIVE.** Included in the attachment is an amendment introduced by Senator Mathern that she is requesting that one of the committee members introduce in the section to be discussed again.

Chairman Pollert: we have to set priorities. Is your first priority what was put in the governor's budget or is this amendment your first priority?
Susan Rae Helgeland: I can't answer that question. A systemic change needs to occur. You and I both sit on the ND State Hospital Governing Committee and we're aware of what's happening across the state and these community based services need to be increased. We need to access more services and I'm hearing complaints and costs much more so in the last year than in the 21 years I have been in ND and it's deeply concerning to me. MHAND Board of Directors has approved the OAR as well as the priorities, so it is impossible for me to choose between those two things.

Representative Nelson: did Senator Mathern introduce this amendment on the Senate side?
Legislative Council: Yes, he introduced the amendment in the Senate Appropriations committee and then reintroduced it on the Senate floor and both times, the amendment was defeated.

Representative Kaldor: the federal match for the optional request for this amendment, what federal source is that?
Susan Rae Helgeland: It's Medicaid funding; Patient Protection Act. It is an attempt to demonstrate that this IMD exclusion is archaic.

Chairman Pollert: what are the difference governor budget 2012 and what this amendment does?
Susan Rae Helgeland: What we see with this IMD exclusion is that people that need help are not able to get help because there's not enough inpatient psychiatric care. If there were an IMD exclusion removed by demonstration project, hopefully we will show some validity that that is no longer necessary. We can show a partnership with the State Hospital, public, private hospitals and we can allow access for additional people. As it stands now, Stadter Psychiatric Center in Grand Forks and Prairie St. Johns in Fargo are two free standing psychiatric hospitals (only ones in ND), they would not be reimbursed for accepting any Medicaid pt for inpatient whereas other hospitals, like Sanford, would be reimbursed because they are a hospital that handles other things than psych care. It's one of those unintended consequences and back in the 60s when it was passed, it was the intention of the federal govt to make sure that state legislators were responsible for payment for state hospitals. We can't get reimbursement from state hospital either from Medicaid. There was an unintended consequence that it also passed on to these free standing psych hospitals which we are fortunate enough to have two. We have inpatient closings in Dickinson and Williston and it's been a huge issue. We need to open up these hospitals so people can get the help they need and we would welcome that private/public partnership.

Representative Nelson: is the RFP that CMS is putting out a guaranteed pilot if we fund this program or is it a competitive...?
Susan Rae Helgeland: It's competitive. What you are doing is allowing us to compete.
Representative Nelson: this pilot program is taking place across the country so how many pilots would be funded?
Susan Rae Helgeland: 5 would be funded. We feel, given the good folks we have in this state, and the encouragement that we received from the United States of America Congress, that we have as good a chance as anybody to get funded.

Dr. Emmet M. Kenney, Jr., a Child and Adolescent and General Psychiatrist, provided and presented testimony in support of SB 2012, labeled as attachment **SIX.**

Representative Kaldor: you didn't speak to the amendment that is being suggested or the IMD proposal, so how does your association feel about these?
Dr. Emmet M. Kenney, Jr.: The ND Hospital Association supports the reintroducing of the OAR into this budget. ND Hospital Association represents all but two hospitals in the state. The request was indicated as priority number 2.

Carla Meyer, beneficiary of services from Dakota Center for Independent Living, provided and presented testimony in support of SB 2012 and is labeled as attachment **SEVEN.**

Brian Arett, executive director of Valley Senior Services and a representative of the 26 agencies that are members of the ND Senior Service Providers (NDSSP), provided and presented testimony in support of SB 2012, labeled as attachment **EIGHT.**

Representative Kreidt: you spoke of the cost per meal as $5.24. Is that just the cost of the food or does that include other aspects that go into making meal like electricity, staff, etc? Could we be provided with a breakdown of with what's included in that entire price?
Brian Arett: Yes we can provide that. The $5.24 is the rate we reimburse restaurants unless it is a competitive bidding process and that doesn't happen in the small towns that we are in because there is only one restaurant. The actual cost for us to provide a meal (outside of the restaurant) throughout the region is about $7 a meal.
Representative Kreidt: aren't there some senior centers (can cook meals onsite) that provide meals in communities, so you have a combination of restaurants, senior centers. Can a senior center provide a meal for less cost than a restaurant?
Brian Arett: We have 33 meal sites in our region and 8 of those meal sites are restaurants, either provided on site or catered to senior center. We've done the cost analysis to see which is cheaper. It depends on how many meals are being served. Making 15-20 meals is more cost effective to make on site versus under 15 (like 8 meals in Hunter, ND) due to having to pay staff to come in, make the meal, clean up, etc.
Representative Kreidt: are we talking congregate or home delivered (most home deliver is volunteer basis)?
Brian Arett: The figures that I am using is for congregate and home delivered meals combined. Volunteers are connected with the home delivered meals programs when it comes to the deliver aspect of it; certainly not with preparing the meals.

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Chairman Pollert: $35000 sticks out in my mind as in the difference in price. Is the county or city paying for the differential?
Brian Arett: With respect to the meals that aren't reimbursed by the state – By about November, we run out of state reimbursement or the state discontinues reimbursement because we've met our contract with them. The county doesn't actually step in and say we are going to pay you for those meals. The county (like the state) says this is the amount of mill levi dollars that are going to be available for you this year with the state match added into it and we tell that that we are going to spend that on our meals program, but they don't dole it out on a per meal basis. They give us a single check. For those 38,000 meals,

certainly a portion of the funding to cover the cost of those meals comes from our county mill levi dollars. A portion of the funding comes from donations that our agency generates from individuals and businesses and foundations in the region or area.
Chairman Pollert: when you say a basket, you are referring to a free will donation?
Brian Arett: Yes.
Representative Kreidt: do you have a suggested donation?
Brian Arett: the Older Americans Act and DHS require us to have a stated suggested donation that shows the actual cost of the meal. In our region it's $7. As far as a suggested donation, every region is different and in our region, it's $3.50 a meal and it's called suggested donation due to the Older Americans Act which funds about a third of our services in our region. That's suggested donation for us ends up being about 29% of our revenues toward that service.

Representative Wieland: the meals on wheels is a great program, particularly when it's taken to the individuals' apartment because it is only the meal, but also the companionship. It's not about the use, but rather the abuse. I'm wondering if there is some way for individuals who can afford it, pay $10 to help defray the cost of those that can't because there are a lot of people who get that benefit that cannot afford to pay $3.50 or even a dollar sometimes.
Brian Arett: We use to be a little bit stronger in how we encouraged the donations and how much of a donation we encourage. The state gently told us that we had to change our process. The OOA forbids charging a fee or a price for a meal. One thing that some providers in the state have done to get away from the suggested donation of $3.50 is to say the full cost of the meal today is $7 and a generous donation will help us to serve as many meals as possible; this is allowable. We also directly with our clientele to education them on the need for additional funding to keep up with the growing demand for these types of services. OOA requires to provide services in a way to focus on those who are lower income or that are more fragile or live in more remote parts of the state. This explains why we have meal sites in rural areas as well as meal sites in low income facilities. Many of the meal sites we have in Fargo and West Fargo are in low income areas. We are looking at opening another one that is being built in South Fargo right now. The people that go to those sites are those that have a much greater need. I do want people who have more resources to contribute more and I'd love to charge a fee to a certain segment, but that's not allowable. We try to encourage donations so the people that have more, give more.

Pat Hansen, executive director of South Central Adult Services and president of the ND Senior Service Providers, provided and presented testimony in support of SB 2012, labeled as attachment **NINE.**

Larry Bernhardt, executive director of Catholic Charities ND, provided and presented testimony requesting that committee include increased funding for corporate guardianship services for people with developmental disabilities. Testimony is labeled as attachment **TEN.** Just wanting to let the committee know that I spoke with **Senator Kilzer** from Senate Appropriations and he stated that the amendments proposed were not discussed and were overlooked, so I am urging you to take the time and review the proposed amendments.

Representative Kaldor: were these requests in the optional request?
Larry Bernhardt: No, they were not part of the department's OARs?

Bernie Zander (DCIL – Dakota Centers for Independent Living) read a letter as testimony written by Tonia Johnston who receives services from Centers for Independent Living. The testimony is in support of SB 2012 and is labeled as attachment **ELEVEN.** There are other letters included in the attachment from beneficiaries of Centers for Independent Living.

Chuck Stebbins, member of the Qualified Service Providers Association of ND, provided and presented testimony in support of SB 2012, labeled as attachment **TWELVE.**

Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 9, 2011
15162

☐ Conference Committee

Committee Clerk Signature Julia Dykstra

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division to order. Clerk took role and quorum declared. He opened hearing on SB 2012 to continue budget detailing.

Tove Mandigo, Economic Assistance Policy Division Director with DHS, provided and presented testimony, labeled as attachment **ONE**, which includes information to assist in detailing the Economic Assistance Policy portion of the DHS budget.

Chairman Pollert: that FTE for health care reform, you are planning on hiring April 2013?
Tove Mandigo: yes, that's correct.

Representative Nelson: in this area, how did the ARRA funding (LIHEAP) impact this budget from an operations standpoint?
Tove Mandigo: It did impact it. We can get into that later.
Representative Nelson: did that increase travel or printing because of ARRA funding?
Tove Mandigo: No, I don't believe it did these things.

Chairman Pollert: I have a handout from Office of Management and Budget. Committee will wait until Lori Laschkewitsch from Office of Management and Budget returns to explain this handout.

Chairman Pollert confirmed alternatives to abortion is included in this section

Vice Chairman Bellew: the other E cards EPT card contractor what are those?
Tove Mandigo: That's the county portion of that

Representative Wieland: what is PERM?

Tove Mandigo: we contract with the federal govt to come out and look at childcare assistance, CHIP, and Medicaid. They come every 3 years and essentially we pay to have them audit us.
Representative Wieland: we pay to get ourselves audited to the federal govt?
Tove Mandigo: yes.

Chairman Pollert: we also pay for the state auditors to come in at about $160,000+
Tove Mandigo: yes.

Representative Nelson: there was a significant decrease in federal funding in these programs. Does the general fund offset anything? Are we picking up more of the share of those programs on a general basis? What happens when $4.5M doesn't come into the state?
Tove Mandigo: Our caseloads have gone down. EA is primarily federally funded. All the ARRA money went away as well which is reflected in the $4.5M. MOE (Maintenance of Effort) is general though.

Chairman Pollert: What is the Indian county allocation for?
Debra McDermott: HB 1540 that passed last session and that changed the way the allocation method is done, based on the SNAP caseload for the preceding fiscal year. Basically, you take the SNAP caseload percentage of those individuals living on a reservation times their economic assistance cost and they are reimbursed that amount of money. If their economic assistance cost for a county was $100, and their SNAP cases living on a reservation was 80% of their cases, they would get 80% of their economic assistance costs. This legislation originated due to SWAP legislation which didn't allow for economic assistance to be reimbursed to the counties. To be able to qualify, you need to have 10% of your caseload living on a reservation and your reimbursement can't exceed more than 90% of your expenditures (of economic assistance cost).
Chairman Pollert: what do the dollars go for? SNAP?
Debra McDermott: When we were working with the whole bill last time and how the counties wanted to change it, they felt that the SNAP caseload was representative of the workload in the economic assistance area which is why they used the SNAP caseload as a basis for their costs. They felt that if you were on SNAP, chances are you may be on Medicaid program also. Those dollars are used to fund their administrative costs for the reservation land as it's not taxable.

Representative Nelson: how many counties qualify for that payment?
Debra McDermott: It's 6 counties
Representative Nelson: one of the areas that isn't part of that calculation is in home and community based care. Monitoring the QSPs on the reservations has been another burden to the counties budgets. Is there any form of assistance that counties can get for those administrative costs?
Debra McDermott: they receive some reimbursement for those services through our Random Moment time studies we do with the counties, although it's limited. If it was for a Medicaid client, they can bill Medicaid.
Representative Nelson: do they do that?
Debra McDermott: Some of the counties do

Representative Nelson: do you have a breakdown of how those limited funds have been used?
Debra McDermott: the funds are social service block grant dollars and the counties can use those for any service or program they choose within social services.
Representative Nelson: you just grant the dollars out and wouldn't be able to show how they spend those?
Debra McDermott: Yes.

Vice Chairman Bellew: how are those county funds figured out ($355,758)? Is that in code?
Debra McDermott: when we use to issue the paper food stamp coupons, there was a survey done to figure out county versus state costs. When we went to the EBT issuance, there was a percentage breakdown of what the county would share in those costs when we went to an electronic benefit method versus the state, so that share is exactly the same. It's a 50/50 match from the federal govt for the EBT issuance and the counties pay 44 cents of that nonfederal share and the state pays 6 cents. That was back in 1994. That is not in code.
Vice Chairman Bellew: I need to see that on a piece of paper so I can visualize it.
Debra McDermott: I'll try and explain it better. If there was $100 that we owned to EBT contractor for the EBT cards, we would submit that $100 to the federal govt, get $50 back from them so there's $50 that's a nonfederal share. 44 cents the counties would pay; 6 cents the states would pay.
Vice Chairman Bellew: who came up with that formula?
Debra McDermott: that was based upon a survey that was done on the amount that the counties had to pay at that point in time in distributing the paper food stamp coupons. There is one caveat this. There also is for the Indian counties, for any EBT benefits issued in Indian county, the feds share in that (75 cents for the dollar) and the nonfederal share is 25 cents – so the counties pay 19 cents and we pay 6 cents.

Representative Nelson: is it all ARRA funds in the onetime funding category?
Tovi Mandigo: Yes, except the one that came from SB 2231 which is charitable food assistance. That also sunsetted.
Chairman Pollert: was the $350,000 a food bank?
Tove Mandigo: Yes, it was charitable.

Vice Chairman Bellew: on childcare, you have a significant decrease. Can you explain this?
Tove Mandigo: Primarily it's because it's harder to meet the requirement to get childcare as people are making more money
Chairman Pollert: in one way you say they are making more money but SNAP is going up?

Vice Chairman Bellew: the other funds, what are those?
Tove Mandigo: that is the SWAP money, FMAP, and MOE (about $1M)
Vice Chairman Bellew: MOE is county dollars?
Tove Mandigo: No, general funds – oh, actually, the other funds are SWAP.
Vice Chairman Bellew: what about the SWAP? Is SWAP county dollars?

Debra McDermott: SWAP is retained funds because of expenditures that the county incurs. Those were swapped out with previous funds that we use to bill the counties for, for the share of the grant costs; the whole basis of the SWAP legislation. They are generated because of county dollars and county expenditures.
Vice Chairman Bellew: they are basically federal funds that go to the counties that the counties give to you?
Debra McDermott: Prior to SWAP they would have gone to the counties, but those federal funds now come and stay with the state and they are called retained dollars throughout our budget.

Chairman Pollert: under TANF regular benefit, when you look at federal funds are dropping, yet we have a general fund increase of $1.1M increase. Can you tell me what that is about?
Tove Mandigo: that is because we have to meet the MOE or else we don't get TANF money.
Chairman Pollert: that's with what?
Tove Mandigo: That's with the federal TANF money. We get $26.4M of federal money and it's about $9M here for MOE so we have to try to find that MOE.

Representative Nelson: the other funds in that category, is that meant to reflect the MOE as well
Tove Mandigo: That would be SWAP.

Chairman Pollert: it looks to me we have to have increased general funds to get less TANF dollars?
Tove Mandigo: It's a block grant so you get all the money and then there's an MOE attached to it and it's for 5 years. You have it and then you use and you'll see it year to year how it goes down. It's due to be reauthorized in Sept 2011. That MOE is on that whole block grant and they give you so much per year.
Chairman Pollert: it sounds like we have to front load it.
Debra McDermott: You have to spend your MOE before you can get any TANF money. When you'll see the TANF schedule, the federal TANF money, carry forward, is increased over what we presented to you last time because we have to spend the MOE in order to get the TANF money. The general fund match is staying the same. Our overall expenditures are decreasing.

Debra McDermott provided and explained a handout (as requested by the committee) on TANF Block Grant which is the revenue/estimated expenditures to the House (2011-13). The handout is labeled as attachment **TWO.**

Chairman Pollert: we are taking in 65, but spending 75?
Debra McDermott: The 65 is carryover of $13M into 11-13 plus the new TANF block grant money and then you have to go over to the federal revenue column. We are spending 57.3. The total column is the total money (including the MOE) that we have to have to spend. If you go up to the very top section, there's the 65M of revenue plus the 57M of expenditures giving us a carryover into the 13-15 biennium of $8M. Our carryover has been larger than what we anticipated and that's due to the TANF benefits that we are actually paying out.

Vice Chairman Bellew: we gave money to childcare. Could you tell us about the rules and regulations about how this money can be spent?
Debra McDermott: you can transfer 30% of the block grant into your childcare development block grant funds, but to that amount. But once you transfer it into the childcare block grant, it takes on all of the rules and regulations – it becomes childcare money so the TANF rules don't apply. You have to spend it within the required timeframes and on the specific allowable costs underneath the childcare development block grant.

Chairman Pollert: in 1790, we could be looking at throwing in general funds unless we figure something else out.

Representative Nelson: how is the reauthorization going to affect states like us?
Debra McDermott: Most likely there will be more reporting requirements put on states, which in turn would lead to more requirements on TANF clients.

Vice Chairman Bellew: $5.5M general fund, estimated expenditures. Does that figure correlated to last sheet of attachment?
Tove Mandigo: Yes, it should be in the TANF benefit area.
Vice Chairman Bellew: But in that area it says $5.387M
Paul Kramer: the MOE can be spread throughout so you can look at TANF Diversion Benefit area and it will add up.

Tove Mandigo: One of the things that we're looking at is trying look at getting all of the remaining TANF clients off all assistance. Because, in the beginning, the purpose of the TANF was to get them off of some assistance, but to keep them on food stamps, Medicaid. One ways to do this, using some TANF money, is building in a program that would allow 40 people to get two years of education. The last couple of bienniums there has been much talk about why use more money to let people get education that would allow them to get benefits in jobs. Why do they have to be at these lower levels where they're aren't benefits? Because our work participation rate is so high (92%), we are able to say that we aren't going to count some of these people, so we're going to take them away from being able to be counted and our work participation rate will go down, but there will be no impact whatsoever. We can allow somebody that has two years of college now to pursue good TANF benefits and get a four year degree which should probably keep them off of Medicaid, food stamps, LIHEAP, etc. Conversely so, we could get somebody into technology for two years, because currently, TANF requirements only allow one year. We are working with counties to assist TANF clients to look at the long range versus what most TANF clients look at, the short range, in that those seeking TANF benefits come in the day they need them. We encourage them to look at changing lifestyle to get off TANF in the next 6 mos or 1 year.

James Flemming, provided and presented material, labeled as attachment **THREE**, that contains information to assist in the detailing of the budget for the Child Support section of the DHS budget.

Chairman Pollert: when is the hire date for the individual for health care reform?

James Flemming: Attorney would be hired contingent on what happens with federal health care reform according to the Senate amendment. Before the amendment, the position would be hired at the beginning of the biennium.

Chairman Pollert: when the Senate approved their amendment, there wasn't any funding delayed or withdrawn?
Legislative Council: that is correct
Chairman Pollert: we are going to have to look at that to finish that amendment?
Legislative Council: currently those positions are in the budget as staggered implementation dates. The Senate added the language that said you cannot fill those positions until you receive the rules. You'd have to make an assumption on whether the dept is going to receive those rules, if you want to change the funding that is currently in the budget.
Chairman Pollert: everything is being set for the redistricting and that is when everything will set in motion, correct?
Legislative Council: that's some discussions that are going on. The positions are in the budget and are authorized.

Chairman Pollert: your overview shows an increase of $3.3M and your general fund increase is $2.9M thus 90%+ is in the salary or benefit increase?
James Flemming: historically, we have received federal incentive dollars treated as the equivalent as a state general fund dollar for purpose of match, so if we budgeted about $1M a year for federal incentives, those incentives draw down an additional $2M in federal under our 66/34 match. Congress took the match away. Last biennium, the ARRA funds were used to replace the lost match and hold us whole. In essence, the incentive match was lost. The increase in general funds is to make up the loss of the money.

Representative Wieland: did they take it away from all the states or just ND?
James Flemming: They took it away from all of the states.

Vice Chairman Bellew: what do you use the incentive funds for?
James Flemming: The incentive funds are required to be reinvested in our program under federal regulations.
Paul Kramer: we don't put in anything as it relates to the incentive dollars. We put in a 34% match and we get a 66% match on the all the programs that are eligible for the federal match. Then in addition to that we get incentive dollars and about 2 biennia ago, it was fully matched. Last time when we built the budget, it wasn't matchable, but towards the end, the ARRA part came in and made it matchable again. So, you guys took out about $2.7M and the funding source switch is replacing that with the general fund that you took out last time.

Chairman Pollert: if I look at fringe benefits of 2.464 times 2 (2 years) and get 5.3 and your current budget has 5.6. Could that fringe benefit be suspiciously high like by a couple thousand dollars?
Paul Kramer: the 5.6 would have included health insurance and not all of the employees are taking the health insurance.

Representative Wieland: there are 3 of your offices are located in Grand Forks county and 1 in Burleigh. Were the rest of them in the court houses before the state took over? Were you being charged rent from the counties when they were in the court houses before?
James Flemming: Since state administration, we've had 2 offices move out of court houses (Williston and Fargo). There are no offices with regard to court house buildings. We were charged rent from the county when we were in the courthouses or they accounted for it for their county agencies. Some of that was transitioned in the 07-09 biennium which was the first one after state administration.
Representative Wieland: we are paying for rental of parking space in the Grand forks office for someone?
James Flemming: It's for the State fleet vehicle in the ramp next to the building as the building is set up so that parking on the streets around the building is only available for about an hour.
Representative Wieland: we are not paying for a staff to park but rather it's a state vehicle?
James Flemming: Correct.

Chairman Pollert: at Prairie Hills Plaza, how much is the total for the whole building?
Paul Kramer: we can get that to you.
Chairman Pollert: I was trying to correlate that with the schedule in the attachment due the amendment that the Senate put in.

Chairman Pollert: do you have annual inflators in all of your contracts?
James Flemming: No, not in all of them. Williston's landlord, United States of America Bank, is firm. I spoke with him as we are due at the end of this biennium and they agreed to the budgeted amount for the lease, but they did not want to go additional renewal terms. With the way things are in Williston, they don't want to have a longer commitment than that. We will be entering into 2 year extension for Williston. In Minot, we don't have automatic inflators, but we do have a longer, initial term and then there's the standard non-appropriation clause in the event that sufficient funds aren't appropriated.
Chairman Pollert: Was Fargo the one where you signed a 10 year lease?
James Flemming: Yes.
Chairman Pollert: does that have inflators in it? I just see it's high compared to everywhere else or it is because Fargo is big in economic development?
James Flemming: It's not an inflator in the sense of some Human Service Centers are told what the increase is every 2 years by their landlord. We started at $16 a square foot. After a certain number of years it goes to $16.50, then it goes to $18, and then if we renew at the end of 10 years, it's $22 a square foot. We were careful and spent a lot of time shopping around in Fargo for a suitable space. This was a good deal, giving the other options we had for the space that we had at the time we had it. There were others that wanted $20 a square foot because they would have to run a tele-communications line and do all kinds of retrofitting inside. There was a lot of internal concern among the staff because we are located west of West Acres, but the courthouse, where we use to be, is where we do our work when it comes to the court actions, so by moving the far from the center of town became a staff issue to have the state fleet vehicle transporting back and forth all day long. It was a choice we weren't real wild about, but I assure you that we would have not moved that far from the center of town if we weren't willing to take a reduced rent that we weren't paying for premium for downtown.

Representative Kreidt: I would assume the utilities are included in the leases?
James Flemming: That is true. We do pay janitorial in some and not in others though.

Representative Nelson: where would the service sheriff show up in this?
James Flemming: Operating fees and services and we'll have a schedule later on that.

Paul Kramer, provided and explained information (as requested by committee) of the FTE Reconciliation (2009-11 legislatively approved vs 2011-13 request to House). This information is labeled as attachment **FOUR.**

Representative Kreidt: with the staff that are transferring, the money goes with them?
Paul Kramer: If it would be an unfunded position, no money would go with them. In essence, though, yes so the money funding the position goes with the person when they transfer to another area.

Lori Laschkewitsch, Office of Management and Budget, provided and went over information (as requested by committee) to include rental rates for biennium ending June 30, 2011.The information is labeled as attachment **FIVE.**

Representative Nelson: I was thinking about that we rent much more than we own. How many of these units are owned by the state versus how many are leased from private enterprise?
Chairman Pollert: is there one overall budget or is each agency on their own?
Office of Management and Budget: We would have a list of the state owned buildings and how many pay rent within the buildings. For instance, in the capitol, general funded agencies don't pay rent, but federal and special funded agencies would pay rent.
Representative Nelson: oh, I don't need this information.

Jenny Witham, provided and went over information (as requested by committee) of a breakdown of IT equipment under $5000 and is labeled as attachment **SIX.**

Vice Chairman Bellew: what's the rest of it for?
Jenny Witham: This is how much incrementally more expensive to maintain the equipment is. 927 PCs in total will be replaced. The difference in what we had in replacement last biennium to the replacement we have this biennium is incrementally to replace 50% of our PCs. To do this we will spend another $150,000. It's not because desktop computers are becoming more expensive, but rather because we are shifting from desktop to laptop which are more expensive. The majority of the spend is in that 4 year replacement cycle of all of our desktop equipment.

Representative Kreidt: the ones that are being replaced wind up in surplus property or what happens?
Jenny Witham: The majority of them do.

Representative Kaldor: my math tells me that you are getting a good deal on PCs.
Jenny Witham: We purchase our computers off the state contract which is negotiated by ITD for all state agencies so we get an excellent price point

Representative Kaldor: are ours bought through the same contract?
Legislative Council: the last time the legislators' laptops were replaced, they requested a special committee select that laptop. I'm not sure if it was on the state contract or not.

Maggie Anderson, provided and went over information (labeled as attachment **SEVEN**), that she utilized to go over the detailing of the DHS budget, Medical Services Division.

Representative Kreidt: who's doing bars work right now?
Maggie Anderson: We are all sharing those responsibilities as well as some of our project staff.
Maggie Anderson: With the passage of the Affordable Care Act, there were very strict provisions for Medicaid Fraud, Abuse and Control and one of them is in the area of provider enrollment where we need to increase what we look at prior to enrolling Medicaid providers. Medicare will also be doing this, so if a provider is also a Medicare provider, we can accept what Medicare does up front to enroll the provider, but what we are doing right now is having to go through each category of providers and determining whether they care considered low risk, moderate risk or high risk. If they are determined to be moderate or high risk, then we have additional responsibilities that we will have to carry out for provider enrollment, including onsite visits and potential finger printing of staff.

Representative Kreidt: when does that go into effective? Is there an effective date of implementing provisions under Affordable Care Act?
Maggie Anderson: the effective date was to be one year after the passage of the Affordable Care Act which would be March 23 of this year. CMS has issued some proposed rules and other information and they are working with states, so we need to be making a good faith effort to move in that direction, but I don't know if there will be an absolute date where they'll say you have to do it, but we are in the process of implementing these items.
Representative Kreidt: if the health care act goes away, are you going to still continue to pursue doing that or what's your intent in regards to that?
Maggie Anderson: We don't know if it will go away entirely, in pieces or at all. This particular piece would likely come back in some other methodology because while some of the funding for healthcare reform was based on savings that was anticipated from Medicaid fraud, this would probably be something the administration and others would agree would perhaps be a good idea, regardless of whether they're full healthcare reform law stood a challenge.
Representative Kreidt: are the recovery audits under the affordable care act?
Yes, it is. The recovery audits have been in place in Medicare for quite a few years and so that's another piece we are somewhat expecting that, even if provisions in the healthcare reform were amended out, that perhaps some of these fraud detection pieces would remain.

Chairman Pollert closed hearing on SB 2012 with plan to reconvene 15 minutes after floor session.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 9, 2011
15210

☐ Conference Committee

Committee Clerk Signature Meredith Trachsel

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert reopened hearing on SB 2012, following afternoon recess.

Representative Wieland: One of the items that were mentioned on the child support report was a $200,000 decrease to remove the funding for a receivables study. Was that study done and what were the results?

Debra McDermott: The study was not done.

Paul Kramer, provided and went over Health Care Reform FTEs (cost to continue salaries for the 2013-15 biennium) and labeled as attachment **ONE.**

Representative Kaldor: On the total fund column, what is the federal percentage that they are using?

Paul Kramer: It will vary by position. The economic assistance will be 50/50 and most of the medical services will be 50/50 or 75/25, depending on how they fall.

Vice Chairman Bellew: How do you figure out a cost to continue when there hasn't been a 3 and 3 raise given yet?

Debra McDermott: That's just the salary as it was funded in the pay plan. We just figured the cost based on the same salary for 24 months, including health insurance. We used the same health insurance rate also as what is funded in the governor's budget.

Vice Chairman Bellew: The salaries were funded for 24 months for the biennium 13-15, and then there is the cost to continue. That cost to continue would be from the 11-13 budget?

Debra McDermott: Correct. She then provided and explained documents (as requested by the committee) that provided information on inflationary increases compared to Consumer Price Index (CPI) and various requested inflation scenarios, labeled as attachment **TWO.**

Maggie Anderson continued her presentation on detailing the Medical Services Division of DHS utilizing information, labeled as attachment **THREE.**

Representative Metcalf: What is the reason for requiring a prior authorization for MRI and PET scans?

Maggie Anderson: We pay for them, but don't authorize them upfront. This would be setting a standard for any MRI or PET scan above a certain dollar level, that we would establish a prior authorization for that. The clinic would need to submit the information to us, and the vendor would review that and made a determination. It is a covered service.

Representative Metcalf: What could the possible determination be?

Maggie Anderson: It would be medical in nature. If the PET scan or MRI is being ordered for something that may not be medically necessary, then we would want additional information or justification for that.

Representative Nelson: In the vendor, under that review, would that be doctors reviewing the need for the tests?

Maggie Anderson: It would be a medical contract. That may include nursing staff, a nurse practitioner, but it would be medical in nature. Presentation resumed.

Vice Chairman Bellew: This clawback payment (attachment **THREE,** page 4) went up approximately 35%. Why the increase?

Maggie Anderson: It's two things. The way the clawback was set up was on a phased down contribution. It phases down the contribution, but then the drug expenditure increase kicks in there, so our rate did go up. The rate that we use to build the budget was an average payment of $101.26. The average in the 09-11 budget was $85.61, and we actually paid $71.82 this biennium. That was because originally CMS said the clawback calculation was not part of the ARRA-FMAP increase, then they later corrected themselves and allowed that to be applied. If you just look budget to budget, it's $85.61 to $101.26, so there's an increase in the per member per month that we pay to CMS. In addition to that, we built the budget for 09-11 on an average caseload of 9,450 individuals, and the 11-13 executive budget was built based on an average of 10,825 individuals. That is increasing because there was a change in the Medicare patient improvement act. There was a change in the asset limits for the Medicare savings programs, which increased eligibility. The population of individuals over the age of 65 is also increasing.

Representative Kreidt: In regard to the drug clawback, at some point won't that go away?

Maggie Anderson: Unless federal law would change, it would not go away. The phase down contribution part goes down to 75%, and then it's static. At that point, you don't have the negative phase down, all you have is the positive increase in drug expenditures, so it won't go away. Presentation resumed.

Representative Kreidt: How many individuals (interested in transitioning out of a nursing home facility to return to their home) are you going out to see?

Karen Tescher (DHS): We've had actually five referrals where they've gone and visited them this year. They determine whether it's feasible for them to go home, and if so, the social worker at the nursing facility makes the referral to the local contact agent, and they come out and do their assessment with that person and let them know what is available in the particular community where they are interested in going home.

Chairman Pollert: Give me basic information about clawback again, and why it went up.

Maggie Anderson: What the clawback is, is prior to Medicare part D, states were responsible for covering the prescription drugs for the dual eligibles. Dual eligibles are those individuals who are eligible for both Medicare and Medicaid. When a dual eligible would go to the pharmacy, Medicaid would pay for that claim. On January 1, 2006, when part D happened, those individuals moved to a part D plan, and most of those individuals should qualify for the low income subsidy to help them purchase their part D plan. They're now receiving their actual drug coverage through part D. If a pharmacy would submit a claim today on behalf of a dual eligible, we would deny that claim because it is supposed to be covered under part D. As part of the financing of the low income subsidy, the federal government came up with this phase down contributional clawback. They based it on the states' drug expenditures in 2004 or 2005, taking that, inflating it forward, applying various metrics to it, they came up with the clawback. Each year the clawback is to be phased down by 1.66%, but then you apply the national drug expenditures, and it's calculated to what your per member rate is. We pay that every month for each one of the duals. For example, the $101 that we're estimating that average to be for the 11-13 biennium, that is going to the federal government to help pay for the part D plans that the dual eligibles are receiving through the low income subsidy. That's the clawback; as to why it went up, twofold with the cost is that phase down contribution is happening but at the same time drug expenditures are applied to that. FMAP plays into the calculation as well, even though this is a state payment to the federal government. All of those factors come into play in bringing the rate up. The number of duals in increasing because we have the change that requires us to do outreach to those individuals who have applied for the low income subsidy, and they qualify for it because of their income, but for one reason or another they may not have also applied for Medicaid. Let's say that there's 100 clients a month in ND who apply for the low income subsidy, and all 100 are approved; 20 are already on Medicaid, and 80 are not. Social Security would then send a file to us, to the Medicaid office, and we send applications out to those 80 individuals advising them of their possible Medicaid eligibility. The Medicare law where they increased the asset limits for the Medicare savings programs also allows more individuals to become eligible as a dual eligible. The third thing with the increase is the increasing over-65 population.

Representative Kreidt: Are you seeing any increase in the drug costs also?

Maggie Anderson: With the clawback payment, it's the national health expenditures; that varies from year to year, but we use that when we estimate our calculation. It's increasing. Presentation resumed and concluded on attachment **THREE**. She then provided and explained information on the costs of CHIP for 2011-13 biennium at different federal poverty levels (160% - 200%), labeled as attachment **FOUR.**

Chairman Pollert confirmed that the Senate approved the level at 175%.

Vice Chairman Bellew: Is there a way to tell us as we go along, what rebasing did to this budget? I know it increased it, is there a way to see how much?

Maggie Anderson: There's no way to look at the numbers and say, we were given X million dollars and X million of those were spent. We could give you a handout on what you appropriated for rebasing, but you won't necessarily be able to look in the numbers and know that 90% or 110% of that money was spent, because it's all built into the rate setting or the fee schedules that are paid to providers. Then you have the whole mix of what types of service they claim.

Chairman Pollert: Yes, we will take that.

Maggie Anderson provided and went over information about rebasing amounts provided for the 09-11 biennium and labeled as attachment **FIVE.**

Chairman Pollert: Did the governor's budget have the inpatient hospital at 100%, but physicians in the original bill was 25%.

Maggie Anderson: That's correct.

Chairman Pollert: The other stuff is the same, or did we switch some of them?

Maggie Anderson: We can pull that information for you.

Chairman Pollert: You don't need to go that far with it. This is pretty self-explanatory.

Maggie Anderson provided and went over information of budget for traditional medical services (detail of selected services), with each page illustrating the details of different services. The information is labeled as attachment **SIX.**

Chairman Pollert: When we looked at caseload utilization last session and with what's coming forward to us right now, is it about $5 million that we were off?

Debra McDermott: You're wondering how much of the Bank Loan are we planning to use?

Chairman Pollert: How much were we (the legislators here) off target regarding caseload utilization? The previous biennium we were pretty close, but last biennium we were off.

Representative Nelson: It's $5.8 million. It's all based on the added FMAP that came with the ARRA funding. It covered our underfunding. That was about 18 million, so the 12.8 million in turnback is what's left of that, is that a fair description?

Debra McDermott: The FMAP is across the entire department, not just in these areas. Are you wondering if that's the reason we didn't need to do the Bank of North Dakota loan or a deficiency appropriation? If we wouldn't have received the FMAP and enhanced FMAP for these last six months, we would have had to use all of the Bank of ND loan and would have likely been in a deficiency appropriation.

Representative Nelson: But that number was $5.8 million, as I understand it, in utilization.

Debra McDermott: I'm not exactly sure where that number is coming from.

Vice Chairman Bellew: The actual units of service for inpatient hospital are what?

Maggie Anderson: It can be a variety of things, based on the methodology of how the facility is paid. Critical access hospital is paid on a per diem; DRG hospitals we pay upon discharge; out of state we pay percentages of charges; each one is different, so the units of service vary. That column is how many units of service for those variety of payment methodologies that we paid for the Medicaid clients that month. Everything in front of you is claims paid, and is not necessarily tied to dates of service.

Chairman Pollert: Is there a methodology on why you would have picked August through June 10th?

Maggie Anderson: We were just trying to make sure we got an average of claims. Because of the rebasing in some of these areas, we wanted to make sure we captured as many affected claims as possible to account for any increased costs.

Chairman Pollert: If I compared the costs of the units to last biennium, and factored in the higher utilization, would that give us a pretty good idea of what the extra costs went up?

Maggie Anderson: It would probably get you close, but it won't account for the mix of services. We paid for more hospitalizations for birth and delivery and flu and cold last biennium, for whatever reason.

Chairman Pollert: Is there a reason you wouldn't use actual persons receiving and the actual costs, instead of units of service?

Maggie Anderson: Persons receiving wouldn't be as accurate.

Chairman Pollert: Is there a reason you didn't use August through November?

Maggie Anderson: We have to submit the budget before that, so we have to cut off at the most recent payment we have and send that to OMB.

Representative Nelson: Do you see any trends that are changing, either up or down, in any of these areas?

Maggie Anderson: We review them every month as we do our monthly spend down reports. We get the different program areas involved if there are specific questions or concerns. There aren't any areas of specific concern, though we do watch them and try to account for spikes or trends, and determine if there is something that we should be doing to manage that trend or if it was an expected trend due to a policy change or legislative directive.

Representative Nelson: Does a change such as the hospitals changing from PPS to CAH skew the numbers for a period of time?

Maggie Anderson: Yes it does, because when we built the budget a hospital may have been PPS and built into those tables; if it is later determined it is critical access, the dollars have been allocated in the wrong spot. It might show underspending now in PPS, but overspending in critical access.

Representative Nelson: Is swing bed part of inpatient?

Maggie Anderson: It's part of the long term care continuum, it's considered an alternative to nursing home care.

Chairman Pollert: Looking at attachment E on your initial handout, if I go to inpatient hospital, and take the monthly average times 24 to get $145 million. What am I missing to get the $165 million in your attachment E.

Maggie Anderson: What you are not accounting for is the 3 and 3 increases; the other part of it is, the monthly averages are only through November, and the second 6% went into effect July 1st, so those are dates of service, and you don't even start seeing the claims for those until August-September, so there is a lag in that 6% as well.

Chairman Pollert: I'd have to look at the 6% and the 3 and 3.

Maggie Anderson: Yes. Presentation resumed.

Chairman Pollert: In outpatient hospital, you had some cost changes and case load increased, versus the cost changes on inpatient hospital. Could you refresh how you do those cost and caseloads changes?

Maggie Anderson: We build this budget in steps. Our starting point is the current biennium, in this case the 09-11 appropriation, and we look at the same information I'm going over with you. We look at our average number of units of service, average cost, and those items shift, for various reasons why people utilize medical services. We look at the shifts in cost, if they're increasing or decreasing, and then we look at those shifts in caseload. For outpatient, last time we thought our average cost per unit was going to be $18 a unit, for example, and when we went to build the budget, what was coming through on the utilization was $15.69. So we built that decrease into the first step of the budget

process. Then we take that step, and look next at utilization. Last time, maybe we thought our utilization was 150,000 units a month, but the actual average we were seeing when we built the budget was 187,412. Then we apply that to the cost change to the case load increase, and that is the $23 million. Presentation resumed.

Chairman Pollert: Why would you add the remaining inflator in there? Don't you have the 6% inflator somewhere in there already? Or do you go by what the base was?

Maggie Anderson: What you are looking at are actual expenditures and actual costs per unit. The 6% doesn't get added in until 7/1/2010 dates of service and after, so it can't be in those previous numbers because they don't have access to it until July 2010 and later. So no, the 6%, the inflation for the second year, is not already in those numbers.

Representative Nelson: When the bill comes across from the Senate that does raise it to 175%, are they still using the $274.03 as a premium? Are they using your growth numbers based on your anticipated additional premiums?

Maggie Anderson: The Senate defeated two CHIP bills in the first half, but they amended SB 2012 to include the raise and this would serve an additional 445 children. They used our estimate on that, and the $274.03 premium. They did not adjust the other caseload projections for CHIP.

Chairman Pollert: When you say the growth of 40, did you basically look at November through June, and take that increase and divide by the number of months?

Maggie Anderson: We went back and looked at what the growth had been, and tried to project that forward. We reproject our budget and expected expenditures on a regular basis.

Chairman Pollert: Do you have some kind of hypotheses about what the outreach has done?

Maggie Anderson: We can provide you additional information. From August 2009 through November 2010, we've added 2,888 children to both Medicaid and CHIP.

Chairman Pollert: You're just hypothesizing that part of it is because of continuous eligibility, part of it could be a number of items, right?

Maggie Anderson: Right, of the 2,888 kids that we did add, some learned about the program because of the outreach effort, some may have had older siblings eligible.... She clarified additional information by referring to attachment **SEVEN.**

Vice Chairman Bellew: What is continuous eligibility costing?

Maggie Anderson: We can tell you how many children are eligible today, based on continuous eligibility coverage. We can provide to you a per member per month of what children with continuous eligibility are costing. Using this to estimate how many of them would not stay on for 12 months if continuous eligibility would go away would be

speculation, but we could provide those two pieces to you. Due to how potential changes in policy to continuous eligibility would affect both their eligibility and reporting time frames, this would not really tell you how much savings a policy change would effect.

Chairman Pollert: We went to continuous eligibility in 2007? Or it was authorized that biennium.

Maggie Anderson: June 2008 is when it was implemented.

Chairman Pollert: There was some Fiscal Note about it then.

Maggie Anderson: There was a Fiscal Note. We used the average number of months that children received coverage prior to continuous eligibility, and then making the assumption that they would have 12 months, and what that would cost. Doing the reverse is a little more complicated, because when you're implementing it, you know they're going to go from 3 months to 12. When you go from 12 backwards, you don't know how many of those individuals would retain their 12 month coverage, or how many would only be on for a month. Testimony resumed.

Representative Kreidt: There is a new tax that went on durable medical equipment (DME) of 10%, does that have any effect on this?

Maggie Anderson: We did not account for that in the building of the budget.

Chairman Pollert: Does it need to be in the budget?

Maggie Anderson: It's certainly a cost that is passed on to providers. Providers have not come to us indicating a concern about current reimbursement rates, so I'm unable to answer that. We have a workgroup of DME providers that we could ask.

Representative Nelson: With that 6% that's going to be kicking in, do you feel comfortable with the way you've built this budget?

Maggie Anderson: There is fluctuation in the numbers. We build the budget with the best information we have available. The number we built represents what we believe we need in 11-13.

Chairman Pollert: Do you know why there was a spike in September 2009 and June 2010?

Maggie Anderson: Perhaps ambulance providers don't have a high volume of Medicaid providers and they bill every other month, it's hard to say.

Chairman Pollert: Are there any further questions on this section? We'll adjourn for the day.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 10, 2011
15237

☐ Conference Committee

Committee Clerk Signature Julia Hejaze

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert opened House Appropriations Human Resources Division. Clerk took role and quorum declared. He opened hearing on SB 2012 to continue the detailing of the budget.

Maggie Anderson: provided and went over information to assist in the detailing of the budget, Long Term Care section. The information (labeled as attachment **ONE**) includes Long Term Care budget account with funding sources (including 07-09 and 09-11 biennium) and a breakdown of the long term care continuum budget with the detailing of the sections within the long term care continuum. Committee members interjected with questions as she went through the information and questions and answers are as follows.

Representative Nelson: is the $0.50 provider increase for the DD staff, the only adjustment that the Senate made to this section?
Maggie Anderson: Yes
Chairman Pollert: can someone get a run sheet on .25 and .75?
Debra McDermott: yes, we can get that.

Chairman Pollert: Is there a formula that provides a ratio equivalent from beds to days, like 1.2 beds to 1 day?
LeeAnn Thiel (DHS): to get this information you can divide the days by 365 per year or 731 for the biennium because of leap year.

Representative Kreidt: for the division, is it private pay, Medicaid pay or what's the percent? Is it 30/70
Maggie Anderson: As of Medicaid penetration it's 52% and private pay is 48%. There's a Medicare piece of it too.

Representative Kreidt: with the conversion, a lot of beds are private rooms and there is an extra charge. Are you aware of the differentials for private rooms? I'm assuming a patient can get a private room, Medicaid picks up their share and families can pick up the difference.
LeeAnn Thiel: We do not track what the private pay differential is. ND Medicaid will not pay for the extra for private rooms and there are no facilities with solely private rooms.
Representative Kreidt: I thought you did tracking of differentials.

Chairman Pollert: When you look at the cost changes on attachment D (included in attachment **ONE**), they increased 1.4% but there is no set formula on that $18M. Those are just cost reports you go through to get your figure?
Maggie Anderson: We estimate that on historical cost increases. Nursing homes have limits for direct/indirect care, other, and the property rate. We track that historically and know that percentage and apply that percentage and then whatever inflation (3 and 3) as well as the rebasing that will happen for Nursing Homes starting Jan 2013.
Chairman Pollert: I'm using the 09-11 appropriation. For the basic care it's 16.5% increase whereas the cost changes on Nursing homes is a 4% increase. Why would basic care have that much more of a cost change?
LeeAnn Thiel: we've had a few new basic care units come on this biennium and their rates have been higher than the ones that have been with us for awhile.
Chairman Pollert: I question the $17M increase on the caseload utilization. HB 1325 addressed subsidization of nursing home beds for that 2 year period. It seems like there's not a big usage of beds. Can you substantiate that figure for me? It is strange that we would subsidize nursing home beds to keep them in the system and yet we have a caseload utilization increase.
Maggie Anderson: If you take the 129 new beds times $187 average that we said our costs would be times the 731 beds for the biennium, you get $17.6M

Representative Nelson: in the increase in the nursing home beds, doesn't the $12.8M carryover skew that percentage as that's a net number. In an apples to apples comparison, shouldn't you add the 12.8 to that 459?
Maggie Anderson: We are estimating our true costs to be $2M for 11-13 for nursing homes.
Representative Nelson: that percentage is over 4%
Chairman Pollert: I am just going by the tables as we go forward. I understand what you mean about the 12.8.
Representative Nelson: I would like to see how we finish this biennium with what we did in the appropriations committee last session in each of these cost centers and how we changed the numbers and how close we hit the mark. I'd like that for comparison. Can you get this? It would be important to have this, especially when seeing how far we were off last biennium.
Maggie Anderson: Deb and I can get this for you.
Chairman Pollert: 2 biennia ago, we were quite close.

Chairman Pollert: if the $8.5M at the Bank of ND wouldn't have been in there the last 2 biennia, would you have had a deficient appropriation?
Maggie Anderson: for this biennium, this big differing factor was the economic stimulus enhanced FMAP. Last biennium, we did not tap into any of the loan.

Chairman Pollert: last biennium, you add the $8.5 as the cost to continue your formulas. With your previous statement, it's almost like we didn't need to include the $8.5M last biennium. I struggle with that.
Maggie Anderson: We didn't tap into the loan in the 07-09 biennium.
Chairman Pollert: I thought that, that was added to the costs. I'll double check.
Debra McDermott: if our expenditures are remaining flat and the loan funds are part of our funding for that budget, we have to do a funding shift because we don't need any more authority but we need general funds to basically fill that hold because our expenditures are flat or increasing, which they have been, so that's why we do a funding shift and say that authority now needs to become general funds. We could do it different and say it's not a funding shift of the Bank of ND loan, it's basically just additional general funds that we need to fund the expenditures that we believe will exist into the next biennium.
Chairman Pollert: I understand why you did that this biennium, but I am more so questioning what we did last biennium.
Debra McDermott: it would be the same principle because, as long as expenditures are remaining flat or growing, I need to change that funding source of the Bank of ND loan.

Chairman Pollert: do you have Dec 2010 or is everything like a 3 month lag?
Maggie Anderson: Yes, I do have information on our expenditure piece and we've been tracking that to make sure it recovered. It went up in December. Some of them are still catching up from that period.

Representative Nelson: you're using the entire average of all the months that are included here?
Maggie Anderson: We used average bed days
Representative Nelson: through this whole reporting period that's listed?
Maggie Anderson: No, the average bed days through April

Due to Representative Kreidt's request, **Maggie Anderson** provided and went over information to include cost to continue nursing facility property limits, nursing facility beds history, and nursing facility rates (high and low) in the state of ND (effective date Jan 2011). The information is labeled as attachment **TWO.**

Chairman Pollert: is there a definition of what is included in property costs. Do you pay for everything from the buildings to paved parking lots? Could you give us the quarterly budget for last biennium?
Debra McDermott: we can get that report.
LeeAnn Thiel: Included in the property cost is the depreciation, identified as capital assets that are necessary to provide services. In looking at the audit cost reports, a portion of the parking lot would be included but not all of it. What is included is defined in administrative code.

Representative Nelson: in the adult family foster care, are they included in the Senate adjustment for DD providers? Would they double up in that area?
Maggie Anderson: we need time to answer that question as we have adult foster care funding in different areas and need to look this carefully.

Representative Wieland: could I get the amount that's used for the program (adult foster care) and how it is provided to the actual home itself?
Maggie Anderson: We pay for adult family foster care in various funding sources like SPED so you'd like us to total those up and be able to tell you how much we have spent on that and how it's determined how much they're paid?
Representative Wieland: yes

Chairman Pollert: We hear we need to go to more home and community based, but yet the numbers don't show that.
Maggie Anderson: SPED is one funding source for home and community based services. We also have personal care where we have seen growth and we're still estimating there will be continued growth there. We also have the expanded SPED program as well as the home and community based and technology dependent waivers. It ends up depending on what the client income and assets are in terms of which funding source they fall into. Due to you asking this question prior, we pulled information on SPED. In 2009 we had 661 SPED cases that closed and 257 new enrollees and in 2010 we had 603 that closed and 438 new enrollees. We added almost an additional 200 clients. The reasons for the closures are consistent every year for the most part. We had about 200 clients each year who were receiving SPED who needed to seek nursing home level of care. Other reasons include clients transitioning to Medicaid State Plan (increased ADL needs), PACE program, Medicaid Waiver and some clients pass away which happens with this age group. This data shows us that the continuum is working. We are serving clients in SPED and as their care needs increase, they move on to other programs that meet their level of need. We did see growth in the SPED program and when clients need additional services, the county case workers make sure these clients get into the appropriate services.

Vice Chairman Bellew: explain the home delivered meals. The Minot Commission on Aging delivers meals to seniors that are homebound. Would this be a duplicated effort?
Karen Tescher: This would not be a duplication of efforts. The ones that you heard about previously for aging deliver meals to those over 60 years old and this program delivers meals to those under 60 years old.

Representative Nelson: how can removal of the point split result in a decrease?
Karen Tescher: the point split was to be an incentive for adult family foster care so that on the monthly worksheet, they wouldn't have those points divided up. It is due to the cost of the point split being smaller than the average cost of this service. It results in a decrease to the average cost per person on note number 2.
Representative Nelson: what does that mean though?
Maggie Anderson: sometimes when you add a service, like an expensive service ($200,000 a month, but only 2 people need it), it's going to bump up your cost up little. This one happen to where the actual cost for the point split was $409 and our average cost in the waiver is the 11362. It would have been a different number when we built the 09-11 budget, but that's the number we have in front of us. It's going to be close to that, plus the 6% inflation. When you put the number of people who were going to be impacted by that in this waiver because it wouldn't be everybody, it actually brings the rate down a little bit. It didn't really add a cost; it actually brought it down a little bit because that particular service is less expensive than some of the other services that are in the waiver. There are other services in the waiver; adult family foster care is just one of those.

Representative Nelson: would it be possible to get us information on the trends in all these areas? It looks like we are trending up more than in previous years or you've been more conservative in your utilization or both. It may be that these numbers may not be adequate in some cases.
Maggie Anderson: We can capture some of that in the information you asked about the in loan money and that whole scenario. We have information that we can provide you that shows the trend line of where we built the budget and how that compares to what's happened to that trend line from the point that we built the budget. That is going to speak more to the traditional services because in long term care, people need to be Medicaid eligible, but they also need to be functionally eligible for certain services. On the traditional side, if you need to see the dentist or need a prescription, there's no functional eligibility tied to that.
Representative Nelson: these are conservative numbers we are looking at. When we see numbers since May that are exceeding what you are estimating in the next biennium that raises a flag.

Vice Chairman Bellew: what is the technology dependent waiver?
Maggie Anderson: There are two criterions. The first is that these clients (on the DD or long term care) need to meet an institutionalized level of care which is nursing home level of care for long term and on the DD side, it's equivalent of intermediate care facilities. The second criterion is that these individuals need to be dependent on technology and in this situation, ventilator dependent for 20 or more hours a day.

Chairman Pollert: the 30 you have in here, that's just a number you think?
Maggie Anderson: That's the number of waiver slots we have that we believe that we would serve. Of course it's very early on in its implementation. We used those same estimates and the dollars are what we used when we submitted the waiver application to CMS.

Representative Nelson: is that a medical decision that comes forward from the provider regarding a child going into hospice? Is that a barrier to enrolling in this program? Is there a light at the end of the tunnel for some kids?
Maggie Anderson: There are individuals, adults or children, that elect Hospice, and there is a turnaround (medical procedure, other type of intervention) that allows them to move away from Hospice. With Medicaid hospice, we have a physician certification regarding the expectations for healthcare and whether that will be able to intervene; basically an expectation that it's a life limiting diagnosis. The parents still need to elect the hospice so what you said, could be a barrier. It's not a barrier we've created, but certainly from a parental side, it would be a very difficult decision for a parent to make.

Chairman Pollert closed hearing on SB 2012 with the plan to reconvene tomorrow morning at 8:30 am to continue detailing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 11, 2011
15312

☐ Conference Committee

Committee Clerk Signature Julia Dykstra

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert opened the House Appropriations Human Resources Division. Clerk took role and quorum declared. Chairman Pollert opened the hearing on SB 2012.

Tina Bay, provided and went over information to assist in the detailing of the Developmental Disabilities Community Based Care section of the DHS budget. The information is labeled as attachment **ONE**, starting with the overview and going to ISLA.

Chairman Pollert: is the high school graduates (22) an accurate figure?
Tina Bay: We project the number of young adults that will leaving the special education system based on a point in time child count data that is collected every December. The children with an IEP are reported based on their primary area of disability. We use that category that contains individuals most likely to qualify for DD program management, for example mental retardation.
Chairman Pollert: what is the Grand forks area for case load growth?
Tina Bay: 4 of the individuals will be going to DHI and 5 will be going to REM
Chairman Pollert: with the Developmental Center, the goal to get those numbers down to 67?
Tina Bay: those numbers are for our current budget and to get down to 95 by the end of this biennium – 67 is for next biennium.

Chairman Pollert: last biennium's sheet in looking at the monthly averages of the actual cost per person. It shows on the sheet at $32.5189 and here it shows at $4,410. Would that increase cost be due to the .50 wage increase and the 6 and 6? Would that be part of that?
Tina Bay: That would be correct.

Representative Wieland: What does ISLA stand for?
Tina Bay: Individualized Supported Living Arrangement

Chairman Pollert: could you give a brief description of an ISLA?
Tina Bay: it's a residential service which provides support to individuals living in home owned, or leased by the individual. Services may include training, assistance and personal care, budgeting, shopping, laundry, etc. Levels and amounts of support may vary depending on the individual's need. The individual is responsible to pay for room and board in those settings.
Chairman Pollert: how many, out of your caseload, would be parents with a child that is eligible?
Tina Bay: People that are providing ISLA for their children is not allowed. It's a provider. It cannot be a family member.
Chairman Pollert: when I get an e-mail from someone saying that they have a family member in an ISLA, that's not necessarily meaning that their services are being done at home?
Tina Bay: Yes
Chairman Pollert: Are there any such programs like that? What would those be called?
Tina Bay: We have family support services, in home supports

Representative Wieland: when I was a freshman, the dept had prepared information with the acronyms and what they stood for?
Tina Bay: Yes, we can provide that for you as well as a brief description of what those services are.

Chairman Pollert: you would have used Aug 09- April 10. Are there any anomalies that we should be aware of? 647 in Nov 10 seem to be lower than the rest of them. Is there a reason why for that so we shouldn't be looking at that number as far as average wise?
Tina Bay: When providers bill, they may not bill one month, rather the next month for the two months, so that will affect our counts. Also, when you look at the actual expenditures, if there is any payback, this would be offsetting so that would cause our numbers to increase or decrease. As far as the number for Aug 10, the last legislative session had appropriate money for enhanced funding for critical need consumers and we were working on getting the new amount out to the providers, so there may have been a delay in authorizations with the increased amount.

Chairman Pollert: you have the 8 from the Developmental Center to get down to the 95 and there will be more to go further down in 11-13. Is the money following the client? It looks like when we are going from 40 FTEs at the Developmental Center and dropping them 40 off, but we are adding 20 FTEs through the whole budget. It shouldn't all go to the DD community because it costs a lot more money to have that individual taken care of at the Developmental Center. I am requesting this information be provided when Alex comes in front of the committee next week.

Tina Bay went of ICF/MR (intermediate care facilities for the mentally retarded) Adult in attachment **ONE.**

Chairman Pollert: can you give us some examples of what's illustrated as an ICF/MR?
Tina Bay: yes, these would include HIT, Inc in Mandan and Enable, Inc and the Developmental Center and Anne Carlson Center are classified as an ICF/MR.

Chairman Pollert: in looking at the information provided when we did the long term care and it was split with nursing houses, basic care, all the way down through. Do you have a more detailed report for the breakdown? You have everything lumped together in the DD home and community based services for the 265,000,000 and that's probably split out in that report. Would you have a similar report as far as the cost changes, case load utilization, etc?
Tina Bay: Yes, we can prepare one of those for you.

Chairman Pollert: I am comparing this information to the attachment from your overview and on case load utilization, when I look at 09-11 you had talked about a total of 240 and on your current information, you have 246.
Tina Bay: That would be our monthly average that we are anticipating.
Chairman Pollert: is that going to show on your caseload utilization changes. How would I trace how you got the $4.5M?
Debra McDermott: We do the DD grants as far as cost and caseload the exact same way that Maggie walked through the Medicaid tables. Basically, we start out with the cost and caseload as the 09-11 appropriation is and then we change the cost based upon the current cost information that Tina just walked though. We'll keep the caseload exactly the same and change the cost. The number that you are looking at is going to be 3 different tables that you are going to walk through with Tina.
Chairman Pollert: Can I just take 6 times 9744 times 24 months?
Debra McDermott: No, because this is all ICF/MR and you are just looking at ICF/MR adult. So, you would add up (on pg 1 of attachment **ONE**), ICF/MR Adult, ICF/MR Physically Handicapped, and ICF/MR Children.

Tina Bay went over Day Supports in attachment **ONE**.

Chairman Pollert: on the 22, 8 and 9 which is the same as an ISLA. Would the ISLA be similar to a housing support and the day supports is to actually take care of them?
Tina Bay: Yes, the ISLA would be the residential and the day supports would be the day programming that they would receive.

Chairman Pollert: explain the difference between the 785 in an ISLA and the day support of 1146. Where would the other 350 or so come from?
Tina Bay: Not at individuals who receive day support live in an ISLA. They may live at home with their family members.

Representative Kreidt: we are seeing the 22 high school graduates again and that is the same as we are saw in ISLA – you are just repeating those same individuals again?
Tina Bay: Yes, that is correct

Representative Wieland: this was an hourly rate, but it's not 8 hours per day. It looks like 5 ½ hours on average. How do you determine how many hours per day?
Tina Bay: day supports is based on the consumer schedule and travel time is not included in this so when the time starts when the consumer arrives at the day program. The consumer may leave at 3-3:30 pm. It is 15 minute increments and yes, 5 ½ is about average

Chairman Pollert: for the 09-11 budget, you had $13.59 for the total hourly cost and on this report you show $16.34. Can you give me a break down on that difference?
Debra McDermott: they would have gotten the 6 and 6% and it's the actual cost that they are billing which would have included the 6% and then we've added the additional 6% (.88) for the second year onto the average billing per unit that we've seen so far.
Chairman Pollert: in a simple format, would it be possible for you to give me a breakout of how you got from the $13.59 to the $16.34?
Debra McDermott: We can provide the simple form for you of that.

Tina Bay went over ICF/MR Physically Handicapped in attachment **ONE.**

Chairman Pollert: could you give me an example of ICF/MR Physically Handicapped?
Tina Bay: It's similar to what an ICF/MR would be; it's just a different group of consumers within the ICF/MR
Chairman Pollert: could you an ICF/MR physically handicapped in an ICF/MR?
Tina Bay: Yes, you could. ICF**/MR physically handicapped are** consumers that are served with higher needs than standard ICF/MR adult.

Representative Metcalf: could you give me a definition of actual cost per unit – what a unit is defined as?
Tina Bay: The unit is a daily rate for 24 hours (all inclusive programming)

Tina Bay went over ICF/MR Children in attachment **ONE.** This would include Anne Carlson and Children's Homes. You'll see a decrease in May which could be a result of a provider having a payback to the dept.

Chairman Pollert: how far out could you go? 12 months? 24 months?
Tina Bay: yes, it's about a year behind.

Representative Nelson: these numbers are fairly stagnant. Is it because the units are basically full?
Tina Bay: yes
Representative Nelson: where does the provider assessment tax go and what's it levied for?
Debra McDermott: in July 2005 there was legislation passed where we tax the ICF/MR facility based upon a percentage of their revenue. It's allowed by CMS for them to pay a tax. They pay that money directly to the tax dept and then the money in that fund or the provider tax assessment fund is used to fund some of the Medicaid expenditures in our Medicaid budget. The monies couldn't be used directly to enhance the services where they're taxed. We couldn't use those revenues directly to fund the DD grants, however we can use those monies that are generated basically from CMS to fund part of our Medicaid budget. It's all in the traditional Medicaid grants budget. It's a federally allowable tax.
Representative Nelson: that's leveraged by a 3 to 1 match by CMS or by federal dollars?
Debra McDermott: yes, it is based upon the FMAP. The first year we implemented it, it was a 70/30 but of course now, it's closer to the 55.

Representative Wieland: as an example, the Anne Carlson Center receives dollars from the school from DPI because they are a school in fact. Is this reimbursed by DPI?

Tina Bay: It is separate. We can provide you with this information.

Tina Bay went over Minimally Supervised Living Arrangement in attachment **ONE.**

Chairman Pollert: what business does the MSLA entail?
Tina Bay: It's a community waiver group home or a complex setting which provides training and community integration, social, leisure and daily living skills. The providers include HIT, Inc. the client is responsible for the room and board in this facility.
Chairman Pollert: MSLA wouldn't need as many services, comparable to a nursing home and assisted living, right?
Tina Bay: it is somewhat comparable

Chairman Pollert: what is the difference between an ISLA and an MSLA?
Tina Bay: ISLA includes living in a home or a rental property apartment complex with 1-2 individuals in a room and MSLA is a group home that consists of more individuals living in that facility.
Chairman Pollert: what's the different between the needs of a person in an MSLA versus a person in an ISLA?
Barb Murray: MSLA group homes started out in the 80s as being a higher level of need than ISLA. The boundaries have gotten blurred over the decades since then as we can have ISLA that are 24 staffing. Generally speaking, MSLA need a little more support.

Tina Bay went over Transitional Community Living in attachment **ONE.**

Representative Wieland: typically where would those 4 people be coming from?
Tina Bay: These clients do not receive services in the DD system, so they would be coming from their home; the individuals may be aging. Their parents may be caring for them currently and they may be aging and not be able to provide the services that the individuals require.

Chairman Pollert: as we continue this transition down the road from the Developmental Center, individuals will be going through all areas of this section being explained here?
Tina Bay: that is correct. Depending on the need of the individual, there are many different services available – not just an ICF/MR, but could be day supports, ISLA.

Tina Bay went over Family Support Services – In-Home Support in attachment **ONE.**

Chairman Pollert: these individuals could be from any age group?
Tina Bay: participants of this could be a child living in home and the parents need assistance in the morning preparing that child for school so a caregiver could come in and provide that service to the family member. The service supports that primary caregiver. The client must be living with their primary caregiver in order to be eligible for this service.
Chairman Pollert: you have QSPs for an elderly, so who would be coming to this home to take care of these children or to help with daily supports? Would it be someone from the DD association, like HIT or Enable could come to provide supports and go back to the agency?
Tina Bay: yes, it would be a provider and the provider staff would be coming into that particular home. They could come into the home for a few hours or so.

Representative Metcalf: you've got an hourly rate. Does that hourly rate vary by location?
Tina Bay: It's provider specific, so it could vary.
Representative Metcalf: so it depends on what the provider bills the agency?
Tina Bay: It's determined when we do our rate setting process, when the provider submits their budget to us, prior to their new fiscal year. We look at historical data and they build their budget based on that
Representative Metcalf: if the provider were a unit like HIT, then you are talking about quite a few people involved in this cost sharing. If you are into an area where there are very few people and you've got one or two people that are providing service, can they develop their own schedule or how does that work? I am concerned that we aren't getting a fair spread of the costs.
Brenda Weisz: All providers have to follow the same cost rules or administrative code for rate setting. With that, they would have to follow the same cost principles and limitations. Even if they would have different level of cost, they would have to follow the same admin distributions, allocations and rate setting rules.
Representative Metcalf: how much difference is there between the people in different parts of the states as their payment per hour?
Brenda Weisz: We will get that information back to you.

Representative Nelson: are most of these individuals QSPs?
Tina Bay: They receive more training than QSPs.
Representative Nelson: is the training similar to training for a CNA?
Tina Bay: The training for the DSP (Direct Service Professional) is comparable to a CNA.

Representative Wieland: this works out to about 40 hours per month?
Tina Bay: It can vary by person, but the average is 40 hours.
Representative Wieland: how do you determine how many hours to utilize?
Tina Bay: when we are building our budget, we are just looking at the average of what historical data has been and the average of the person using the services. In home support receives 40-42 hours per month, so that is what we base our current numbers on. We take an average as some may only receive 5 hrs a month and some receive more than 42 hrs.

Tina Bay include information to prefacing the next section (Infant Development) and stated: you'll notice the actual units of service in the gray areas are higher than what we've had since August 2010 period. Prior to July 1, 2010, infant development programs were billed a daily rate for each weekday from the day the child was found eligible, for services until the child left the program. The daily rate was different for each provider, but the same for every child in a specific program. A claim was submitted for each weekday, even if no services were delivered. The rate setting model did not account for the many ways services are individualized to the children. CMS also required that we change our methodology so therefore, effective July 1, 2010, we switched to a fee for service. She referenced the note at bottom of the pg that illustrated the process used. **Tina Bay** went over Infant Development in attachment **ONE.**

Representative Metcalf: would you give me a break down for a unit in this section? Days? Hours? The original unit is what I am looking for.
Tina Bay: that was a daily rate, 5 days a week.

Brenda Weisz: the method was required to be changed by CMS as it wasn't hinged to any kind of outcome and what kind of services were provided during that daily rate. There wasn't a true definition as to what was that daily rate. We converted it to the 4 pay points to make this switch.
Representative Metcalf: it'll differ for each child involved so it could be 5 hours or 5 minutes, so you average these out and that's what you come up with as the unit?
Tina Bay: If they saw the child, they go paid is the old system. We had to come up within our budget the 4 distinct payment methods.

Representative Wieland: you had to make some changes, so now show me the calculations.
Tina Bay: the 4 pay points: the evaluation can be billed at $411, ISSP (developing the plan) is $398, a home visit is $120 and a consultation is $250.
Representative Wieland: how does that turn into $149.15?
Brenda Weisz: we looked at how many visits and how many consults we expected for the children. We retrofitted that into the spreadsheet you are familiar. We'll pull the spread sheet that laid that out. We'll bring that forward to you. It'll look different than this sheet.

Representative Kaldor: when you arrive at that conversion number, what would happen here is that home visits would be the overwhelming quantity of services so that's why the average is lower.
Tina Bay: yes, that's correct. We anticipated 2.5 evaluations and did those calculations, but home visits is certainly the service that has received more.
Representative Kaldor: that explains the lower number and you confirmed that here so I don't need to see that requested information.

Chairman Pollert: Were all the funds asked for in 09-11 used up? You had a total of 963 for the 09-11 budget and an average of 72 between Aug 09 – Aug 10, so your caseload utilization was not as high in this particular area on the budget. You can answer that when we get the schedule breakdown for the caseload utilization.
Tina Bay: As we switched to the new methodology for fees, we have experienced delays in billings for providers. We have providers that are experiencing some difficulties and they have had several claims that have been denied and we are working through that with the different pay points. The numbers that you see from July and on may not adequately reflect what actual kids are receiving services.
Chairman Pollert: it looks like about every 3 months there is something happening there because you have a lot less reporting of persons.

Cal Rolfson Anne Carlson Center: I am going to answer Representative Wieland's question. He correctly identified that Anne Carlson receives funds from DPI for their special education services. The question was does the ICF/MR tax include tax on funds paid by DPI to the Anne Carlson Center and the answer is no. The tax is just based on each licensed bed and does not include DPI dollars.
Representative Wieland: they receive funds from DPI in addition to the funds that we are talking about here?
Cal Rolfson: Yes
Chairman Pollert: are those federal dollars?

Cal Rolfson: It would be whatever dollars DPI provides for special education, so it would include some federal dollars.

Carol Olson provided (as requested by the committee) a glossary of human services terms and acronyms, labeled as attachment **TWO.**

Tina Bay provided information (requested by committee) illustrating DD Hourly Wage Comparisons and effects of wage increases (.25, .50. .75) and **Jamie Wilke** went over this information.

Chairman Pollert: the .50 includes the 33% that we talked about in testimony?
Jamie Wilke: The 33% fringe benefit is actually not changing at all. All we are doing is .50 hourly increase to the providers wages.
Chairman Pollert: does the $5M include the 33% in the fiscal note?
Debra McDermott: the 33% is based upon salaries, so yes, basically if you give them a salary increase, they also get additional 33% because the 33% fringe benefit is always based upon salaries. It's stays static at the 33%.

Representative Wieland: is it included in this information? Is the 33% included in these numbers?
Jamie Wilke: No, they are not.

Representative Nelson: the last column is the way the Senate brought the bill over to us and we don't have a net as to what the executive budget put forward as far as the 3 and 3 included?
Jamie Wilke: If you looked at the first FTE, you'd be looking at 7/1/11 being $17.76 and for 7/1/12, you'd be looking at $18.29 per hour. Do you want to go through all of them?
Representative Nelson: No, that's okay.
Chairman Pollert: can you get us this information later?
Jamie Wilke: Yes

Chairman Pollert: we allocated $4.2M general funds to go to enhanced DD grants. How are those DD grants handed out? If a facility had 50 clients, did they all get the incremental increase or did you pay out the $4.2M increase by severity of case. If you have a facility with more severe case, reasonably, they should get more money because it costs them more to have those kids. How is that $4.2M divided out?
Tina Bay: We had the facilities complete the Oregon assessment on each consumer. We worked with the stake holder group and determined what a cutoff should be for each category (6 different categories identified for the critical needs). We cut off at 50 and above so if an individual scored 49 and below did not receive any enhanced funding. However, if a client scored 50 and a client scored 70, they would receive the same dollar amount. The scoring process was the same as the past, but the universe of people was expanded (children, adults) so the number of those assessed were much greater in number.
Chairman Pollert: on your handout of the 11-13 executive budget of the DD buckets of the 8.4M, what is the 8.4 consisting of? Is that the 4.2 plus the federal match dollars?
Brenda Weisz: the 4.2 is included in that number as well as that bucket money that started a couple of bienniums ago. The money for the emotionally/behaviorally challenged had special money added for that purpose. There has been additional money added over

the bienniums due to how complex it has gotten, either by the governor or the legislature. We've separated out that money because it's been too complex to add it into the rate setting. It is a combination of what's been added by you, the 4.2, in addition to what's been added before. It's about 6 buckets of money.
Chairman Pollert: tell me about medically fragile again.
Tina Bay: the scores that we use for the medically fragile was 16 and above for 5 of those categories. In our last bucket, which included a lot more people, we lowered the score to 13.

Representative Wieland: are we going to get (in regards to the funding on the bucket) something in addition for what we've already received for the next biennium?
Tina Bay: we have a spreadsheet that shows each bucket of money, the scoring that we used, and the people that received that type of funding.

Chairman Pollert: if we wanted it to get that money to the more medically needed, we should have specified that in the amendment. We put the $4.2M in a large bucket and let you guys distribute it out administratively.
Tina Bay: our current system is the retrospective cost based system so it makes the additional funds more complicated. We worked with the stakeholder group and for the next fiscal year, we are looking at weighting those scores and we worked with the provider group as well to see if it would make more sense to wait. If a person scored a 50 and a different person scored a 70, they would be a different dollar amount per assessment. At this point in time, we are waiting to see how SB 2043 plays out.

Chairman Pollert: so 2043 has had the funding taken away from it or had it pulled out of the bill?
Legislative Council: SB 2043 has never had funding in the bill. There's a fiscal not attached to the bill that says the amount of dollars that's needed to implement the bill.
Chairman Pollert: if the bill was to pass, then would DHS have to do the funding according to the policy in 2043?
Legislative Council: If SB 2043 would pass with no funding in it, the dept would have to fund the dollars somewhere to implement the bill.
Chairman Pollert: if SB 2043 would pass today in its current form, then would the DD funding buckets of the $8.4M be administered in the way that 2043 is being asked for?
Tina Bay: SB 2043 gives us an implementation period so the money that you are looking at in our 2011 budget probably would be distributed the same way it was in our prior biennium. The fiscal note that's attached to 2043 is administrative costs.
Chairman Pollert: it's not as simple to a retrospective payment system to a prospective payment system. It looks like you are trying to get the money and pay it up front instead of paying it out back.
Tina Bay: that's correct

Chairman Pollert: you deal with grants to the Developmental Center. When we are dropping caseloads down at the Developmental Center, are there people around that region trying to accommodate the possibility of clients going into the Grafton area?
Tina Bay: the provider group has been very active in looking at getting those numbers down at the Developmental Center and what kind of service they can provide. It's been

statewide in that we've had some more to Grand Forks and some we are looking at moving to the Bismarck/Mandan area.
Chairman Pollert: With Alex, we are talking about the detail of the appropriations for the Developmental Center, but yet at the same time, there are always discussions of where are these people going and somewhere along the line, there has got to be some sort of guardianship for the more severe cases. I question whether this system is set up for that or not.

Debra McDermott provided and went over information (as requested by committee) about comparison of net Medicaid Eligible's (less QMB's only, SLMB's only and QI's) and unduplicated recipients (Jan 09 – Dec 10), labeled as attachment **FOUR.** She then went over attachment **FIVE** (2009-11 Biennium, Budget vs Projected Need for Traditional Medicaid Grants and 2009-11 Biennium, Budget vs Projected Need for Long Term Care Grants).

Representative Nelson: what we did in the house 2 years ago, the difference would be in the 26204 and the 13476?
Debra McDermott: what was done in the house was the $13.4M cut. The difference between the $26M and the $13M would have been our deficient appropriation. We would have been short in authority even without the cut. But with the cut, we are $26M in the hole in this area.
Representative Nelson: as we tried to figure out the gap, this chart would show that.

Andrea Pena provided and went over information to assist with detailing of the DD Council section of the DHS budget and is labeled as attachment **SIX.**

Andrea Pena: The operating line item has increased significantly because we are looking into hiring a contractor to implement requirements from our federally mandated developmental disabilities act. This was recommended in order to fulfill obligations from the federal DD act. In other words, when we had a fiscal review, the federal govt stated that we need to move forward to either add additional staff or hire a contractor to implement requirements out of the DD Act. Previously we were doing this through a grant funded program. The organization that was providing those services to us is no longer providing those services to us so we were looking at utilizing a contractor.

Representative Nelson: when that contract runs out, that staff would go away?
Andrea Pena: Yes, but it will depend on the reauthorization of the DD Act as to whether that money would roll back into the DD grants or we would need to renew the contract.

Chairman Pollert: called Senator Mathern up to discuss amendment as he had requested
Senator Mathern, Fargo, Senate Human Services Committee: you sent a bill over to the Senate 9HB 1152) which provides additional funds to critical access hospital and the original amount of $18M was taken down considerably to $3M. Through our discussion we learned about patient centered medical homes and a conference was held on this topic when you were working on the bill. At the conference, there was information provided that the implementation of this concept of patient centered medical homes will not just be implemented through the efforts of BCBS, but also through the offices of Medicare and Medicaid. There are some who believe that there will be positive consequences in terms of

people's health and lowering costs of medical care, it may also decrease the number of days that people are in these hospitals up to 30-40%. The concern we have as a committee is that even though this money is important to these hospitals, there may be bigger issues that we should give attention to in the interim to prepare for the greater challenges that these small hospitals will have. We thought it would be important to share this information with your committee as you are dealing with SB 2012. I offer this amendment (attachment **SEVEN**) to you for your consideration if you believe that there will be issues we should be studying to get ready to help these small hospitals to a greater extent than this dollar amount, and then we would ask you to put this amendment on the bill and address it in that respect. If you would like further information, there is a large packet that will be kept in the Senate Human Service Committee room that you can address.

Representative Nelson: HB 1152 is the bill. It is my recommendation that this be added to the human service budget only from a practical stance that I didn't want that bill to go into conference.
Chairman Pollert: we will have some further discussion on it.

Senator Mathern: There are challenges on 1152 in the Senate and I believe we need to do whatever we can to help these small hospitals. I think that bill and doing this are good components, so next session, we can come in with some other efforts as what we are doing now is more like a band aid.

Representative Nelson: I would like to commend Debra McDermott on her fantastic job this week and stepping up to the plate when Brenda Weisz was absent. Nice work.

Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 14, 2011
15415

☐ Conference Committee

Committee Clerk Signature Julie Ziegler

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division back to order to resume detailing of the DHS budget.

JoAnne Hoesel provided and presented information to assist in detailing of the Mental Health / Substance Abuse division in DHS and is labeled as attachment **ONE.** Just to note, the research analysts are assigned to a policy division so they deal with all the policies in DHS and in different divisions. This allows us to have backup staff for the work that we do and that they have oversight from a lead research analyst.

JoAnne Hoesel: One of the major changes in this budget is the use of the 6 of the FTEs from the Developmental Center to move into this division. Of that $913,203, $837,637 is federal dollars that are designated for those prevention specialists and we have taken them from what use to be contracts and moved that money up to the salary line item.

Chairman Pollert: where did that funding come from?
JoAnne Hoesel: From our substance abuse, prevention and treatment block grant
Chairman Pollert: has those proven to be a stable fund?
JoAnne Hoesel: yes. There have been variations throughout the years, like increases.

Chairman Pollert: what would the 6 FTEs do?
JoAnne Hoesel: answered question by going over attachment **TWO** (information requested by the committee prior that describes different entities and what they do within the entity in terms of prevention; also addresses what DHS does in terms of substance use/abuse and how these 6 prevention specialists are operating). This is direct funded. This is money that these departments receive directly for prevention efforts in the state. They may give to other state agencies, but that would be a pass through. DHS focuses on substance abuse prevention.

Chairman Pollert: Did the former first lady use SAD funding?
JoAnne Hoesel: She may have, but the funding she received from DHS was used for Parenting for Prevention as well as PSAs to encourage parents to speak with their youth about underage drinking as they got into their teens.

Representative Nelson: regarding the DOT funding, is that increasing? Do you have a handle on any of these areas as how the grants are coming to us?
JoAnne Hoesel: outside of what is happening with the Safe and Drug Free Schools and community dollars to the DPI, I have not heard that any of the other agency funding is changing. I believe it's NITZA funding.
Representative Nelson: would that be 402 and 408 money?
Office of Management and Budget: the money that DOT is using for the drinking and driving is different than the 402 and 408 funding. They are using that money for the highway patrol; the law enforcement software and some of the data.
Representative Nelson: I'm going to find out what they are using that money for, that they use to put into the health dept.

JoAnne Hoesel: our prevention specialist, within DHS, is role based. They each have an area of expertise that it's important in the area of prevention. They are able to focus on that and we are able to provide that direct service to communities if that's an area that they identify as something that they would like to work on. For instance, one of them is the media as it relates to prevention. So, if a community wants to get the word out through messages like present information to their community members regarding the efforts in their community and to gain the participation of community members, we would send out our media prevention specialist. We have 1 for education; 1 for Law enforcement; 2 that go out into the communities and do assessments and strategic planning and when the communities identify the direction they want to go, these specialists bring in the resources from the other members of the team to meet the community's needs; 1 is media; and 1 is for prevention and recovery. It depends on the community, but we may work with Public Health in these efforts so the tobacco prevention/cessation (local public health) is done at the same time as substance abuse prevention.

Chairman Pollert: are you using existing federal funds for the 6 FTEs for these prevention specialists?
JoAnne Hoesel: By making these changes, we are spending less on staff and we have more direct services that can go out to communities and efforts. We are focusing on environmental strategies based on the results of our readiness survey and that means that we need to provide opportunities and have an increased awareness for people. When Representative Metcalf had asked about sending information out to schools, that's where that money (not increasing, using the money differently) goes. We're able to have those printed materials and able to do those sorts of things, where we weren't able to do that before as the money went into one staff person or one contract in each region.
Chairman Pollert: the money hasn't increased, but yet you are going to increase FTEs and free up money?
JoAnne Hoesel: Yes.
Chairman Pollert: how do you do that?

JoAnne Hoesel: we went from 8 contracts to 6 (a state team) and then with the money that we don't need for their operating expenses and travel, we use with programming material in prevention.
Chairman Pollert: if you are realigning the 8 contracts, why would you need the 6 FTEs from the Development Center?
JoAnne Hoesel: It's a total different approach. It's a team whereas there was not a team before. Another reason we can do this, is that in each contract the agency would charge us an administrative costs, so we do not have to do that any longer. We will have more of an impact as we are working as a team. Instead of expecting that one person in the whole region has all of those skill sets necessary to make an impact in prevention, we can send the whole team or just choose the pieces depending on what the community needs to help them make a difference at the community level.
Chairman Pollert: I am still confused.
Brenda Weisz: What we use to have is 8 individual contracts with 8 communities. We tried to accomplish the goals that were just laid out (law enforcement, media, etc.). We tried to find an individual that would have all this in their background and establish them in the 8 communities. As this wasn't working, we tried a different approach. They reported to 8 different bosses. We didn't have the continuity across the state and our numbers weren't changing as far as youth and abuses of substances. We tried a different approach and we went with one main contractor that had the same type of approach, but one employer (Minot State University). They employed those same type of people in the region. We went with a unified employer to try to look for the continuity and they charged the administrative fee and placed the people in the community, sometimes the same people. We found that we're still not having the continuity we needed and you were still looking for the same person who was the jack of all trades. It was a broken down system; we couldn't afford it. All that money that you had seen in the budgets before were in the contracts or operating fees and services. During this contract period, we looked at a different approach to try things differently. We looked at hiring experts. If you look at fiscal, we wouldn't hire people with all kinds of different hats, we hire the fiscal people and in the program areas, they hire their program people. Minot State said isn't working and we're not doing the contract anymore and so we had the experts. Instead of having 8, we narrowed it down to 6. Instead of having the administrative overhead fee, we don't have that anymore. We have the depts. overhead fee. I am processing the expenditures and fiscal so you don't have that same Minot State charges their overhead. That's where we were able to save some of the money and why we're able to put the staff on. Instead of having 8 pockets of people (one in each region), we can do it with a team of 6 that are located out of the central office. They'll go out to the regions that need the help.
Chairman Pollert: these 8 regions or contracts were not employees of DHS?
Brenda Weisz: that is correct. It was actually one contract operating. It was in your operating fee and services line and now, instead of being in that line, you are seeing them in the salaries and fringe benefits line. They're going to be cheaper as we had 8 people under contract before and now we have 6, but we're still able to do the other areas of operating.

Representative Wieland: were all the 8 contracts the same amount of dollars?
JoAnne Hoesel: Yes, they were. We took the funding and we gave them $65,000 a year. It's all federal dollars.

Representative Nelson: How did Minot State University react to this change?
JoAnne Hoesel: Rod said he would be willing to come down and talk about this was a mutually positive thing. They were asking for more administrative dollars that we couldn't afford.

Representative Wieland: you would have to add in travel because they would have to travel the whole state because they are located out of Bismarck?
JoAnne Hoesel: Yes. 4 of them are out of Bismarck, but 2 of them (the two community people) live in Minot and Wilton.

Chairman Pollert: the general funds drop and the federal funds increase on the operating lines.
JoAnne Hoesel: if we would skip down to operating, I will be able to demonstrate exactly what Representative Wieland has identified that when you move the money out of a contract, it's going to show up in our operating. We are able to let you know where that's happening and what's driving the increases or decreases.

Regarding travel, we've only spent a portion of what we budgeted for, and yet we are asking for another $82,000. I had our financial liaison do the spend down up until Jan 31 and we have spent $102,690. We moved from the contract to operating in Oct 1 and so that's where the travel would have been for those individuals prior to that time. The whole change of this is a matter of moving from a contract to now these are people that are in our division. If we would remove that, it would actually be a decrease.

The next decrease is in the supply/material and professional. The majority of this money is spent for our prevention resource and media center and we have moved from a far more active media center than a passive center. Instead of purchasing books and hard copies of things, we actually use much more electronic media and that's less expensive.

The decrease in miscellaneous supplies is due to losing our safe and drug free schools community funding; DPI got the main part of it. The governor had identified DHS to receive the community portion.

We have an increase in printing and that is a move from an active approach to environmental strategies. For instance, we have an inhalant tool kit that we want to make sure schools and parents are aware of. We're quite concerned of inhalants by children in our state.

We have a decrease in equipment under $5000 because anything we needed to adjust in terms of ergonomics has been completed.

We have an increase in IT-communication which is a result of moving from prevention contracts to operating and this is for the prevention staff who need cell phones and internet cards when they're out.

Chairman Pollert: why wouldn't taking money out of mental health/substance abuse block grant work? You'd have to re-allocate where your money is going.

JoAnne Hoesel: The purpose of a governor's prevention advisory council is to bring those agencies together. Our funding is specifically for substance abuse. The executive order is broader. We have to take in to consideration that we have all of those agencies on tap. Because of the limited dollars with that, the committee said they wanted to make sure the funding gets out in grants to the communities that are using evidence based programs. A lot of that tends to be curriculum.

The professional development has decreased due to the loss of safe and drug free schools and community.

In operating fees and services we have an increase of $3.1M, which is broken down in Operating Fees and Services spread sheet in attachment **ONE.**

Representative Wieland: can we get what the actual cost of those 6 FTEs are in terms of salaries, benefits, travel, etc.
JoAnne Hoesel: Yes.

On the operating fees and services, the sex offender treatment contract is the contract we have with rural CPC. This is the community based high risk sex offender treatment program in the state. They hire staff in 6 regions and we get referrals from the Dept of Corrections and Rehabilitation (DOCR) and the State Hospital when individuals from the secure unit are discharged from the State Hospital.

Vice Chairman Bellew: did that amount increase (sex offender treatment)?
JoAnne Hoesel: No, it did not.
Vice Chairman Bellew: is Robinson the same?
JoAnne Hoesel: Robinson did receive a 3 and 3 inflationary increase

Chairman Pollert: in regards to the sex offender treatment, those are people who have served their sentence at DOCR or State Hospital and are in need of further treatment?
JoAnne Hoesel: those coming out of that commitment program in the state hospital (we have budgeted for 6 from State Hospital). The majority come out of the state penitentiary or their other secure facilities that they have served their time. They are in need of continued treatment. We use a containment model so you have a counselor that provides the treatment, but we also meet with the probation officer, a victim advocate and the person that does the lie detector test (have it done every 6 months). With the four professionals working with this individual from different angles, it ensures the individual is doing what he/she needs to do to prevent reoffending.
Chairman Pollert: how many individuals?
JoAnne Hoesel: We have budgeted for 69.
Chairman Pollert: how many do you have during a biennium?
JoAnne Hoesel: Currently, we are treating 71. That has gone up to over 80. We believe that longer sentencing will allow us to have a little bit of time before we see any need for increase.

Vice Chairman Bellew: does this overrun with parole and probation? Is there a duplication of treatment?
JoAnne Hoesel: this is therapy. They still have probation officers.

Vice Chairman Bellew: when they are released from prison, they are not cured?
JoAnne Hoesel: yes, that is absolutely correct.

The gambling treatment and 2-1-1 contracts are done through Lutheran Social Services (LSS). They have the compulsive gambling treatment program in the state.

Chairman Pollert: was that only onetime funding? Didn't we have some gabling dollars last biennium?
JoAnne Hoesel: This is what this is and has been in place since 2005. We get lottery dollars and general fund dollars.

We will continue to contract with the 4 tribes for tribal prevention coordination (federal money).

Representative Wieland: on the tribal prevention, is any of that suppose to be used for suicide?
JoAnne Hoesel: not specifically, but by participating in and focusing on prevention, you can certainly identify people that might be at risk, but this is for substance abuse prevention.

Safe and Drug Free Communities contracts has actually ended. This is spending authority that we would be able to use through the end of September of this year. We're using the remaining funding that we have to provide additional efforts in the 4 tribal areas. Prevention Infrastructure grant is to get 85% of those funds out to communities to do the same kinds of things we are doing with our community team.

Vice Chairman Bellew: explain the governor's prevention committee support.
JoAnne Hoesel: We use that to help manage the Governor's prevention advisory council. We do strategic plan. We have worked with Audney to do a brand called "Not Our Kids." We have 14 agencies that are represented on this council. We are looking at this being a brand that will help those agencies together in terms of message, even though we have a different role in prevention. We will be launching a website in the next month or two called ndprevention.com and all the agencies will have their websites connected to that. It will be the hub for people wanting to find information about ND and prevention. They help us manage those contracts. We have five contracts through the Governor's prevention advisory council.
Chairman Pollert: is this part of the $100,000?
JoAnne Hoesel: we will be finding that in the grants line.
Chairman Pollert: when we get to that I'd like to have an explanation of the difference between this governor's prevention committee support and that $100,000 that goes to SADD, right?
JoAnne Hoesel: we have $43,000 of the $100,000 that go to SADD on the grants line.
Chairman Pollert: is the governor's prevention committee support steady from 09-11?
JoAnne Hoesel: yes

Chairman Pollert: is the $4.4M infrastructure grants an increase?
JoAnne Hoesel: definitely an increase; all federal.

Chairman Pollert: last week, we had the kids in and we were talking prevention and we can't find $300,000 out of the $4.4M for them?
JoAnne Hoesel: We were given notice in Oct about the process that we need to use with this infrastructure grant. We now have 9 months to do a strategic plan. The plan is based on the data that is coming from the Attorney generals' office, DPI, DHI, all the data around the state – plus our readiness survey. We have to get that okayed by the feds before we can spend any money. We will now be able to spend any money until after July or August. It's due July 1. We are targeting the culture in our state.
Chairman Pollert: my observation is the young adults in SADD are pretty mature, so are you targeting the mature children that don't need as much help or are you targeting the young adults that need this type of supervision?
JoAnne Hoesel: To truly turn things are, we need to address everything that is going on around the kids. What can we do as communities to not make it okay to have the graduation keggers and to not have the New Years Eve events where the drinking is the event?
Chairman Pollert: couldn't it be said that the students in SADD have primary focus of outreaching so they are reaching those types of students who are doing the keggers, etc.?
JoAnne Hoesel: From our youth council and kids that I have worked with over the years, tend to be drawn to the fringe versus kids who would be in SADD. Prevention needs to affect all of us and we all need to be involved in the solution. That involves the SADD kids, the parents, and those that aren't on the right track.
Chairman Pollert: the $4.4 is going at a targeted group of young adults?
JoAnne Hoesel: It would have to be the communities that identify that fits in their strategic plan. It may very well do that but I don't want to mislead you to say that we can absolutely do that when I have no idea that we can and what the federal project officer would say about that. I think they very much need to be a part in all of the solution. I also don't want to say that and then it not happen. As we don't have a strategic plan, no one truly knows what this is going to do because we just got it and we are working on some preliminary information.
Chairman Pollert: is this a onetime funding?
JoAnne Hoesel: This is not permanent funding. The positive thing about environmental changes is that you are looking at the culture and the mindset and you don't need money to continue to do that.
Chairman Pollert: the prevention infrastructure grant is a different line item than the substance abuse and prevention grant?
JoAnne Hoesel: yes, it is totally different.

JoAnne Hoesel went through the grants, benefits and claims section of attachment **ONE.**

Vice Chairman Bellew: is there a required county match (voluntary treatment program)?
JoAnne Hoesel: Yes
Vice Chairman Bellew: that is 25% of non federal money?
JoAnne Hoesel: Yes

(continuing through the grants). Funded through SB 2198 is Head Injury Association of ND contract, Hit, Inc. contract, and Community Options contract. That is providing services to individuals with TBIs. Mental health extended services includes job coaches to those with SMI. This is where we have our gambling treatment services (some of them). The

substance abuse prevention line is the grants that are funded out of the Governor's prevention advisory council.

Vice Chairman Bellew: your budget shows a $1.49M general fund increase. Could you go through where the increases are?
JoAnne Hoesel: $755,388 is for job coaches (mental health extended services), $230923 (part of the grant line increase, gambling (use to be in operating line and moved to grant line)), $312569 for TBI (use to be in operating line and moved to grant line), and $129,065 in enforcing underage drinking.

Representative Wieland: on pg 13, you show $1.7 under TBI, but those 3 lines don't add up.
JoAnne Hoesel: We do have more in TBI. We have asked for spending authority to submit another grant for a TBI grant so that would be $743,125 (HERSA grant). We currently have a grant that will be ending in March (implementation grant) and we would like the ability to apply if HERSA would offer TBI grants again to states.

Chairman Pollert: on the $755,388 for job coaches, did you have an opportunity for federal grants for half of this? What is it going to be for?
JoAnne Hoesel: The majority of that will be to pay for job coaches ($520,000)
Chairman Pollert: what drives that?
JoAnne Hoesel: the extended services are tied to the DD reimbursement system, so when you have given increases to the DD system, the rates for extended services go up, however this extended services are for those with TBI and seriously mentally ill. In the next biennium, we want to separate the reimbursement process from the DD system because our funding sources don't go up. We are moving to a prospective rate. We'll be working with the providers in terms of arriving at a rate that reimburses them appropriately, but we will also have adjustments in the program to make sure that it truly is targeted to those with SMI and TBI. We've needed to separate reimbursement wise from DD because DD get increases where this world does not and it's causes us financial problem in this area. We are in the process of putting together a specific program.
Chairman Pollert: the DD would not have been reduced with this general fund increase?
JoAnne Hoesel: no, this does not represent anything to do with DD. DD would show up in DD grants.
Chairman Pollert: you say you are trying to get a split away from it. When you get a split, it's almost like you'd think it would be a grant away from the DD and come over to this. It's not because it's an increase.
Brenda Weisz: We don't have sufficient funding to provide the services that they need out there. They are not eligible for any federal funding. Extended services are something that's available in the DD world and the same providers provide the service so it's an allowable service under the DD world. When the 6/6 is granted on the DD side, since we don't have a different payment mechanism, we don't have a different way to treat it on the mentally ill side, they end up getting paid the same way and we don't have enough money to do it. We've had to try and figure it out. We have to pay the money so we have to support our clients. We want to cover our costs for these individuals, ensure that they have the job coaches they need to be independent in the community and to provide for themselves in the community. We want to split them from the DD world so they're not dependent on that system. For future years, we don't have to deal with them being linked to a system that they

should not be linked to. We're trying to implement change and look at them as a separate population. We need to fund what the need is out there and that's what we are presenting to you.

Chairman Pollert: From your overview I wrote down, SB 2163 $110,000 general funds for TBI services. Is that in this budget or that is a separate bill that they are trying to get funded?
JoAnne Hoesel: That is a separate bill. Those 3 grants (HIT, Community Options, Head Injury Association) is a continuation of SB 2198 from last session. This bill is requesting a person to do what the head injury association director does on the western side of the state, on the eastern side of the side. It's the same thing, but it's an increase from what you see before you.

Representative Wieland: how much money is projected to be spent on TBI in the next biennium?
Brenda Weisz: $330,000 would be a continuation of what was passed last time in 2198, then another $145,000 of general funds in that area. Federal funds include $802,761 as well as some other money in supplies, travel thus the total of general and federal would be $1,134,301
Representative Wieland: in 2163, they are asking for another $110,000?
Brenda Weisz: Yes

JoAnne Hoesel provided and went over information as requested by Representative Wieland regarding trend data for other years regarding arrests made for driving under the influence of alcohol; percentage of arrests made for DUI, Liquor law and drug abuse violations; and percentage of individuals (male and female – given separately) admitted to ND State penitentiary that have a drug/alcohol abuse/dependency and mental health diagnoses.

Tina Bay provided and presented information on Developmental Disabilities (DHS) to assist in the detailing of this section. The information is labeled as attachment **FOUR.** She started with the organizational chart, stating no new FTEs are being requested. She proceeded to the summary by subdivision and budget account with funding sources. There is an increase in travel line and of the increase; $200,075 is federal dollars for part C program. This increase is due to increase monitoring requirements by CMS and OCEPT. We are anticipating that we'll need to do additional training to staff in the field.

Vice Chairman Bellew: explain the part C program to me.
Tina Bay: This is a federal grant program for infants and toddlers with disabilities that provide early intervention services. The age group is from birth to 2 years of age and their families. Part C focuses on enhancing the families' ability to maximize their child's development while part B (age 3-20) focuses on the child's educational needs. ND provides early intervention part C through the DD program management system to enhance the waiver funded family supports and Medicaid benefit available to families.

Vice Chairman Bellew: you had to move a member of your staff in your division, but that resulted in an increase in salary. Why was that?

Brenda Weisz: previously, we had joined up and had a director that did the director of vocational rehab and DD together and with the requirements of the DD division and the various things that was required by the federal govt, it wasn't working out to have a director that oversaw both areas because of the demand. We actually put in a director of DD which makes it uncomfortable for Tina to speak of it.

Chairman Pollert: what is the increase in the other equip under $5000 about?
Tina Bay: that is all part C dollars as well. It's to purchase new OE and temp equipment which allows for us to do in home hearing screenings for children. As our programs have grown, we have additional infant development providers and we need to purchase some additional equipment for them.
Chairman Pollert: repairs?
Tina Bay: That is also for those new machines. That is where our agreement for those maintenance agreements goes.

Tina Bay went over the Grants, Benefits and Claims schedule in attachment **FOUR**.

Chairman Pollert: is the Minot State University training modules contract stable?
Tina Bay: that is stable. We have not done an increase in that contract.

Tina Bay went over Operating feeds and services schedule in attachment **FOUR**.

Chairman Pollert: what are the section 11 support living contracts?
Tina Bay: Section 11 was funded by the ND legislature to provide residential and employment services, supports to individuals who do not meet the level of care to access federal funds under our waivers. Currently, we have 59 clients under this service with different providers throughout the state.

Chairman Pollert: regarding Catholic Charities and the increase they stated they needed plus the FTE, is there a bill out there about this or did they approach you about their increase needs?
Brenda Weisz: Catholic Charities has been providing services for DD clients for as long as I can remember. They did approach us this biennium. They did have an accreditation visit and the client to staff ratio was not up to par with their visit. In working with them and looking at the contract we have with them, we did provide funding this biennium to help them to add a part time staff. Te did reprioritize our budget to continue that into the 11-13 budget. The amount of money for that was $141,994. The amount for the continuation of the 6% for the second year was $49,866. The amount for the 3 and 3 was $81,599. That entire contract is general funds.

Vice Chairman Bellew: what are the other funds in the self-directed supports and quality assurance? Where do the other funds come from?
Brenda Weisz: That's the one other place most of the provider assessment money goes everywhere in the Medicaid grants to fund, except a small portion does come into the DD grants area to provide the funding in quality assurance area and the Acumen contract.

Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 14, 2011
15352

☐ Conference Committee

Committee Clerk Signature Julia Ziegler

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division to order. Clerk took role and quorum declared. He opened SB 2012 to resume detailing of the DHS budget.

Debra McDermott provided and went over requested information by the committee, labeled as attachment **ONE.** The information includes DHS quarterly budget insight (biennium to date information on selected department programs, July 2009 – December 2010).

Representative Nelson: in each of these cost centers, is there a different lag that exists in each one; for instance, a one month lag?
Debra McDermott: If you look at the last column, there's an asterisk for TANF to go down to the footnote on the bottom. Basically, the TANF grants at this point in time that we thought 18 months would have expired for those grants because they are paid at the beginning of the month, for the month. Medicaid and Childcare Assistance are on a 17 month actual expenditures through this time period and that's because they are paid at the end of the month for the preceding month.

Chairman Pollert: for instance, inpatient hospital shows at 71.8 and the months are at 70.8 for Medical Assistance, Medicare clawback, long term care continuum and the DD, right?
Debra McDermott: yes, if you use the very simple math with it being 17 months used divided by 24 months.

Chairman Pollert: on the last pg of the DD, is there any significance regarding the dip in March 10 and May 10?
Debra McDermott: We have a program note there. A lot of that is due to the fluctuation in the DD providers billing because they don't always bill consistently. It could be their settlements, for expenditures.

Chairman Pollert: because of the retrospective and when you get everything together and determine whether there is a plus or minus payment.

Jan Engan, provided and presented information to assist in the detailing of the Aging Services Division section of the DHS budget, labeled as attachment **TWO.** She started with the Organizational Chart for the division and described each position, highlighting the responsibilities of the positions. Ms. Engan proceeded to walk the committee through the summary of subdivision and budget account with funding sources with committee members asking questions throughout and questions and answers are as follows.

Vice Chairman Bellew: in your salaries, there were increased general funds and decreased federal funds. Can you explain this?
Brenda Weisz: it is tied to a budgeting error made last time. We had a turnover of staff, so during out biennium (09-11), as we went to monitor the budget, we realized there was a budgeting error. We allocate and draw down as much general funds as we can in our indirect cost allocation and there was too much money that was used or tried to be used for our indirect grants and executive office and administrative support and that money's not available. It left us short general funds in our budget so we have to correct it in this budget. We've had to come up with that money this biennium, by cutting back in other areas in our operating. We have to budget correctly, now that we've seen the mistake.

Jan Engan moved on to address the travel expenses. The budget change is attributed to having to more expenditures from our Ombudsman cost center to the 4201 (our administrative) because we've ran out of federal authority under that dept ID. We've had an increase in the general funds for the Committee on Aging (committee of volunteers appointed by the governor and looks at issues of aging, serve as an advisory group to the division). It is anticipated that more volunteers are going to be added as well as increase in their travel and education forums throughout the state. The Aging Administration Account has been increased because we've picked up the cost from the Ombudsman program for increased Ombudsman travel due to the increase of facilities across the state which requires visits from the Ombudsman as well as some of the volunteers. Due to program training requirements, there will be increase in travel for staff. The ADRC has a good chunk of this funding and that's complete federal funds. The ADRC in Region 7 has expanded out of Burleigh county into 4 other counties in Region 7, however they do take calls from other counties, should they come in, so they will be increasing their travel throughout Region 7 and will roll out completely into Region 7. There will an increase of federal funding in the Senior Employment Program and that is again due to training requirements and mandatory monitoring that we have to do for our CCEP program.

Representative Wieland: during public testimony, we received information that the ADRC in Bismarck provided a bus ticket for an individual to go from Bismarck to Fargo to get to the Cooper House. Is that part of what ADRC is suppose to do be doing?
Jan Engan: No, that is not part of what the ADRC does.
Representative Wieland: Can we get something in writing as to what that project is suppose to do and accomplish.
Jan Engan: Yes, I can get that for you. The ADRC is a virtual agency. It has no building or structure. It is a pilot project in Region 7 and has rolled out in Region 2. It provides information assistance, information and referral as well as provides the options counseling

piece which are trained individuals that work with clients and family members in looking at choices to meet their needs with the goal of remaining independent in the community. ADRC is also connecting with medical communities in our towns and working with individuals and the medical staff to allow for medical staff to be connected to these individuals and their families and taking into account of specific needs. Being acquainted to the medical service providers allows ADRC to be aware of all the options in the community and communicate these accordingly. There is also an evaluation piece to evaluate the type of individual receiving services with ADRC and the outcome.

Representative Wieland: Yes, I would like to see it in written form. I am questioning duplication of services as there are 53 Social Service agencies in the state that seem to provide these same types of services, and/or can be easily trained to implement what ADRC does.

Jan Engan: The partnership with the ADRC and your local County Social Service agencies as well as other organizations (CILS, the Alzheimer's Association in ND/MN) all work together to ensure that when a consumer knocks on the door, they will get service in some fashion. For the most part, many people enter into long term care facilities as private pay and soon end up on state funded/waiver programs. The intent is to keep the individuals in their homes for a longer period of time. Generally speaking, individuals who are private pay would not get services through the county social services, but would get services through the SPED program and waiver program, so we have to have a place for those who fall through the cracks where they can get service and get answers to their questions.

Representative Wieland: my point is, that even though County Social Services does not normally deal with private pay, they could. They've never been approached about this as I've asked several directors about this. I realize there is a stigma attached to seeking social services, but they need to get over that and look at it as a place to get help. For us to create another agency to do just doesn't make any sense to me when we have all of these people that could function as that.

Carol Olson: last session, DHS came before you for a general fund request for ADRC as well as the Community of Care. Things fell apart in the support for the DHS's requests for the general funds in conference committee, so I withdrew our request for general funds for ADRC (I will not get into specifics here as to the reason) and put our support behind the Community of Care. Later on, we became aware of an opportunity to apply for the federal grant for the ADRC and we received it, however the emergency commission said no. Upon contact with Senator Stenjham and inquired about how to get this approved in the emergency commission and he said get rid of the 1 FTE. We decided to do that and we got it. Now we are moving with the ADRC grant, along with all the other states in the nation. At the national level, they are pushing all states into these ADRCs and putting their Title 3 funding behind them. We are moving them into the regions of the state and we are incorporating all of the entities that work with the seniors to collaborate with ADRC. This allows seniors to have access to all the services out there and we know we weren't doing that before, as for whatever reason, the options and choices were not clear.

Representative Wieland: the problem that I have with this is knowing that down the road, Federal Grants go away and it is up to the state to pick up these costs, thus we need to look at whether it is necessary to fund this at the forefront.

Carol Olson: There is not going to be any cost for this program. The staff are those on board right now. The CILS, the 211, those in the Human Service Centers are all those staff in the ADRC. All they needed was training and organization to get them going. This is a

mindset. This is a training opportunity that the feds are funding. It is expanding what these individuals already do.
Representative Wieland: Please include the list of counties that are part of ADRC in the information I requested about ADRC.

Vice Chairman Bellew: what is the cost of the ADRC for this budget?
Jan Engan: The cost is federal dollars.
Vice Chairman Bellew: can you get me a list of what it costs?
Brenda Weisz: It is $324,629 that is included in the Aging Services Budget.

Jan Engan continued to go through the subdivision and the reasons for increases. We expect to see an increase in printing cost for our brochures and information that we make available to the public i.e. The Graying of ND. These are provided to community upon request as well as when we go out to do health fairs, presentations, etc. The rent increase is for Prairie Plaza and ADRC (regional human service center – federal dollars). The increase in operating services and fees is to address our various contracts and direct services to individuals, for instance, the guardianship program.

Representative Nelson: when you are going through this line by line, can you illustrate in what areas and the reason the $640,000 increase came from?
Jan Engan went over this information that was included in her overview testimony and is labeled as attachment **THREE**

Vice Chairman Bellew: what is congregate nutrition?
Jan Engan: The meals that are provided in congregate settings and this includes senior centers where seniors go into a place to eat.
Vice Chairman Bellew: are you providing meals at a reduced rate and that is why there is an increase in the funding?
Jan Engan: We cannot charge a fee for congregate or home delivered meals. Additionally, there has been an increase in raw food costs and increase in costs of transportation for delivery.

Chairman Pollert: state funds to providers for the $1.1M; what is that entailed of?
Jan Engan: the changes in the state funds is related to that – all 3 and 3 related (3% inflationary)

Representative Nelson: the increase in general funds is all related to that and the increase in congregate nutrition area – most of all of the other increases is all federal funding, correct?
Jan Engan: Yes, basically

Chairman Pollert: under grants, is the $1.2M for the Alzheimer's Demonstration Project, steady from 09-11?
Jan Engan: Yes it is
Vice Chairman Bellew: who gets that money?
Jan Engan: That contract is with the ND/MN Alzheimer's Association
Vice Chairman Bellew: who are they?

Jan Engan: it's a nonprofit organization that serves both MN and ND in a variety of ways. They primarily work with individuals with Alzheimer's or related Dementia and their families.
Vice Chairman Bellew: wouldn't the ADRC take care of something like this? Or even county Social Services?
Jan Engan: To a degree, but not the way the law was written. It was to do in homes.
Sheryl Pfliger: The law was written so the Alzheimer's Association or private contractor could provide services, not only to the individuals with Dementia, but also to the family members. They do trainings, help with behavior characteristics that are adverse, go into nursing home and provide training for staff in nursing homes so that the issues can be dealt with more efficiently both the person with the disease as well as the family members and care givers. In essence, it is to help maintain individuals in their home for a longer period of time
Vice Chairman Bellew: where are they located?
Sheryl Pfliger: They have main offices in Fargo and Bismarck and with this grant, they did increase staff so that we have staff people in each of the 8 regions. These people go to the very rural areas of the state and make the in home visits and visit with the family members/caregivers and give them additional tips. It was HB 1043 from last session that did this.

Representative Kreidt clarified that cost was for about $1.2M (general funds).

Vice Chairman Bellew: Alzheimer's Demonstration Project - how long do demonstration projects stay in effect?
Sheryl Pfliger: Dementia Care Services program is funded through...
Vice Chairman Bellew: will we see results for these programs?
Sheryl Pfliger: The Alzheimer's Association is working with UND to do an evaluation of the programs and the final report is due June 30th

Jan Engan resumed going over attachment **TWO.** In the grants, there is a tele communication, equipment distribution of $280,000 and that is other money that comes in.

Chairman Pollert: If there is going to be increase in federal funds for ADRC, would there be a decrease in federal dollars for county Social Services? It seems like there are duplication of services in having the ADRC in Burleigh County as well as Burleigh County Social Services. I was gone briefly earlier, so I may have missed something in regards to this.
Jan Engan: Having both is the concept of the "no wrong door" so when people do come to you, they can get the correct answer. They may not always get the direct service, so if somebody were to call Burleigh County and need services, but did not qualify for the services that were provided there, they could make, through our agreements (memorandums of understanding) they could call an ADRC, be hooked up with an options counselor, and then proceed with responding to their questions and their needs and fit that into their plans so that they can make choices on how they would like to age in place. The same would be true if somebody were to call the resource link and through the question and answer process, it was determined that this would be a good fit for the options counselor, the live referral would take place between the consumer and the options counselor and the options counselor then would take it from there. Some options counseling can be done by the telephone, but it's most appropriate as it's done in the

home. At that point, they would talk with the consumer and make the determination and fit them with community services where they are available and hopefully that individual then would be able to live independently in their communities.

Chairman Pollert: where are you going to expand to next biennium? Is there going to be an expansion of services with ADRC?
Jan Engan: The initial pilot is in the rollout area and they are in Burleigh, Morton, Kidder, Mercer, and McLean counties and next biennium, they will roll out into the other counties in the Region 7. In Jan 1, 2011, the ADRC concept rolled out in Region 2 (Minot area) and Jan 2012, we will be adding Region 1 which is out of the Williston area and Region 8 (Dickinson area). In Oct 2012, the pilot grant will be over so they will completely transition to our title 3 funding and then we will roll out in the rest of the state which will be Regions 3, 4, 5, and 6 in Jan 2013.
Chairman Pollert: what is the difference between the ADRC and what is going in Arthur, ND (Community of Care)?
Jan Engan: They are similar. The Community of Care is where volunteers (like the Village movement) from communities come together (some have membership fees) to provide services to the aging population. If you have more types of services like this (there's group in Bismarck – Volunteer Caregivers), the ADRC concept is not needed.

Vice Chairman Bellew: is the Community of Care funded in this budget?
Brenda Weisz: all general funds in the long term care area of the budget (medical services section)
Brenda Weisz and **Jan Engan**, in response to Vice Chairman Bellew's request, stated DHS will provide further information Alzheimer's Demonstration Project.

Representative Nelson: if the ADRC concept is granted, are you comfortable giving up the Community of Care? Let me phrase that differently – what are the differences between the Community of Care and the ADRC? I am concerned about duplication of services.
Carol Olson: One of the main differences between ADRC and Community of Care is that Community of Care offers direct care. ADRC is NOT direct care. We will provide information about this service to the committee.

Chairman Pollert: is it a possibility as the ADRCs expand, that the Community of Care could be an ADRC? In essence, we are wondering about duplication of services.
Carol Olson: Community of Care: They're structured differently; they use volunteers; it's a much more integrated program. It's NOT an ADRC. It's a resource, like an addendum. Let's get the information to you and then we can have another conversation on it. It's much more complex and complete than an ADRC.

Tara Muhlhauser provided and presented information to assist in the detailing of Children and Family Services Division of the DHS budget, labeled as attachment **FOUR.** She started with going over the organizational chart, highlighting the responsibilities of each position. Tara indicated that over the past few years, there has multiple changes with employees, but that the transition is about over.

Representative Nelson: Can you let me about the vacant position you have there? How long has it been vacant? What does that person do?

Tara Muhlhauser: That is a person in our background check unit. The position has been vacant since mid November. We have kept that position vacant to allow us to do analysis of the workflow that is going through our criminal child background check unit. We have 2 temp positions to maintain the workflow (we have upped their hours). We are looking what skills we want to hire in this position as we've caught up with the background checks. We brought early childcare into the background checks as of last session which was a significant increase in criminal background checks. They were quite different for us in terms of the offense and the information that was reported back to us than the checks for foster parents, adoptive parents, and relative care providers. The work has increased in this area due to this.
Representative Nelson: are you looking to see if this position will get hired through the contract help? Or are you looking to fill this position?
Tara Muhlhauser: We will be hiring for that position in the next month and that position is essential.

Tara Muhlhauser continued to go over information, highlighting changes in the budget and reasons for the changes. We had salary decreases were related to retirement payouts. Some money from background checks had inadvertently gone into the salary line and was removed back out. Some salary costs were decreased due to transitions like having staff retire and we filled those positions with a slightly lower pay.
Representative Nelson: we often see increases in salaries, but you have decrease in salaries, so it makes us question this. When you place a new person in position of management in a grade 14 or 15 for instance (not sure if that is a good comparison), I'm assuming that's an internal transfer. Where would that person at in that new position from a general sense?
Tara Muhlhauser: In response to Representative Nelson's question about requesting an explanation for the decrease in salaries, she described the different positions, stating that several of the management hires were internal so they came to the dept with significant program skill, but not necessarily the management skill, so the pay was lower. For instance, part of the biggest change happened in child protective services and she stated that she was in the position prior and I was paid significantly higher than the person hired behind her based on experience and education.
Representative Nelson: So, just because an individual has upward mobility within the organization, it doesn't equate to a pay grade raise?
Tara Muhlhauser: Yes, that's correct.

Tara Muhlhauser continued with the detailing, following salaries and proceeding to travel on the summary by subdivision and budget account with funding sources. In response to Chairman Pollert's concern about the travel expense being high, she stated that with the transition and audit from the federal govt (done in April 2008 and received in February 2009) CFS was informed of improvements for travel. Prior, they were using their travel budget for doing local CFSRs (Child and Family Service Reviews). Upon analyzing the federal PIP (performance improvement plan), she felt that with the resources at hand, these weren't entirely necessary, so the travel for CFSRs were taken down for a year. When the PIP was in place, it was federally required that they continue to do the CFSRs as they had been, so they budgeted the travel back for the second year of the biennium.

Tara Muhlhauser: Under professional development, the difference is directly related to the child and family services reviews. We have honoraria dollars that we pay some of our reviewers and the human service reviewers don't request that. If we would have carried forward with the CFSR activity in that professional development line item, we would have anticipated a cost of about $57,000 that would have been added to that year one cost, that we took down with that activity.

Representative Nelson: in the IT area, there are reductions. Can you explain this?
Tara Muhlhauser: we decided that we did not need that amount in that IT software budget. We don't do the microfiche anymore.

Tara Muhlhauser went to operating fees and services due to committee's request.
Chairman Pollert: what is AASK? Where is the total increase at? Go over the changes in this area.
Tara Muhlhauser: AASK stands for Adults Adopting Special Kids. It's our special needs adoption contract. There is no cost increase in the AASK contract. In the grants, there are some additional dollars to provide for additional AASK activities, but it's a pay for performance contract (no 3/3). Our changes come in the background checks and the intensive in home contract. The changes in the intensive in home contract are made to follow the inflation (3/3). That's an RFP contract. It exists with the Village family Service Center. The changes in background checks reflect the caseload increase. We have predicted a 25% attrition rate in background check fee numbers. We are over this as there is change in staff, particularly in center based operations.

Chairman Pollert: is there a set price on the background check?
Tara Muhlhauser: Yes. $47.25 is for most of the background checks (adoption and foster care). For our early childcare checks, we pay $17.25 which is the cost of the FBI portion of that check. BCI covers the remaining $30 because that was directly placed into their budget. The $47.25 checks are the full federal checks which includes state offenses. We do a child abuse and neglect index check for any child abuse neglect activity as well as a check on ND courts for any court activity in ND. If they've had any MN resident addresses in the past years that they report to us, we check on the MN court site as well.

Representative Nelson: in the other funds category, is that the BCI portion?
Tara Muhlhauser: That's recipient liability for adoption funds. What happens with adoptions is the prospective adoptive parents pay that and we reimburse them that cost later in another payment.
Representative Nelson: that's a constant number?
Tara Muhlhauser: It has not changed to a significant degree, but we have had a small increase in a number of adoptions.

Tara Muhlhauser directed committee's attention to Children and Family Services (11-13 biennium) County Breakdown (as requested by Vice Chairman Bellew)
Vice Chairman Bellew: do you have a breakdown of how these figures were arrived that? Doesn't the law state that 25% of all non federal funds are allocated to the counties?
Debra McDermott: It depends on each one of the different grants that we pay and how works. There is a state law that says they are supposed to pay 25% of the non federal share. Percentages change based on the federal matches. Some of the foster care cases

are paid with 4E dollars so they are paid at FMAP. Basically the non federal share is split 75/25 between the state and county. Some of the programs are basically funded with the emergency assistance under the old emergency assistance programs, so it's TANF money. Basically the counties pay 25% of that entire cost and the TANF money picks up 75%, so there's a variance with the different ways those percentages are arrived. We have a schedule that we can provide you with. There's also a different caveat (like with the EPT contract) on what we do with the Native American cases because those have a different percentage as well because the counties aren't billed for those at all. The state picks up the entire non federal share on those.

Chairman Pollert: in regards to the green sheet (attachment **FIVE**), on number 16, on pg 5, it looks like a double up. Can I get an explanation of the two different breakdowns of those dollars?
Brenda Weisz: In my overview testimony, I combined the FMAP change for you as the $171.4M that Deb provided for you. Part of it was because the stimulus money or ARRA money did go away. Part of our foster care grants are funded with 4E money which is based on the FMAP. The FMAP dropped to 55.4 so that would be the other difference. Tara has a walkthrough for you on the grants.

Representative Wieland: there are still some SWAP funds that are mentioned in Children and Family Services. What is that related to?
Debra McDermott: you are going to see all of the retained dollars on the next schedule that Tara is going to go through, the grants. You are going to see those in the areas of the county reimbursement. We have used retained dollars or SWAP dollars in that area for several years and that's to reimburse them for the FTEs for determining the eligibility into the State Hospital, Developmental Center, Walsh County work, Rolette County work for the EPSDT program. Those were items that were not swapped out when we went through the whole SWAP calculations. Those are just dollars that are reimbursed back to the counties.
Representative Wieland: will that go on for awhile, beyond this biennium?
Debra McDermott: Yes, we plan on using SWAP dollars to reimburse those areas as long as we can keep generating the SWAP money.

Tara Muhlhauser went over Grants Summary. Committee asked questions throughout presentation, with questions and answers as follows.

Chairman Pollert: what would the reduction in other funds be (Child Abuse and Prevention)?
Tara Muhlhauser: That was based on $100,000 that we added in 09-11 as a onetime funding for Child Abuse Prevention activities.
Chairman Pollert: Independent Living Programs are unchanged?
Tara Muhlhauser: we had onetime funding that was removed from that, which was ARRA funding for a subsidized employment program for foster youth. / / The $3.6M drop in Child Care grants is due it being an ARRA funded program. It was called Quality Rating Improvement System (QIRS) that went to the CCR&R with onetime ARRA funding.

Chairman Pollert: this reduction has nothing to do with the $4M in the Commerce budget?

Tara Muhlhauser: I have not been a part of the budget billed for those activities or any part of the process, so I don't know if they are looking at something that looks like QIRS with that additional dollar amount.
Chairman Pollert: the dollar amounts are similar. Office of Management and Budget or Legislative Council, do you know anything about this? I thought the Chamber of Commerce was at $3.someM last biennium and then it went as an amendment in the commerce budget for $4.5M.
Tara Muhlhauser: I can certainly inquire about that.
Chairman Pollert: what would have the $3.644M been for?
Tara Muhlhauser: those were for the QIRS. They offered incentives to providers, had additional staff that was focused on brining in new providers that engaged in training and recruitment activities to ramp up the number of available childcare settings as well as the quality of the settings.
Legislative Council: according to statement of purpose that was attached to the commerce budget on the first half; they did add funding from the general to provide grants in collaboration with the DHS under 50-11.1-14.1 to childcare providers for workforce development, quality improvement, and technical assistance.
Chairman Pollert: this is a replacement?
Tara Muhlhauser: We have been collaborating with them on the incentive grants that were allocated to commerce last biennium. That's the only section that we have been actively involved in.
Chairman Pollert: would there have been any dollars in 07-09 for this and the ARRA funds would have been in 09-11? Now we are basically replacing ARRA funds with the general fund, but increasing it by $1.3M?

Vice Chairman Bellew: regarding refugee grants, can you further explain the $2.7M moving to Lutheran Social Services (LSS). Is that in this current budget? If it is, what is the source of funding?
Tara Muhlhauser: Those are federal funds. Those funds come to LSS because they administer the official state refugee assistance program. We had administered that through CFS. Our program lead retired. We did some analysis and we had a large contract with LSS to do a significant component of the work. It made sense for us to just pass the program through a MOU process to LSS, so LSS receives the federal money now ($2.7M). We have retained a small component of that for the unaccompanied refugee minors that come into the county.
Vice Chairman Bellew: LSS gets the money or do you guys get the money and give it to them?
Brenda Weisz: the federal govt designates a point of entry or an agency that an agency that can accept the refugees and that agency was always LSS. Those funds always came into the dept and we had to pass them through to LSS. Instead of doing that middle man shuffle, we asked the federal govt to give the money directly to LSS and did the paperwork to make that so.

Representative Nelson: if you look at that then, you'd say that the dept is taking $2.7M for administration?
Tara Muhlhauser: it wasn't administrative dollars. Those were dollars for direct service costs that we then provided to LSS to work directly with the immigrant population.
Representative Nelson: the total grant didn't go up that much?

Tara Muhlhauser: No, it did not go up.
Brenda Weisz: the total we always receive was approximately $4, so they get it now. Refugees get a TANF payment (included in the $2.7M), so instead of us making the TANF payment, LSS will make the TANF payment. It's direct assistance and some administrative. The stuff that we are going to do is the unaccompanied minor (tied to foster care that we have to do) is the remainder of the $4M - $1.3 and the rest LSS will handle directly.

Tara Muhlhauser: The increase in Child Abuse/Neglect payments is due to the 3% inflationary as well as increasing the number of assessments by 5 per month (flat rate for assessments).

Chairman Pollert: can you explain the reimbursements to the county?
Tara Muhlhauser: the $998,000 was removed and replaced with targeted case management. At the time the budget was built, we were not able to bill wrap around targeted case management. The wrap around case management was given a 3%. We have the additional $200,000 for the short term shelter care program (youth works pilot project). We have addition in the juvenile case management that is based upon our actual 4E billings for that. We have a 3% that's being added to our parent aide contracts with the counties. Again, the largest item under there is wrap around case management which we could not bill last biennium because there was a moratorium on that service. We are able to bill that again and that is a $2.4M change.

Vice Chairman Bellew: family preservation and family services county funds has an increase. Can you explain this?
Donna Aukland: This comes from the wrap around targeted case management. The counties actually pay the non federal share for that portion.
Vice Chairman Bellew: where does that figure come from? Is there a percentage that they pay?
Donna Aukland: when they bill Medicaid, Medicaid reimburses them the FMAP rate and then they are responsible for the non federal share. This is an alternate funding source that they had available to them instead of going through county reimbursement, so they go ahead and bill what they can for wrap around case management.
Vice Chairman Bellew: how come they haven't done this before?
Donna Aukland: Last biennium, the feds told us that we were unable to bill for wrap around case management so it was not built into the budget at all. Mid way into the biennium, they reversed that decision, so we built it back into the budget.
Vice Chairman Bellew: what are the other funds in that category?
Donna Aukland: That's for the children's trust fund.
Vice Chairman Bellew: what's that?
Donna Aukland: We are able to use children's trust fund monies in order to provide certain services.
Vice Chairman Bellew: but what is it?
Brenda Weisz: children's trust fund is the money that's paid when you pay for your birth certificate so that is what provides funding for this budget.

Tara Muhlhauser: You'll see an increase in the subsidized adoption. We anticipated about 81 cases a year which was an increase and we've had consistent increase in this area. We have an additional number of children who come to us for that particular service. We place

children in what we determine to be permanency placements. We've also put 3% inflationary amount on those subsidized 4E and regulatory adoptions as well.

The foster care increases are due to increased cost, increased caseload and the 3/3 inflator (referenced and went over attachment **SIX**).

Chairman Pollert: are these numbers actual or estimations?
Tara Muhlhauser: They are calculations based upon on actual numbers. When we took a look at our snapshot number of our one day total in foster care from this year to last year, we had a difference of about 115 children. We recognized that our greatest number of kids come from the 4 E from the tribal area. We watch those numbers closely, in terms of trends.
Chairman Pollert: are the 4E showing up under family homes (attachment **SIX**)?
Tara Muhlhauser: The majority of them show up in family homes. Right above that (21), we anticipated 15 of the 21 would be those tribal 4E youth who needed those specialized services.

Tara Muhlhauser: In looking at the grand total, 44% of the increase is based on the 3% inflationary increases. Overall, the budget building process, in terms of building a hold even budget, went well and we had lots of decreases in many areas, but the inflationary increases as well as the increase in sub adopt and foster care was what made up the increase.

Office of Management and Budget provided and went over information about the HB 1018, 601 Department of Commerce, Childcare Funding Comparison, labeled as attachment **SEVEN**

Representative Nelson: when was the last time, we took a lesser amount of onetime funding away and put a greater amount into the continuous funding?
Chairman Pollert: You'd have to talk to Representative Hawken from the Education and Environment section of Appropriations. I believe they took away funding from Center of Excellence ($15M) and added in the $4.9 and they showed an $8M reduction.

Chairman Pollert closed hearing on SB 2012 with the plan to reconvene fifteen minutes after floor session to continue detailing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 15, 2011
15446

☐ Conference Committee

Committee Clerk Signature Julia Jeigle

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 to resumed detailing of the DHS budget.

Marilyn Rudolph, Director of Northwest Human Service Center (NWHSC) and North Central Human Service Center (NCHSC), provided and presented information to assist in detailing of these human service centers as part of the DHS budget. The NWHSC information is labeled as attachment **ONE.**

Marilyn Rudolph started with general information. She reported that she has been monitoring the admissions at NWHSC since ND is in the middle of the oil boom and it's moving east, thus believes the same thing will be seen at Minot. Since July 2010 there has increased number of clients to the point that it has increased by 700 appts per month. Those are individuals who are requesting to be seen for medication review and coming in from every state in the union, either on medications from other states and need refills or haven't been on past prescribed medications and need to go back on. In order for these individuals to be functional in the oil field, they need to take their medication. Additionally, we are starting to see increase in our addiction services, especially since Mercy Recovery (primary addiction provider) has closed. NW is the addiction provider in the region. We have a continuum of care for addiction and there are 2 other private providers who do evaluations.
Chairman Pollert: why did Mercy close?
Marilyn Rudolph: They (addiction) closed in December 2010. In March 2010, Mercy closed their mental health unit because they lost psychiatrist and they can't operate without an onsite psychiatrist. They lost several LACs for Mercy Recovery and were unable to recruit additional LACs to make up for the loss. The CEO at Mercy Recovery is trying to recruit psychiatrist with the goal to open a few psychiatric beds. This would help to keep people in the community versus running them to Trinity.

Chairman Pollert: you can give us a breakdown of what's going on regarding staffing as this is the time to do so.
Marilyn Rudolph: This boom feels much more permanent than the last boom in the 60s and 70s. People are coming to town and buying homes, but we do have a lot of people camping as well. Haliburton and Schlumberger and some of the large companies are coming in and leasing hotels totally, so to get a room in Williston is impossible. Recruiting is difficult in Williston as housing is hard to come by. If I recruit, even a psychologist, easily $1200 a month is the rent for an apartment. It's difficult to recruit unless someone has a connection to Williston or an ability to find housing in another way like move in with family.
Chairman Pollert: do you do tele medicine due to the staffing shortage for psychiatric work?
Marilyn Rudolph: Williston has 2 Clinical Nurse Specialists (CNS) now and we have affiliation with the local clinics to do the Title 19 reviews. Basically our nurses and CNSs do the psychiatric care and we consult with Dr. McClane. We have tried to recruit by advertising and other means, but have been unsuccessful. I am requesting a psychiatrist for NCHSC, however I am not optimistic as this is a nationwide issues with psychiatrist shortage. In the rural areas, we are looking at our clinical nurse specialists as our go to people, other than telemedicine.

Representative Nelson: in the governor's budget, there is a position for NCHSC for a psychiatrist. Is part of the issue in regards to recruiting salary issue?
Marilyn Rudolph: No, I don't think so. We are competitive with wages. It's that there are very few medical students who are going into psychiatry and there's a shortage nationwide, so you have to attract with special criteria. To get a psychiatrist in more rural locations, there usually needs to be a connection to that area for that person. I am hoping to recruit one of the three psychiatrists at Trinity as their contracts are coming to an end with Trinity and an attractive feature we will offer is working 5 days a week with no on call work.
Representative Nelson: what is the workload looking like as far as clientele going into this biennium? You mentioned you had increases and do you anticipate that, that will continue to grow?
Marilyn Rudolph: It's growing and right now, with the 45.75 FTEs for NW, we are at capacity.
Representative Nelson: are these more complex cases that you are generally used to?
Marilyn Rudolph: We are seeing younger and young children in our acute care and more complex families in chaos. These are oftentimes families who have never put down roots and have traveled all over for jobs. A huge help is having an entire staff of LICSWs.

Chairman Pollert: I have heard frequently that there is a shortage of psychiatrists, but I continue to get e-mails saying that UND won't admit more students into their psychology masters or doctorate program. I am confused about this.
Marilyn Rudolph: my daughter graduated from UND medical school in 2000 and only one in her class went into psychiatry and he is not practicing. It's a difficult decision for those to make.

Marilyn Rudolph: (went over written piece of attachment **ONE – pg 4).** The salary changes are due to the governor's budget package. At NW, our operating expenses decreased by 2.5%. Part of this is a decrease in the travel budget based on usage and developing this when the budget was being prepared. There was a decrease in the purchase of office

equipment and furniture. We've had a decrease in building rent as we pay $8.50 a square foot for years. The owner seems satisfied with this and the building in fully rented.

In response to the closing of Mercy Medical Center, we have developed beds or residential options to go along with the addicition services we provide, so we do a 3.5 level of care day treatment program with residential beds. We have a long term program, called Hearth House (harm reduction program) for individuals who have difficulty with treatment (have to have gone through at least 3 treatments) or maintaining a chemical free life style. We've developed 17 addiction beds and 9 beds to serve seriously mentally ill (SMI). We also have one safe bed due to Mercy closing for individuals who have had a petition signed which commits them to the state hospital or to a treatment facility. If the individual is not suicidal, they can stay at the bed for 72 hours and be assessed to go to court with the individual and give the report to the court. Otherwise, we could have to ask the sheriff's dept to transport that individual to Trinity and that costs all of us money.

(proceeded to the organizational chart) As you can see from the organizational chart, we have had no changes. I'm anticipating 3 retirements by August so we have been trying to recruit.

Chairman Pollert: do you have an HR in your staff?
Marilyn Rudolph: Yes, we do.
Chairman Pollert: but you end up doing a lot of that?
Marilyn Rudolph: I ended up doing a lot of recruiting for NW. It's personal conversations I have about talking to people about what's available there and what the community is like and what we can offer them as far as professional development.
Chairman Pollert: is your turnover rate pretty stable?
Marilyn Rudolph: We have had a pretty stable long term staff and they're now aging out.
Chairman Pollert: you haven't lost staff to the oil industry?
Marilyn Rudolph: No, we have not.

(proceeded to the detailing) committee members reviewed summary by subdivisions and budget account with funding sources. Questions and corresponding answers are as follows.

Representative Metcalf: you said caseload is going up so much that you can't keep up?
Marilyn Rudolph: We are at capacity at this point
Representative Metcalf: do you believe you will increase to the point of being beyond capacity?
Marilyn Rudolph: I have not asked for that at this point.

Chairman Pollert: Normally we see salaries going up, but yours are dropping down. Is that because of having retirements and brining in new hires at a lower pay grade?
Marilyn Rudolph: Yes, it is.

Representative Kreidt: in regards to the caseload, do you feel you are going to continue to increase or do you think you will level off at some point?

Marilyn Rudolph: I hope there will be some leveling off. I will continue to monitor the numbers and check in with staff and see how they are doing. I will look at capacity and we will go from there.
Representative Kreidt: you've got a steady increase right now. Are you seeing some slow up in that?
Marilyn Rudolph: I am not, but oftentimes spring and summer brings a slow down. We'll see what kind of staff we can recruit for the positions that we are losing. Otherwise, we are able to handle it at this point.

Chairman Pollert: $8.50 a square foot is very reasonable.
Keith Welsh, Business Manager: all of our leases have basically a 5 term renewal. We are on the last of the 5 terms of this biennium. We are at the end of the 10 years so it is possible our landlord will think the land is worth more and it will go up.

Representative Nelson: have you entered into any discussion as to what the renewal may be? We are seeing across the board a wide array of lease prices. In fact, the Senate amended some caps on rental leases in Bismarck.
Keith Welsh: Our landlord is willing to negotiate because we have been long term renters. There will likely be an increase, however.

Keith Welsh went over Operating Fees and Services (attachment **ONE)**, line by line. He gave information about assistance for homeless clients stating it is services that help individuals find housing and stay at the housing they are at.

Keith Welsh described Aging Services Outreach Program. It started as a pilot at NC and went out to the other 7 regions. This money goes to pay for people to go out and visit people in their homes and assess for what kind of services they may be eligible for or could utilize. These people are Qualified Service Providers (QSPs).
Chairman Pollert: these people are QSPs for this $38,000 and they are doing in home visitation?
Marilyn Rudolph: They basically do an admission to see what services are appropriate for that person to receive.
Chairman Pollert: are the QSPs independently employed or are they part of an agency?
Marilyn Rudolph: They would be self employed.

Keith Welsh: radio – TV – newspaper includes the cable fee for the TV that is at the Centre. Research fees include fingerprinting every employee.

Brenda Weisz: I want to give you an additional explanation of the Aging piece as you will see it at all of the centers. It incorporates the whole concept of retraining and not creating a new agency and uses all federal funds.
Chairman Pollert: is this part of the breakdown of the ADRCs of the $323,000?
Brenda Weisz: It's the retraining and the rethinking. It's taking what already exists as federal outreach dollars and allocating it to the human service centers (as different amounts depending on needs in the region) versus having them all in the central office.
Chairman Pollert: is that stemming from the funding of that $323,000 or not?
Brenda Weisz: It couples with that, but these are outreach dollars so Title 3 dollars that we were already receiving. With the outreach dollars, we can further this options counseling or

to provide options to people when they're contacting the centers. So, no matter who they call, we just retool and have everybody in the same mindset so they get the right answer and the same answer no matter who they call.
Chairman Pollert: in moving onto the grants summary page, are there any questions?

Representative Nelson: most of the grants are constant, but the funding sources are changes. In the first column, there was a loss of federal funds and in the last column; it looks like there was an increase in federal funding. Can you explain what happened there?
Brenda Weisz: when we fund the Centers budget, we look at how much Medicaid funding would be available. All the services we provide, depending on our Medicaid eligible clients, would be eligible for Medicaid funding. We look at historically how much we can collect from private insurance like BCBS-ND. The rest would be required to be funded by general funds. You basically fund an overall budget and it's all individual pieces. When you look at our overall budget, (we call these department IDs or cost centers), it depends on how it gets plugged into a cost center.
Representative Nelson: In residential services the federal funds have increased significantly and special funds have dropped. Would I assume that Medicaid utilization has increased and third payer reimbursement has dropped?
Brenda Weisz: overall, collections have gone up. On the third page of attachment **ONE** and look at budget changes column, due to FMAP general and federal went down, but our collections in total went up.
Representative Nelson: what are collections made up of?
Brenda Weisz: Third party insurance like BCBS-ND. Philosophically, collections went up slightly, but how we applied it this time towards that service was applied differently. We would have applied collections to a different service, differently. It would have been the priority on how we budgeted the services, depending on how we looked at which service we are budgeting first and as we got the information and the statistics from who we are going to serve and what contracts we have to enter into and would have applied it.

Chairman Pollert: Is the residential services going to be a part of the psychiatric inpatient monies?
Brenda Weisz: It will show up on your grants schedule under residential. After NC, Alex (NDSH) will explain the interim work we did on the inpatient psychiatric hospitals and I can explain how we arrived at that OAR amount. We built on what was in the base budgets for inpatient psychiatric.
Chairman Pollert: is there a one sheet synopsis of this?
Brenda Weisz: I have the computation for you and Alex will give you what transpired over the interim. There is a hold even amount in NC's base budget for inpatient psychiatric hospital and you'll see that at 4 other human service centers.

Marilyn Rudolph proceeded to go to the detailing of NCHSC, starting with the organizational chart. There is an increase of one FTE for a psychiatrist.
Chairman Pollert: what happens if you don't get the psychiatrist? You will continue with CNSs and tele medicine.
Marilyn Rudolph: Yes. We currently have Dr. Shield working one day a week as well. She lives in Bismarck and drives to Minot. We have her under contract. We are trying to get her to take more time, but haven't had any success with that.

Chairman Pollert: we will ask Nancy then how many psychiatrists you are short and how often you need to do the tele medicine.

Representative Nelson: how many placements do you have in the State Hospital from these 2 human service centers?
Marilyn Rudolph: We average about 70 a biennium
Representative Nelson: they are full, basically. If you are having troubles attracting a psychiatrist, is there another option out there? We have psychiatric hospitals in the state. Is that an area we can look at in providing those services?
Marilyn Rudolph: The additional money that is hoped be put into contracting with the psychiatric hospitals will help us greatly because we can use the psychiatrist and inpatient days at Trinity rather than routing them to the state hospital.
Representative Nelson: do you think they have enough capacity at Trinity to address the needs that you have?
Marilyn Rudolph: They seem to have been able to manage. That bed gets tougher to manage without a payment source.
Representative Nelson: I'll wait for Alex's explanation.

Chairman Pollert: last session, there were e-mails circulating around about costs of psychiatrist, expenditures, appropriations in the DHS budget. Are the services provided in the DHS budget, a federal mandate for mental health services as far as clinical help? Or a state mandate? When it is a psychiatrist suppose to do the care versus a CNS? In other words, if you had 4 psychiatrists versus 15, for instance, that would be ideal to have, could you get by with 4 to do tele medicine and have CNSs fill in the gaps?
Marilyn Rudolph: In rural ND, telemedicine is the wave of the future. You can certainly manage difficult situations with a psychiatrist who also has his/her MD. CNSs (Masters in Psychiatry and additional coursework in psychopharmacology) are called advanced practice nurses and have prescriptive authority. When you get difficult, complex cases, you often need the expertise of that doctor. If you had no psychiatrists, it would be a struggle as far as where to go to get the expertise for the complex case.
Chairman Pollert: I am not saying that 4 psychiatrists should take care of the entire state. I am just wondering when do you need a psychiatrist and when do you need a CNS.
Marilyn Rudolph: a lot of it is just comfort with technology. People have voice aversion to being treated by someone on a television screen, but what research shows, that overtime, people have grown satisfied with tele medicine. With what we are up against, it is going to be the future.
Chairman Pollert: if you don't hire psychiatrists, do you have outside services that will be higher in an appropriation than having psychiatrists on board? We will look at that further when we get into the detailing.

Marilyn Rudolph: with that, I'd like to talk about the OAR ($1.4M) that we have for SMI/crisis stabilization unit. As DHS is a statewide system and provides services to everyone in the state, if we got the funding for a crisis unit, it would be a place for Williston, but also a place for the people for the North Central region and for the rest of the state if need be. When we looked at the projected cost, we looked at what staffing would we need to staff 24/7 for 8-10 beds? To answer this, we looked at the staffing pattern at our Kay's Place that operates 24/7 (residential facility that serves adolescent girls). We felt that there needed to be a program coordinator that would need to screen the individuals that come

into the unit and work with the psychiatric staff to make sure services were provided and that discharge planning was done appropriately (according to licensure and Medicaid rules). This is not part of the OAR inpatient psychiatric days.

Chairman Pollert: you must have a growth in this area to request this as compared to last biennium or the biennium before. Could you give me some numbers?
Marilyn Rudolph: This was part of the global OAR last biennium, but did not get funded. We have consistently about 70 people from Region 1 and 70 from Region 2, in the 2 year period, need to be hospitalized and cannot necessarily be treated on an outpatient basis. In the past, we have utilized Trinity (which may not keep them long enough) or the State hospital. This would address that 140 people on an ongoing basis that needs some kind of intervention to maintain stability. The though process is, that stabilizing in one's own community allows the family and outside providers to be involved translating to stabilizing more rapidly and maintain that stability longer versus a few day acute stay or stay a long distance away.
Chairman Pollert: what specific population?
Marilyn Rudolph: Seriously Mentally Ill
Chairman Pollert: age group? Genders?
Marilyn Rudolph: Fairly equally among age and gender
Chairman Pollert: are you saying this amount is going to grow more than what it is now, as we didn't fund it last biennium and state hospital is full? You are saying it will be less people that will need to be moved to the state hospital, then why would we need all the residents at the state hospital?
Marilyn Rudolph: Basically the population at the State Hospital fluctuates so it is unknown if they have a bed open at any given time. If they are full, you may call Trinity or check with St. Alexius or MedCenter and this would prevent that.
Chairman Pollert: I am trying to correlate this. If we were to fund this, it would seem that we would be relaxing the caseload at the state hospital, so you wouldn't need as much money at the state hospital.
Nancy McKenzie: there were 3 residential pieces (set aside the psych hospital): crisis unit in Minot, 4 additional beds in Bismarck and 15 beds in Fargo. In the overview, we affirmed that it would be likely the state hospital would decrease clients if these were funded, however this would be potentially, eventually, as it would NOT occur in the same biennium. You have to see what that impact is. It is our aim to serve more people at home and fewer in the hospital.

Representative Nelson: some of the nonprofit psychiatric hospitals are being uncompensated for care, so that population has to be accounted for first?
Nancy McKenzie: Yes, you are referring to the private psychiatric hospitals. That is part of those inpatient bed funds that are built into this budget so that we can make sure we have beds available and they can be compensated at that Medicaid rate.
Representative Nelson: that population we are considering in these numbers because you can't take this group of people the SMI crisis unit would treat away from another area as there is that gap there we aren't covering right now.
Nancy McKenzie: yes, that's a fair assessment

Chairman Pollert: if we are going to fund the psychiatric hospitals, wouldn't there be a decrease somewhere? If we fund crisis beds, then we won't need as many inpatient beds?

Alex Schweitzer: we have been running at high capacity. It does fluctuate. The intent of the inpatient and residential days that are built in this budget is a decrease at capacity at the hospital. Hopefully, the residential will decrease the need for the expensive days at inpatient psychiatric hospital (residential costs much less). We will be looking at the impact. However, we have already been dealing with it as we've underfunded our budget on the state hospital side, which is already indicating that we feel there will be a drop.
Chairman Pollert: you can explain that to us further when we get into the State Hospital section.

Marilyn Rudolph: this OAR is a fairly intensive residential service. If you are going to contract with a psychiatrist and you are going to have a registered nurse on staff, you are looking at an intensity that is not equal to the inpatient hospital, but very close, because that is what it takes to maintain people in the community and stable them and get them back to their homes. It is a struggle as we don't know for sure if this will take care of the issue, but we hope so. I have heard from my staff that they are having difficulties with treatment the SMI cases as the individuals are in need of something longer term than an inpatient hospital stay and residential can provide this and is more cost effective.
Chairman Pollert: is this the prior step to going into psychiatric residential days?
Marilyn Rudolph: Possibly. They could utilize this service before going inpatient to a psychiatric hospital or instead of going inpatient.
Chairman Pollert: do we have this in a detail somewhere as cost of psychiatric residential versus cost of inpatient psychiatric hospital (State Hospital, Trinity Hospital)?
Brenda Weisz: yes, we can get that to you.

Keith Welsh continued with the detailing of NCHSC (Rentals and Leases – attachment **TWO**). The rent is going up .38 a square foot at human service center building. There was a 4% increase per biennium in the contract. Kay's Place is staying the same due to renewal contract. With New Town Office, we are just paying the extra insurance to be there. The House has been in the central office budget for a number of years through a grant originally and the grant ran out halfway through this biennium, so the $36,000 is what the rent is for two years.

Chairman Pollert: what does A and D stand for?
Keith Welsh: Alcohol and Drug. // The Rugby Office is the same rent we've been paying. Stanley Office continues to charge us only $100 a month and has been for 20 plus years. With Supported Living, we may be assisting someone with rent to keep them in or to get them settled into a place of their own that they will eventually take over themselves. This may be the last biennium with the current rate for Transitional Living so I'm not sure how that will change in two years.

Vice Chairman Bellew: you said the rent stayed the same, except for the increase at the main building, but on the green sheet it shows $170,000 increase.
Keith Welsh: in our operating expenses, there are 3 things of rent. One is VRAT lab which was not in our previous budget, but we've been renting it this biennium.
Vice Chairman Bellew: what is that?
Keith Welsh: It's assistive technology for vocational rehab. We are renting 5600 square feet for this which is located in our main building. That started up late 2008. Our budget was already done at that time, so we've been paying that out of our current budget, but it

was never in there as an expense (accounts for $113,000). The $36,000 (not in our previous budget) and the 4% increase is the $170,000. Those 3 things make up that $170,000 increase in rent.

Representative Nelson: explain the 4% increase.
Keith Welsh: that's in our contract; 4% per biennium.
Marilyn Rudolph: when we moved to that building, the way the lease was written was with the 4% increase and there is no rent adjustment ongoing.
Representative Nelson: In Minot, it's difficult to rent there.
Keith Welsh: we started out at $9.25 and went to $9.62 and now it's $10, so that's the 4% progression.
Representative Nelson: where is Kay's Place at? What does it do?
Marilyn Rudolph: It's a residential facility (located in a residential district, off 16th street) for adolescent females such as adolescent females who are expecting. It's expanded into more foster care.

Chairman Pollert: moving onto operating fees, it's double in operating fees?
Keith Welsh: it's in the purchase of services – aging services outreach program. (went through operating fees and services).

Vice Chairman Bellew: Minot Commission on Aging does similar things as the outreach program for the aging services. Is there collaboration with the Minot Commission on Aging?
Marilyn Rudolph: It's a pilot program where we use QSPs to go into homes of the elderly to check on them and see what services they need. We work closely with the Minot Commission on Aging and the programs they also provide. The Commission doesn't do outreach anymore.
Vice Chairman Bellew: they operate Prairie Rose services and it's QSPs as well to help seniors with cleaning, etc.
Marilyn Rudolph: That is another service, but not outreach. Outreach is an admissions to services; an assessment.

Keith Welsh proceeded to grants and with the request of the chair, went to the residential services. // The increase there is that OAR ($1.4M)

Nancy McKenzie: there are NO FTEs attached to the psychiatric hospitals or residential beds; it's contract dollars. In fact, the only FTE request across the Human Service Centers is the one in NCHSC for the psychiatrist.

Alex Schweitzer: I am going to take some time and explain inpatient psych. During the interim, Carol Olson had asked me to chair a workgroup of individuals to look at this. We've met with representatives from all the 7 private inpatient facilities: Altru, Stadter Center, Sanford, Prairie St. Johns, St. Alexius, MedCenter One, and Trinity Medical Center. In the past, some of these facilities have had contracts with human service centers to provide inpatient services for individuals in their specific regions. Stadter and Prairie St. Johns were not part of that. This came about as an effort to contract with these private facilities to deal with individuals that were referred to them in the local community and looking at that as a shorter term option than sending them to the State Hospital, where you have the issues of transportation and potentially longer term stays and to work on setting up a contract with

that local hospital to manage lengths of stays. Part of it, as well, was they were providing services to indigent population and not getting paid for it. As a result of that, we worked on the number of days that these individual hospitals were not getting paid for and worked out to the 4,932 days that were not covered. It was in an OAR and now it's become a part of the budget. The total funding is $4.2M and you have to back out what's in the base budgets for the human service centers for a total of $3.4. This is set up on a Medicaid rate. It's an attempt to localize the services. There will be a contract between DHS and each individual facility; an agreement to provide services for people in their region. There is a part of this process that we call utilization review which the human service center will be providing for that hospital and will be working with the hospital to manage length of stay and step that person down to a residential or a community setting as quickly as possible because that's the less expensive alternative. It helps the capacity issue at the State Hospital. It helps the system in general. In the long run, you should see less people utilizing State Hospital and more people using local resources and it is more cost effective (sheriff transport to NDSH).

Representative Kreidt: when your group completed the process you went through, was there a final report? Could we have a copy of that?
Alex Schweitzer: we had three working groups and each submitted a report to Director Olson. We can provide that (4-6 pgs).

Representative Nelson: in this committee, we get caught with choosing either/or as options, but in this case, it appears to me that you can't just compensate those private psychiatric hospitals for inpatient care and not have that other piece of residential service to go to after the stay is done or we lose what we've gained.
Alex Schweitzer: Yes, that is true. You have to be able to have a step down. Otherwise a person stays in the inpatient program much longer and it's much more costly. They are a companion.
Representative Nelson: give me an estimate of the cost of a psychiatric day.
Brenda Weisz provided attachment **THREE** which lists Medicaid rates per diem for the 7 private hospitals mentioned above.

Vice Chairman Bellew: if these are Medicaid rates, why isn't there a larger federal/ state split like 55/45?
Brenda Weisz: this is for SMI or addicted clients. These are for clients are not Medicaid eligible, so it's all general funds.

Chairman Pollert: we have 4,932 days and the hospitals had to swallow the costs, and the state hospital was continuing to have admissions, is there any savings that I can trace?
Brenda Weisz: when you have uncompensated care in facilities that are not even paid yet, there won't be any savings because nothing was paid.
Chairman Pollert: were some of these people going to the state hospital under admissions?
Brenda Weisz: Yes, some were and some were not. Some were being taken care of by these facilities.
Alex Schweitzer: These 4932 days were being taken care of by the local hospital and did not come to us and they were not being paid for them.

Representative Nelson: the $829,000 was compensated by the Human Services so the uncompensated gap was the $3.2M that we have to get to before we start seeing the savings.
Brenda Weisz: Yes. The number of projected days was far greater than the 4932 that we started with. We felt that we needed to start incrementally. Alex asked for the hospitals to provide him with days that they were seeing for uncompensated care for clients that would be the DHS clients. We held it at either the lesser of what you were seeing or 1,000 days. The dollar amount as we initially started was far greater so we started lower. We obtained the Medicaid rate that's in place that was rebased for the Medicaid population last biennium. The Medicaid eligible folks have a rebased rate that's paid for their inpatient days. These individuals that go to the same hospital that are not Medicaid eligible, the hospitals do not receive any kind of reimbursement at that level at all. They are receiving the dollar amounts you see below which is what each of those human service centers negotiated with them for their stays. So the hospital would receive the same compensation for the same service they were provided (whether it be a Medicaid eligible client or a non Medicaid eligible client), this is the rate that's in effect on July 1, 2010. We did the math across the column times the days and arrived at the dollar amount of $4.2. As those centers come before you and you look at their grant schedule, you'll see the same amounts in the grant schedule for this. Essentially, we subtracted the amount that was in the base budget and then the request was made for the difference for the $3.4M. The efforts of this OAR were to address the uncompensated care that's going on there to include the 2 private hospitals that we haven't contracted with previously and to pay them at a rate that's equal to the payment they're receiving for an individual that is Medicaid eligible because there is no difference in the care that's being received by that client. The only difference is on the Badlands schedule. On their grants schedule for inpatient hospitalization, they actually have $130,000 in their budget. On this schedule only $80,000 was actually for inpatient and the remaining $50,000 is for medical detoxification.

Representative Nelson: what's the main reason why that client base would be Medicaid ineligible?
Brenda Weisz: If they are in the age group of 19-64 and don't qualify with a disability, they won't receive Medicaid reimbursement (and above the income requirements). Disability is operationally defined thus one may have a disability but it isn't severe to qualify or they may have an addiction where they need high level of care, but addiction by itself doesn't qualify as a disability.
Representative Nelson: income eligibility is not the only qualifier then?
Brenda Weisz: You can qualify by income or with a disability. Individuals ages 19-64 and in an Institute of Mental Disease (Prairie St. Johns, Stadter, State Hospital) will not be covered by the federal govt.
Representative Nelson: if you are under 19 years of age, they would qualify for those facilities?
Brenda Weisz: Yes
Representative Nelson: so, they could be treated inpatient at age 18 and turn 19 and then they are kicked out of the compensation category, but they could still need the services and be in that facility?
Brenda Weisz: Yes, that's correct.

Vice Chairman Bellew: if they aren't Medicaid eligible, then why can't they pay for some of this themselves?
Brenda Weisz: many of the individuals don't have the means to pay for that, themselves because they are indigent or have a mental illness that is so severe that they are not employable at the same level you and I are.

Chairman Pollert: where would these individuals be staying?
Brenda Weisz: Supported housing, their own home, or some are homeless.

Chairman Pollert: is there any individual count that this might be?
Alex Schweitzer: it's by facility. They are only calculated by facility.

Representative Nelson: I am surprised at the projected days for the Stadter Center. It appears that Grand Forks would have a greater need than that. Is it a lack of beds at Stadter?
Alex Schweitzer: the max is 1000. That's the actual number they gave me. That's what they assumed was their indigent days.

Chairman Pollert: can we expect this to rise, stay stable, decline?
Alex Schweitzer: it's an incremental process. We started out with what we thought was a reasonable number.

Kate Kenna, Director of the Lake Region Human Service Center (LRHSC) and Northeast Human Service Center (NEHSC), provided an overview of the budget of these Human Service Centers. She started with LRHSC (information on this cost center is labeled as attachment **FOUR)** and summarized the written component of attachment **FOUR.**
Kate Kenna: I will go to the I bars report and speak to those that have had some changes. The salary changes are there in alliance with the governor's budget. The travel increase is due to that our staff are traveling more out into the communities. We have an increase in rentals due to $50 a month increase in our Rolla office. The increase in our IT communication rates is the increased rates that it costs. We have an increase in professional development to match the state recommendation, set statewide of $150 per staff (prior we were at $100). Our operating fees and services are up due to aging outreach services and advertising costs. LRHSC has had staff turnover, however we have been successful in recruitment with the exception of a couple of addiction staff.

Chairman Pollert: what is your turnover percentage? It's been pretty stable?
Clinton DeVier: it has. Typically, we have about 4-5 vacancies, but now we are at the 2 for addiction counselors.

Kate Kenna: In grants and benefits, we have a decrease. We use to run an adolescent addiction unit at LR that was in the same building as our adult CRU. We didn't have as many adolescents who needed treatment. It was difficult to maintain them in the same facility as the adults. We transferred some of that federal money to NEHSC where we operate a 24 hour adolescent facility to allow for LR adolescents to receive care there.

Vice Chairman Bellew: in going back to temporary salaries, there is a sizable increase. Can you explain that to me?

Clinton DeVier: We've gotten a family care position years ago and we combined it with other people. We had adult protective services and Ombudsman. Our Ombudsman does both LR and NE and there was some money, so we wanted to increase that person up to 80% in just that one area. So what we did was take that one position and made it a full time and then we needed a temp position to cover the adult protective services and the family care giver. Because when we go the money there wasn't positions with that. In our extended care area (SMI)(we had one person retire and a new one come on), we never did a lot of outreach and we were having more of a need for outreach in the area, so when that one person retired, we have her working 25%. We brought her back so she works in Devils Lake and that allowed one of the other case managers to start proving outreach in some of the smaller communities in our area.
Vice Chairman Bellew: why wouldn't these be permanent versus temp? Are they working part time?
Clinton DeVier: No, they are working full-time with no benefits. We recently had a person leave in an area and the person who is now in charge of it thought that they had enough staff with the two of them so we are trying to free up their other position to do that, but we need some time to make sure that they're not going to need it in that area first. It could change next biennium, if we are able to cover it with the two.

Vice Chairman Bellew: explain travel to me.
Clinton DeVier: Our travel is based on the past costs. Motor pool started out the biennium charging us about 27-28 cents a mile for using their vehicles. Currently, it's at 31 cents. Every penny that goes up costs us about $4,000. Their projection for next biennium is 37 cents and the way gas is going, I expect our 31 cents to keep climbing. Additionally, with the road situation, a trip to Fort Totten that use to be 13-15 miles, it will end up being 40-50 miles this spring because people have to drive around. This next biennium, from the travel end, it's going to be tough as multiple roads are closed due to construction.

Chairman Pollert: is that figure regarding the cent increase and corresponding costs, solely for LR and NE?
Clinton DeVier: No, that is just for Lake Region.
Chairman Pollert: didn't we have a history with Lake Region about child support enforcement? We don't need to go there. It must have gotten solved or we would have heard about it.

Representative Wieland: back on pg 4 and 5 of your testimony, you speak of 2 new suicide prevention committees that have been formed in the Devils Lake and Spirit Lake area. What's involved with that and can you give me a sense of the dollars that are involved in that?
Kate Kenna: It has not been additional dollars from LR, but rather an additional commitment of staff time. The 1 staff is in Devils Lake and working in collaboration with other providers, doing workshops, having speakers, presenting information for the community and working with the schools. The 1 in the Spirit Lake Nation is working closely with tribal representatives who have had a significant increase in near misses or suicides and working with them about educating people out on the reservations and in the school systems and supporting families.
Representative Wieland: there are no grants involved?
Kate Kenna: there is not.

Chairman Pollert: what is experienced parent contract?
Kate Kenna: it's a program that's offered to families who have a child who is born with a disability. It's a contract that we have where one person will go out and meet with the family, talk to them about resources, be a support network to a family who has a child born with special needs (developmental disabilities).

Chairman Pollert: when you speak of psychiatric services, is that what we were just talking about as far as contracted services?
Clinton DeVier: LR doesn't have any outside psychiatric hospitals that provide that service, so we rely on the state hospital. Our contract in here is for Dr. Terry Clickenbeard. He works 2 half days a week for us.

We had an increase in the Recovery Center. There's a peer support program we started in there. Our Recovery Center has always ran in the hole and progress has had to make up money for it. We had to increase that so the disparity isn't quite so bad. We also have the continuation of the 3/3. Under residential, we've had the decrease of $110,000 for moving the adolescents over to Grand Forks so we transferred that money over there. We also had a slight decrease in the use of that area. We have an increase of $82,000 for the governor's new projected inflationary.

Chairman Pollert: what is the difference between SMI residential and what is in the NCHSC? Isn't it NC that's asking for $1.4M for the SMI population? Is the SMI being taken care of better at LR than at NC?
Clinton DeVier: At LR, we have 2 residential facilities. In our area, as compared to other regions, we have a lot more of the addiction compared to the MI. We have a unit in Rolla that is strictly A&D and the 1 in Devils Lake is the share of the MI residents that we have there. Typically it runs on about 1.5 people in our unit and we have up to 15 beds if it's the right mix of male/female and SMI/A&D.
Chairman Pollert: the NC is more SMI directed, where this is more alcohol and drug directed?
Clinton DeVier: Yes.

Kate Kenna went over attachment **FIVE** which consists of information about Northeast Human Service Center (NEHSC) for the purposes of detailing this piece of the budget. Committee members interjected with questions throughout testimony and questions and answers are as follows.
Kate Kenna: in starting out with comments about program trends, I want to mention that we have been successful in hiring an additional full time psychiatrist. This has allowed our contract dollars to decrease and the psychiatrist is able to spend more time at NEHSC.

Chairman Pollert: is the caseload heavy enough for the new psychiatrist that he wouldn't be offering services to NC, for instance?
Kate Kenna: The caseload is such that he has a full caseload. That's not to say that we wouldn't help the other Human Service Centers out. We do have the capability to do some of the tele medicine. We have done this and will continue to do this. We are very open and have had NC call and schedule times with our psychiatrist.

Chairman Pollert: who sets the guidelines for mental health services and whether you see a psychiatrist or a CNS, for instance? Is it federal guidelines? State guidelines?
Kate Kenna: It's based on the clinical needs of the individual. We do an intake and determine what those individual needs are as far as what type of provider that would be the best fit for that individual. That need could change as well where he/she might start out with a psychiatrist and once he/she has been stabilized, moves to a CNS.

Kate Kenna went over functional organizational chart. In medical services, we have 3 physicians and 1 CNS. We do contract for a pediatric psychiatrist for Ruth Meiers Adolescent Center (RMAC).

(summary by subdivision) Our salary increase is to comply with the governor's budget. As far as the travel increase, we under budgeted the last biennium and as a result have been spending more. We find that we are doing more outreach services within our region as well.

I am going to skip over the areas that have small increases. Miscellaneous supplies had a reduction which has to do with Ruth Meiers Adolescent Center and Duane R. Dorheim (transitional living center for adults with SMI). We also had a reduction in office supplies. The reduction in equipment is due to being able to do ergonomic assessments on staff earlier and get the kinds of ergonomic needs met earlier. Another part of the equipment reduction is that the vocation rehab is taking over responsibility for the equipment purchases for the assistive technology labs that are at the human service centers so it was a reduction in the budget as it was moved to the central office. We had an increase in rent which had to do with several facilities that we have and slight increases at the county office building (Cornerstone, Ruth Meiers, outreach office).

Lynn Bingham: our rates for all of our facilities stayed the same this biennium. In the current biennium, we were short $8,800 so this basically brought the budget up to our existing level that we are paying in the current biennium and no changes for the 11-13 biennium, past that $8000.

Representative Wieland: under rentals and leases, you have state fleet parking leases. How many state vehicles do you have?
Kate Kenna: We have 27 state vehicles.
Lynn Bingham: 21 of them are parked at the county office building where our main office is. One requirement for state motor pool vehicles is that they have to have the electrical plug ins, thus we pay a monthly rate for electrical costs.

Kate Kenna: IT communication increase is due to cable at Ruth Meiers and the use of air cards which have been used more and more. With the air card, staff can access the ROAP system from their computers when they go out on visits to allow the staff to do the work right from the clients' home and get the information into the system.

Chairman Pollert: In your testimony, you speak of additional staffing needs for Ruth Meiers. What would be the difference on that as compared to Altru under the psychiatric residential days? Can you explain the Ruth Meiers versus what you do at Altru?
Kate Kenna: Ruth Meiers is psychiatric residential treatment facility. One of the requirements for kids getting into that facility is that they've had psychiatric hospitalizations

and they need a longer term place to work on their issues and work with their families, so they can eventually go home or to a therapeutic foster home. These kids are quite involved behaviorally and psychiatrically.
Chairman Pollert: they could have spent time at Altru and then go to Ruth Meiers for awhile before they are discharged completely?
Kate Kenna: the length of stay at Ruth Meiers is up to a year (intensive therapeutic work, has onsite school). A psychiatric hospital stay has the purpose of getting the immediate needs met.
Brenda Weisz: this is a child welfare service that's provided, so this is one level of child welfare.

Chairman Pollert: is there more caseload at Ruth Meiers?
Kate Kenna: Ruth Meiers serves statewide and consistently is full
Chairman Pollert: if it is always full, then why would you need additional staffing?
Kate Kenna: You might have a kid who is at a significant safety risk (suicidal, aggression) and you need a staff to be one on one with that child.
Chairman Pollert: are the types of cases like that increasing?
Kate Kenna: It seems stable. The age of the children that need this level of care is decreasing. It use to be that we would be full with age 15-16 and now we are seeing more 12, 13, 14 year olds.

Lynn Bingham: we have an overall reduction in our grants and contracts of $123,911.
Chairman Pollert: but on your spend down it shows an increase of $144,945?
Lynn Bingham: yes, $123,911 is existing levels of cost. In addition to that there is $268,856 increase for the governor's proposal for inflationary increases. The net of that is the $144,945 increase.

(reviewed pg 13 of attachment **FIVE**, grants information). The $25,000 is reduced in our supported residential because we found that there was a need for increasing another level which is called SMI case aide services. We took a half time benefitted case aide person and allowed her some additional time under temp salaries. This $25,000 offsets part of the temporary dollars that are in the temporary salaries line.

Chairman Pollert: would the 3/3 apply to psychiatric residential days after this is funded?
Brenda Weisz: going forward, we would treat it just like the Medicaid rates reimbursed. We would reimburse that rate 3/3. Right now, it's not included in the computed 3/3 that went forward. The base amounts in the base budget were inflated.

Chairman Pollert: earlier you were talking about what to put in the budget for the 4900 psychiatric days. Let's say we fund this and we keep it in the budget. What's going to happen a biennium from now? Are you we going all of the sudden see 6500 days because now that the foot's in the door, there are more days?
Brenda Weisz: We first have to get through this. We'd have to look at what is going on out there; what does our existing budget look like; what's the message in the governor's budget; what's happening at the hospitals - once we gather that information and prioritize, that's when we would make the decision of what the next step is.
Chairman Pollert: we gave the days and the $3M+ for these days so if next biennium, we see a 50-60% increase in psychiatric day payments...do you see where I am going here?

Brenda Weisz: I do. There are more than the 4932 days. We're always an agency that will bring forward to you what we've seen. What we are able to put forward as far as the governor's budget and as an optional adjustment request is something we can't answer at this point. There will be more days because we already knew there are more days.

Vice Chairman Bellew: where will we see the correlating reductions from putting on a full time psychiatrist?
Lynn Bingham: The offset is the $94,000 reduction in the contracts. We did not have full time psychiatrist so it is an increase in hours that we're getting psychiatric time from what we have contracted before to go to a full time psychiatrist. The contracts are in the grants line item (psychiatric, psychological, medical services).

Chairman Pollert: Federal dollars seem to be staying steady in the HSC budget.
Lynn Bingham: Yes, other than the federal medical assistance and FMAP reductions. We did increase the amount of other collections fairly significantly from last biennium to this biennium and that is due to having more collections from Ruth Meiers and a CD adolescent program (more insurance payments) and as a result, looking at the revenues we have been taking in from other collections, we increased those revenues.

Chairman Pollert: under the grants item, what is SMI adult?
Kate Kenna: Adults who are seriously mentally ill who need a supportive, therapeutic environment in order to do as well as they can.

Vice Chairman Bellew: what is a recovery center?
Kate Kenna: it's a place that we contract with where people with severe and chronic mental illness can go. They learn daily living skills and involved in a peer support program. It's a supportive environment where they may go for lunch, to play cards and have field trips.

Chairman Pollert: if I look at your grants line item, it says $2.4M in year 1. If you double it to $4.8M, are there other things coming on board of the remainder (to reach $6.1M). I know you have the 3/3 for $200,000+. Is there something that is not on board yet?
Lynn Bingham: One part of it is the social detox that was funded for the 09-11 biennium, but we have been working to get that operating. It's a collaboration of a number of agencies in Grand Forks, including Altru Hospital. The goal is to operate a social detox facility. We have $150,000 that we have not spent in the current biennium as a result of not having it operational. The goal is to put it together this year.

Representative Kreidt: could you explain the foster grandparent program?
Kate Kenna: This program works with low income senior citizens to provide services in daycares, school systems, etc. It's federal money that comes to us to be used across regions. We have 2 staff at our office who works to get the foster grandparents approved and help work with work sites. They go and get a stipend of $2.65 an hour for working in the system for kids who are at risk.

Due to committee's request, **Brenda Weisz** provided 2010 turnover rate for the Human Service Centers put together by human resources. This information is labeled as attachment **SIX.**

Candace Fuglesten, director of South Central Human Service Center (SCHSC) and Southeast Human Service Center (SEHSC), provided and presented information to detail these sections of the DHS budget. She started with SCHSC and the corresponding information is labeled as attachment **SEVEN.**
Candace Fuglesten: we do have an opening in the psychiatric area. We have an individual who is on the verge of receiving her nurse specialist degree and we are hopeful we can move her into prescribing meds at some point. (moved into the budget detail)

Chairman Pollert: you've got about $780,000 that's due to the 3/3 and the second year of the 6%. When I look at your increase of $880,000 and there's some miscellaneous stuff there, $700,000+ is due to the governor's budget and the continuation of the 6.
Candace Fuglesten: Yes. In the salary areas, we actually decreased in our medical services area because we had been using temp and contract kinds of services, but it's offset by an increase in adult protective services and support services. This region has the oldest average age in the state so we have a significant amount of individuals who are reported and need corresponding abuse/neglect investigations.
Chairman Pollert: explain the increase in travel
Mark Anderson, fiscal analyst: increase is due to increase in state fleet vehicle utilization. We are providing additional services in the Valley City area in the form of addiction and case aide services.
Candace Fuglesten: A lot of the work that we do at the center is going to individuals and homes and the communities where they live. We have 7 cities in the region that we do outreach in terms of acute types of services and we will be increasing our addiction outreach services now that we have a full complement of addiction counselors.

Vice Chairman Bellew: explain the food and clothing category to me.
Mark Anderson: The food and clothing are food costs for our transitional living homes. It increased due to recently adding 2 more clients. The room and board costs are all paid for by the clients, but it's budgeted here. We purchase the food for them and they pay us a daily rate for being in the facility.

Candace Fuglesten: (professional development and operating fees) that has increased at SC. We had agreement with the other human service centers that we would budget $150 per staff for professional development. We put in some additional money for some specialized development of one staff member.

One of the increases in operating fees and services is in our aging service outreach. They start at different times across human service centers and SC's starting date is January of 2013. There is nothing in this area that is significantly changing.

Vice Chairman Bellew: the job announcements and yearly civil rights legal notices: explain that to me.
Candace Fuglesten: when we have job openings, we choose to advertise, especially for those that are difficult to recruit. Part of the requirements that we have is to alert the public that we do provide services as well as employ people without regard for race, religion, etc. and there's a cost to do a public announcement.

Representative Nelson: what is the reason that the aging service outreach implementation is staggered across the regions?
Brenda Weisz: It's staggered so we can get it right. We are starting in Region 7 with the ADRC, but then as we retrain people, it takes time to retrain. We're retraining the people at NC and we're making the change in Minot first. There's more money there. As we roll out, we'll learn from each of the regions. We don't want to roll everything out right away so we can learn and before we rollout and train, we want to learn from that region and we can learn from how we retrain and retool in that region. As we change the role at the centers, we can look at what we can do different and better. We are just taking the same federal allotment under the supportive services dollars (outreach dollars) and just do a better job and perfect what we are doing.
Candace Fuglesten: (grants summary) there was an increase in our allocation for experienced parent program which is federal funding. We had adjustments in the recovery center category so inflation along additional capacity to provide peer support in the recovery center. Also, under the residential services, those are costs to continue and we've had some decreases in some of our operating costs.

Chairman Pollert: where did it come in at ($100,000 increase about)? Or is it all over? Or does the 3/3 inflation work there?
Candace Fuglesten: most of it has been inflationary. There have been adjustments both ways in terms of the cost.
Chairman Pollert: what is the SMI transitional living dealing with?
Candace Fuglesten: Places such as Bridge Point (15 beds) and Cottage lane (10 beds) where we have individuals receive, in a group living environment, the services they need to continue their recovery in terms of their mental health and their mental health issues. It varies and is all individualized. It can be anywhere from less than a year to more than a year, depending on the individual.

Representative Nelson: your SMI residential has a line item in residents, right?
Candace Fuglesten: Yes.
Representative Nelson: is that a growing concern as Jamestown is in your region?
Candace Fuglesten: We have a number of individuals who end up settling in the Jamestown area (after release from state hospital). Four years ago, the governor and legislative did grant us additional transitional living facility dollars to contract for one and Bridge Point came on board within the last four years. It is an area where these services are used quite extensively.
Representative Nelson: what part of this is Bridge Point?
Candace Fuglesten: $951,312. We have an open door facility in Valley City which is semi-structured ($1.14M).
Representative Nelson: what is the growth in that particular cost center? The 951 money would be new?
Candace Fuglesten: No
Representative Nelson: what is the growth in SMI residential and SMI transitional?
Mark Anderson: the total growth in the residential services areas would be the $83,890. Social detox, SMI res, and CD res are all provided in one residential setting. How the client gets in there, determines the payment source. If the client gets admitted there for social detox, it's all happening in the crisis residential unit itself. If they get put in there for CD residential because they're attending our day treatment program, the CD residential picks

up the cost. You'd have to add social detox, CD residential and SMI residential together and that would be our crisis residential contract.

Chairman Pollert: what is in this list that is in the old highway patrol building?
Candace Fuglesten: By McDonald's, that is our crisis residential unit and that is short term (social detox, CD residential, SMI residential) and serves both MI and addiction individuals.

Chairman Pollert: the long term stays would be over by the job service building?
Candace Fuglesten: Those are our transitional living facilities like Bridge Point and Cottage Lane and the facility (open door) in Valley City.

Vice Chairman Bellew: in your grants, you have respite care and in your operating fees and services, you have a respite care for families. Are these different?
Candace Fuglesten: They are different. The one under the contracts is a safe bed for children. We don't have a constant demand for that, so we contract for that sporadically when we have a child who is in crisis that we need to have a safe place for. The respite in the operating costs is dollars that are available to provide relief for families who have children with severe mental illness who have high needs. It is a break for the parent or the guardian.

Chairman Pollert closed hearing on SB 2012, to reconvene later today at about 2:15 pm.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 15, 2011
15481

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division back to order to continue the detailing on SB 2012.

Brenda Weisz: I just want to let the committee know that SEHSC has the largest increase. The whole $3.4M (for psychiatric hospital stays) was put into the SE budget. We'll contract with each of those hospitals we spoke about earlier, but we wanted it to start out in one place and see where the client needs are in terms of these services and have the money follow the client. One of the OARs was going to go to SE as well.

Candace Fuglesten, Director of Southeast Human Service Center (SEHSC), provided and present information to assist in detailing of this human service center. The information is labeled as attachment **ONE.** She started with going over written piece of attachment **ONE** (pg 1-6). Ms. Fuglesten proceeded to go over the organization chart, followed by the I Bars report.

Vice Chairman Bellew: you transferred $503,000 from the salaries permanent to temporary. You left that amount in and you added another 500 for this upcoming biennium. Is that right?
Candace Fuglesten: The governor's budget asked us to fund existing positions, so the temporary positions that we did add in order to meet the caseload demands (DD case management, SMI case management), those positions are continued in the budget as temporary.
Vice Chairman Bellew: you're funding them again in the temporary line item but you reallocated that $500,000 back to your permanent salary line item also?
Candace Fuglesten: That is accurate. We added those temporary positions with rollup. Because of the turnover we had, we were able to add those individuals as temporary staff. In preparing the governor's budget: because of that demand to keep

those individuals in those temporary positions, we still need the additional salary to fund the permanent FTEs we have. You will notice later we have underfunded our salaries to reflect some of the turnover.

Representative Wieland: can you tell us about your current vacant positions?
Candace Fuglesten: Our turnover rate at SE was right at 13.54. The temporary positions have allowed us to generally have our permanent positions filled more often because we are filling from temporary and moving them into regular. We do not have a large number at this point of vacant positions.
Representative Wieland: do you have some long term vacancies?
Candace Fuglesten: We do not have any long term vacant positions with the exception of a .20 of a position. Recruiting nurses for 40 hours a week has been difficult, so in order to obtain nurses with the skill level needed, we have only been able to find nurses that are willing to work 32 or 36 hours a week, which leaves us with a .20.
Representative Wieland: you said you were underfunded and used the rollup funds to resolve that. What would have happened if you were able to fill all of those positions?
Candace Fuglesten: We only used temporary positions when we had the funding to provide to continue those positions. If we had had no turnover, we would not be having the number of temporary positions that we have.

Vice Chairman Bellew: you took $500,000 from permanent last time and left that amount in and you added in the $92,000. Can you explain this?
Candace Fuglesten: Because we have the ongoing demand at the front door (additional SMI, DD), our direction from the governor was to fund those from those as temporary positions.
Vice Chairman Bellew: what about the $92,000 increase in temporary salaries? Is that to give those people raises? Are you going to have more temps?
Candace Fuglesten: The funds are to support the increases that temporary employees would get into the cost of continuing into the next biennium. We have as many temporary employees as we can manage and wish to have. We are going to be very cautious in how we add those. With the MA waiver, we cannot have waitlists, so people cannot be sitting and waiting for services because if they are, we jeopardize our waiver within the state of ND. In DD licensure criteria, we are to carry a staff ratio to clients of 1 to 60 so temps help us meet that licensure ratio. These are all individuals that we've needed to meet the demand.
Vice Chairman Bellew: how many temporaries does that add up to be?
James Gebhardt: we have 16 full time temps, 6 part time temps and we also fund our sheltered workshop (50 clients)
Vice Chairman Bellew: how many do you have in that program?
James Gebhardt: there are 50 clients

Representative Kreidt: you have 11 FTEs that are going to retire. When they retire, are you going to move up temporaries into that?
Candace Fuglesten: Where we are having the retirements, doesn't match the needs for the care staff. We evaluate each of those positions to see if we need to refill that position and if so, look at whether we would refill in the same way. Then, we would

recruit, if necessary, for some of those positions, either internally or externally, depending the series that they are retiring in.

Representative Wieland: on repairs, are we talking about building repairs?
James Gebhardt: it's all of our contracts for our janitorial services, snow removal services, and things of that nature to maintain our building. There are no monies in there to repair the building. It's essentially upkeep.
Representative Wieland: do you have building repairs?
James Gebhardt: the building is 19 years old. We have building repairs like we are getting ready to paint all of our hallways. We do have some money budgeted to repair one of our parking lots and that's really the only major repair that we have. The rest of it is ongoing upkeep. Unless we have some kind of emergency, we don't need a large appropriation to maintain our building.

Vice Chairman Bellew: can you explain why there is a charge for rental but you say you own your own building?
Candace Fuglesten: if you go to the rental schedule, you will see that we do rent additional property. It is called our off main facility. It is centrally located in the city of Fargo and out of that setting, we provide additional services, generally to individuals with dual diagnosis. We do provide medication monitoring, case management, a whole host of services out of that building.

Candace Fuglesten went over the major changes in the grants summary. The most noticeable is under inpatient hospitalization. As you heard earlier in testimony, you will find the amount of money that SE has historically had in a hospital contract with Sanford as well as the statewide additional psychiatric inpatient beds for the whole state. Psychiatric/ psychological/ medical services are to run the residency program (inflation increase) at SEHSC. The next area with increases is our residential services area. SE has a 15 unit facility that is used for crisis and for substance abuse crisis which was previously funded and is in this budget. Previously funded as well is services to those in Dakota Pioneer which is an apartment building (supportive services). In this budget, the new thing you will see is the 15 bed residential unit ($9319,159) for addiction services as well as the second year of funding for an 8 bed facility for addiction treatment called Serenity Shack. Those dollars are in CD residential ($201,203).

Chairman Pollert: had you requested that in previous biennia?
Candace Fuglesten: Yes, we requested it last biennium and probably the biennium before.
Chairman Pollert: where have that clientele gone? In other words, how have you lived without this in the past?
Candace Fuglesten: Part of those is the increasing in our hospital admissions (33% increase). Essentially it's about having the right level of care at the right time for the individual. If we make room for them in the hospital, we need to have room to either step them down from the hospital so they aren't going back and forth to the hospital. We need to work with those individuals for longer treatment in a residential facility which is at less cost than a daily rate at a hospital and we need to continue that treatment so we don't see them going back out and entering the hospital later.

Vice Chairman Bellew: there is still $1M increase in general funds in that category. Can you explain the increase? I realize $939,000 was for the new unit, but there is still $1M left.
Candace Fuglesten: The other service in this area includes the approved services for Cooper House like an additional position approved by the governor (24/7). Those are a contract position and not FTEs.
Vice Chairman Bellew: how much do you have in the budget for those 2?
Candace Fuglesten: We added an additional $498,502.

Chairman Pollert: how did you figure that figure? Do you have a ratio you use?
Candace Fuglesten: Last biennium, the legislature approved the funding of 1 full time FTE for Cooper House. It was approved for 14 months so we needed to take the 1 position to expend it for the whole 24 months and then we added another position so that there would be 2 full time positions, 24 hrs a day.
Nancy McKenzie: he is asking about the formula used for a 24/7 position? In other words, how many people does it take to staff 2, 24/7 positions?
Candace Fuglesten: I do not know, but I will get that information for you. I can check with the contractor.
Chairman Pollert: what are these 2 positions for?
Candace Fuglesten: Individuals at the front door who watch the door so it's a closed entry and respond to crises in the building i.e. escalation between individuals in the building, individual cooking and starts a fire.

Vice Chairman Bellew: how much money is in your budget for Cooper House?
Candace Fuglesten: The addition is $498,502 and for contracting for the 2 positions, the total is $813,862
Chairman Pollert: when does Cooper House became a state obligation versus a local obligation?
Candace Fuglesten: The human service centers' mission is to work with our community providers to provide human services (help our consumers to benefit and to remain in the community). In the SE region and across the state, we look at affordable housing as a critical piece for keeping individuals in the community and promoting their recovery. Rather than expect human services to be the housing experts, we look to the individuals in our region, who are the housing experts across the state. Projects like this are viewed as a partnership between the state, local entities, federal entities, etc. We do have federal funds and private resources that go into this project. We have a number of individuals from Cooper, receive and are paying for affordable housing and trying to develop long term housing. There is perhaps a time when you would need less of the front door positions, but there will probably always be an ongoing need for front positions in that housing project if we continue to target it for long term homeless individuals. It's a housing first model. They don't come with their disease managed, so we are working with them to get them into services with housing used as an incentive with the goal to be transitioning them eventually into permanent housing.
Chairman Pollert: in other parts of the grants line item, where would individuals in the Cooper House be getting other assistance?

Candace Fuglesten: 22 of the 42 residents are receiving services from SEHSC. When they entered Cooper House, only 4 were receiving services from SEHSC, so there has been an engagement and getting people into services at the center. We also have some individuals who have been evicted from the facility who also are continuing to receive services at the center. Through the Cooper interventions, we have connected with many of those long term homeless individuals in terms of providing services. Within the residential services grant, Cooper House is a combination (split 50/50 between SMI and CD residential).
Tim Sauter, Director of West Central Human Service Center (WCHSC) and Badlands Human Service Center (BHSC), provided information to assist in detailing of these human service centers. He started with WCHSC and corresponding information is labeled as attachment **TWO.** Committee members interjected with questions throughout testimony and questions and corresponding answers are as follows.

Representative Wieland: I see part of the increase is $26,000 to provide for annual and sick leave lump sum pay outs for 5 FTEs who are expected to retire. Are we not going to provide just a central funding location for that where all retirees will be taking money out as opposed to using rollup?
Legislative Council: that has been discussed as part of the Hays group but there has not been any implementation thus far of those concepts.

Tim Sauter continued with the detailing, going over written testimony and summary by subdivision and budget account with funding sources and then preceding to rental and leases (attachment **TWO**).

Chairman Pollert: is the rental increase all related to Prairie Hills Plaza?
Tim Sauter: Correct
Chairman Pollert: are you looking to move to a different location for that large facility?
Tim Sauter: I think we are very satisfied with the facility.
Chairman Pollert: is there anything in Bismarck that is comparable to the size you need?
Tim Sauter: there really would be no place that I am aware of that could accommodate an agency of our size. At this point in time, it would have to be a new building.

Tim Sauter moved to operating fees and services, then to grants. The increase in grants is due to the request for the additional 4 crisis beds (going from 10 to 14) and inflation for our providers. With the 10 beds we currently have, there is typically a waiting list for clients to access those services, 30-40% of the time. In looking at the inpatient stays, we believe that having these beds will help us do step downs for those who are in inpatient. That means that we can get them out of the hospital quicker and save money by doing that.

Chairman Pollert: Where is the $309,000 at under the grants line item?
Tim Sauter: It would be a combination – part of it would be under CD residential Adult and SMI residential. We have it listed separately at the bottom.

Chairman Pollert: have you been requesting this in the past or is this something new?
Tim Sauter: This is a new request for us.
Chairman Pollert: how much as your caseload increased as far as this part goes?
Tim Sauter: We've seen a 4-5% (substance abuse and mental health) increase per year so a total of a 9% increase for biennium.
Chairman Pollert: if you've had a 9% growth, do you need 4 extra beds?
Tim Sauter: That's a 9% of all clients at WCHSC that receive mental health services.
Chairman Pollert: do you have an amount of the caseload for the 10 beds that you were currently at last biennium, so how many people would have went through that facility?
Tim Sauter: 10 beds – we served 210 individuals during this last year – we typically have a 90% occupancy and 30-40% of the time we have a waiting list for clients who are trying to get into those beds.

Vice Chairman Bellew: what is the average length of stay?
Tim Sauter: It is about 15 days.

Tim Sauter went over information illustrated in written piece of attachment **TWO,** regarding trends. WCHSC has partnership with Standing Rock Sioux Tribe Psychology Internship Training Program (started in 2008). It has gone very well. We've gone from about 3 applicants to be a participant in that program to 17 this past year. All of our top candidates that we selected got accepted. As a result, 4 have completed. Lake Region has had the benefit of hiring one of those psychologists and the others have been staying on Standing Rock so we are keeping those individuals in the state.

Tim Sauter provided and went over information regarding BHSC, labeled as attachment **THREE.** He stated that Dickinson anticipates the trends that Williston has been having as far as a population influx due to oil impact.

Chairman Pollert: Can you explain why WCHSC has a turnover of about half that BHSC has (10.17% - about 8 employees)?
Tim Sauter: Typically those centers are low. Over the last 5 years, we average between 5-6%. This last year has been an anomaly for BHSC. In regards to recruiting therapists, we've hired a lot of staff who are fresh out of college. They get their training and they leave for better jobs. Many of those have been females who are following their spouse to other jobs.

An issue for the whole region is affordable housing and it impacts both our staff and clients. For instance, we hired a therapist and he finally found an apt. He was in a one bedroom for awhile and then found a 3 bedroom for $1500 a month. He brought his family out, but he still couldn't afford that, so his family is living in Bismarck and he commutes to see them because it's cheaper for them to do that.

Chairman Pollert: where is Badlands located?
Tim Sauter: It's in Dickinson (Dickinson State University campus in Pulver Hall).

On a client level, as far as the housing issue goes, we had a client who spent 19 years in the same apt, but the rent has gotten so high that she could not longer afford it so she lost her apt. We are seeing that same issue with a variety of our clients.

The other big issue is that St. Joseph's Mental Health Unit closed about four years ago. I believe we have been able to serve those clients without a psychiatric facility, although ideally it would be great to have some beds.

Chairman Pollert: can you tell me what the temporary salaries is about?
Tim Sauter: If you look at it, there is about $28,000 that is not showing up under temp salaries. We budget our emergency on call under temporary, but these staff are regular employees so the money that pays them actually comes out of the regular salaries line item. If that was there, it would probably be equal to half.

Chairman Pollert: can we talk about the rental and lease? You are trying to get approval for office facility, non-vocational rehabilitation.
Tim Sauter: We are looking at the possibility of moving out of our current facility as there have been safety and security concerns. We have leaking in the basement that is damaging our records. We have a lot of space that isn't usable space. This is an old converted dormitory. There are extra bathrooms we don't need and large waiting spaces on each floor. There is the issue of meeting and group room space. I don't have a room big enough to meet with all of my staff at the same time. The rooms we do use have poor ventilation. We don't have enough space for treatment groups.
Chairman Pollert: under the rental and lease, where are you looking to move to? Or is this just budgetary with respect to this exploration of moving?
Tim Sauter: We've had discussion with the builder and with the Start Development Cooperation, so we've looked at a few different options. We have a builder who is very willing to build and has space. Another issue is difficulty in finding property. We want to stay budget neutral, but that is next to impossible to do this with prices changes. It would be an increase there. Part of the budget increase is to accommodate a rental increase from Pulver Hall if we don't move.
Chairman Pollert: Pulver Hall?
Tim Sauter: Pulver Hall is where we are located on Dickinson State Campus.
Chairman Pollert: Dickinson State is trying to charge you more for a facility that's not up to date?
Tim Sauter: They are increasing their rates.
Chairman Pollert: you are thinking of trying to build and if you can't build, you are looking to increase within Pulver Hall?
Tim Sauter: The increase is to accommodate the rate change. We are not asking for more space there.
Chairman Pollert: I thought you were looking at building something and you would rent from them?
Tim Sauter: That is correct. That is what a portion of the rent increase would be.
Chairman Pollert: you are looking at two different options?
Tim Sauter: Yes.

Tim Sauter went to operating fees and services and then to the grant summary (pg 8 of attachment **THREE** explains the changes in these areas).

Vice Chairman Bellew: how did you move the psychiatrist from the grant line item to the salary line item without increasing FTEs?
Tim Sauter: I had a support staff that became vacant so I converted that to use for the psychiatrist. I didn't need the funding because I already had it in the contract area.

Representative Nelson: it appears that both in Williston and Dickinson, the loss of the psychiatrist occurred at the same time as when the hospital transitioned from a PPS to a critical access hospital. Is there a relation with that?
Tim Sauter: It occurred before that happened. The primary psychiatrist for St. Joseph's Hospital retired. They were unable to find a replacement for him. As we are talking about vacancies and shortages, I read recently in a psychiatric journal that there's an estimated shortage of 45,000 psychiatrists in the nation. It is a nationwide issue.

Chairman Pollert: has your caseload increased and this is the reason you want to move?
Tim Sauter: Our numbers have remained somewhat stable the last several years as far as mental health, substance abuse and VR, however there have been an increase of 18% for DD (most are children). We are expecting that with the population growth and all the boom that is happening with the oil and other energy industries, that we will seeing increasing numbers, just like Williston has seen. Just a reminder, on our inpatient hospitalization, it shows that we have $130,000 in the budget and $80,000 of that is with the two hospitals in Bismarck that does the mental health crisis stabilization and the other $50,000 is with St. Joseph's to do medical detoxification.

Russell Cusack, Vocational Rehabilitation Director with DHS, provided and presented information to detail this section of the DHS budget. The information is labeled as attachment **FOUR.**

Chairman Pollert: do you have any vacancies or trouble filling positions? Any long term vacancies?
Russell Cusack: We do have one vacancy and that's our client assistance program manager and we anticipate having that position filled and providing that service.

(summary by subdivision and budget account with funding sources) The salary increases that are displayed represent the increases to support the governor's salary package. We are 78% federal funds. A majority of the items represent a decrease. I will draw your attention to the increases. I'll start with travel. $10,000 of that increase is for staff travel to our regional offices for training on a new electronic case management system that we are hoping to be able procure.

Vice Chairman Bellew: by regional offices, do you mean human service centers?
Russell Cusack: Yes.

We also have a new director to our disability determination unit and she'll be traveling a bit more this biennium in terms of attending required training in Baltimore. This budget item also supports our rehabilitation council and the state independent living council. Those are made of up citizens of ND, citizens with disabilities that help to guide the division's activities. Some of these individuals have significant disabilities so this pays for their attendance at meetings and it pays for the attendant care services that members need. It supports the ongoing quality assurance work that we do. Our policy staff travels out to the human service centers and do case review of a sample of the cases that are worked by our counseling staff and we assure that we are meeting federal and state requirements.

Chairman Pollert: on the Prairie Hills Plaza, is there a yearly inflator on that?
Brenda Weisz: there is a biennial inflator. It's a 3% every biennium. The rental rate also takes care of the oversight of the building (electrical), snow removal, and janitorial work.

Russell Cusack: There's an increase in professional development. The federal requirements for the rehabilitation act require that all of the counselors in all states have a Master's degree in rehabilitation counseling and meet national standards. The state office of vocational rehabilitation supports counselors' efforts to attain those academic credentials and thus national certification. We put additional money in the budget to pay for those credentials.

Chairman Pollert: is that with a specific number of employees you did that with?
Russell Cusack: We have 41 counselors.

Chairman Pollert: professional services?
Russell Cusack: The increase is all federal funds and that is to pay for an increase in the physician's services at the disability determination service. Those doctors are required to review medical information that is received by the disability determination unit.

We had a reduction in operating fees and services. One of the services that we were provided was for some grants for the tribal programs. We were assisting Turtle Mountain with some funding and that was onetime funding.

Chairman Pollert: what do you mean by media contracts for VR business services?
Russell Cusack: We are required by our federal funding source to perform outreach to the community and certainly, we would outreach to the business community since the results of vocational rehabilitation is for individuals to obtain employment. This includes ads on the radio.
Chairman Pollert: you have to do a federal requirement of advertising?
Russell Cusack: We have a memorandum of instruction from the rehabilitation service administration that speaks to outreach to the community in terms of consumers as well as business.

Chairman Pollert: can you tell me about client service grants?

Russell Cusack: Client service grants are the funds for individuals that come to VR and these individuals have a plan for employment developed. Those plans of employment could include college training, vocational training, on the job training, assistive technology devices, home modifications, medical services as well as professional counseling and guidance (occupational therapy for instance). It's a whole host of services that are bought for that individual with the goal of that person's employment. All services on an the plan for employment through this grant must be directed to the individuals obtaining employment.
Chairman Pollert: are the federal funds staying steady?
Russell Cusack: The state federal vocational rehab program celebrated its 90th birthday last year. I've been with the program for 34 years. It has a great deal of support on the federal level.
Chairman Pollert: have those funds increased, decreased, or stayed stable?
Russell Cusack: the funds have increased. Under Regan's administration, there was a clause put in the regulation of the rehab act for increases to be tied to the consumer price index. VR is one of the few federal programs that has enjoyed a steady increase of federal funds into the states.

Chairman Pollert: there's a reduction of $900,000+ in federal. Where is that at in the grants?
Russell Cusack: We've had a reduction in that level of funding because we are not longer going to receive ARRA funds. That was onetime funding.

Chairman Pollert: the Centers for Independent Living Contracts are stable?
Russell Cusack: That funding is included in the rehabilitation act and is a stable source of funding for the state of ND. Regarding the general funds that the legislature has appropriated to the division and the division then grants out to the Independent Living Centers, the Centers' directors nor the division heads did not ask for any additional state funds this biennium.

Chairman Pollert: are they eligible for the 3/3?
Russell Cusack: No

Brenda Weisz provided schedule that the committee had requested about the cost of 6 prevention coordinator FTEs compared to the contracted 8 FTEs from the mental health/substance abuse section of DHS from March 14, 2011's detailing (JoAnne Hoesel). This information is labeled as attachment **FIVE.**

Chairman Pollert closed the hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 16, 2011
15507

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 to resume detailing of the budget.

Alex Schweitzer, Superintendent of the ND State Hospital (NDSH) and ND Developmental Center (One Center) with DHS, provided information about per diem rates for psychiatric residential services (attachment **ONE)** and stated that the costs is $367 per diem at State Hospital which is significantly more than cost of residential care.

Vice Chairman Bellew: why does the NC cost more than the other two?
Brenda Weisz: it's higher intensity with medical staff needed.

Representative Nelson: that's with Trinity?
Brenda Weisz: it's for whatever RFP they contract with

Alex Schweitzer: The question had come up about the number of uncompensated days at psychiatric hospitals and the actual total was 15,084 uncompensated days. We put a budget together at 4,932. Because we couldn't get an accurate definition of charity care and uncompensated and the difference, we used the 1,000 days as the maximum.

Alex Schweitzer provided and went over information about North Dakota State Hospital - Traditional Services (attachment **TWO**) to assist in detailing of the budget. Committee members interjected with questions throughout and questions and answers are as follows. The increase of .49 FTE is due to a request for a pharmacist for the tele pharmacy for the State Hospital to support the 8 human service centers (HSC) with pharmacy services. The majority of the budget increase is in permanent salaries because of the governor's pay package. Temporary salaries have decreased because of moving $182,000 over to secure so we could balance that out. We had a psychiatrist that was temp that was terminated.

Reduction in salary is the underfund. We are anticipating if we have more community based services, we will have less capacity at the hospital.

Representative Wieland: do you have any vacant FTEs at this time and if so, how many and where at?
Alex Schweitzer: 23 FTEs are open at traditional and secure services with NDSP.
Representative Wieland: out of that 23, you are actively seeking how many? Have any of those been vacant for more than one year?
Alex Schweitzer: We are filling all of these. 8 of those have been vacant since Oct 2010 and the rest have been vacant in this biennium.

Chairman Pollert: you had asked about hiring a forensic psychologist. When you did that, you had mentioned you would take away the salary of a security officer and an occupational therapist. Did that get done?
Alex Schweitzer: Yes. That was a change we made when we made the transfer of a position over from traditional to secure.
Chairman Pollert: I was asked if that was a necessary transfer and I had agreed with that. But I also told, the lieutenant governor at that time, that I would make sure that when the budget came forward, to verify whether that had happened or not.
Alex Schweitzer: The forensic psychologist is a position we had to have because of doing sex offender evaluations and timelines that the court expects for us to get evaluations complete.

(highlighted changes in budget summary) There is an increase in travel due to transportation issues (gas increase, fleet services). Law enforcement will often take patients to the required location, but do not necessarily take them back. Chemicals for the boilers in the heating plant account for the increase in supply/material-professional. The increase in food and clothing is due to increase in food costs in transitional living. Office supply increase is due the Gobbler (patient store) which is resale supplies. There's a decrease in equip under $5000 because the current budget had a unit dose med system and lab equipment in there. Office equip and furniture had increase and $20,000 of this accounted for (high/low beds) hospital beds plus additional furniture replacement. Utilities increase is because we are now connected to the city of Jamestown's sewer system so we are paying for utilities.

Chairman Pollert: was there a reason for that?
Alex Schweitzer: We use to have our own system and deal with a lagoon, etc. In the long haul, working with the city will save money. We didn't have the expertise or the staff to continue in the way we were going.
Chairman Pollert: you would have been asking for capital improvements?
Alex Schweitzer: Absolutely because we would have to pay for continuing our own utility system.

The increase under rental/leases (equip and other) is due to joint commission and needing a pharmacy bar code system (have to purchase a scanner) and physicians use it for inventory control and medications. $73,000 of the professional development increase is for stipends. We have two nurse practitioners in class and we're paying for their education so that they'll return to work for us. We have 1.5 openings in psychiatrists and this will be

difficult to fill, so we are growing our own. To date, we have educated 3 of our own nurse practitioners and they have stayed with us for a long time, so it is a worthwhile investment. The rest of the increase is due to training for the rest of our FTEs. Professional services increase is due to paying for medical expenses outside of the hospital for those who come to us without any kind of payment and need a service that psychiatric hospital (state hospital) cannot provide. In the $1.8M request in land and buildings, we are asking for a generator ($1.3M), testing fire and smoke dampers ($250,000), and wiring for New Horizons building ($300,000). Senate added $161,840 for flooring throughout the campus. That was an OAR that the governor funded ($1.8M of the $1.96M).

Chairman Pollert: should that be in the OAR listing?
Alex Schweitzer: It was not funded by the governor so it was removed from the OAR which was $1.96M and he only funded $1.8M. The senate put the difference back in.

Our total expenses are essentially the governor's salary package. Operating increased by only 5.4%.

Chairman Pollert: will the $1.3M on the generator been phased in?
Alex Schweitzer: Yes, these are the phased in projects and it's to be complete by the end of this biennium. It's been 3 biennia that we've been phasing in (energy update).

Vice Chairman Bellew: what are the other funds in your budget? Are those third party payers?
Alex Schweitzer: Yes, they are.

Chairman Pollert: tell me about the New Horizons building again.
Alex Schweitzer: It's where we have out treatment mall. Clients spend an entire day in that area. We have groups there, activities, therapy. We also use it for our 8 beds Cross Roads which is a residential facility. We added that because of capacity.

Representative Wieland: in getting back to the updating of your utilities, shouldn't that have a positive effect on your utilities after you have done that?
Alex Schweitzer: Yes, it should. We have seen some of that already. We have schedules that show those savings. Some of those costs in this budget are because of the sewer system. The majority of our increase in utilities ($80,000) came in the area of the sewer system. The rest of it would be some generalized costs.
Representative Wieland: is that sewer cost a onetime cost or is that going to be ongoing?
Alex Schweitzer: It will be an annual cost.
Ken Schulz, COO: We will have a continuing bill (monthly bill due to the city) due to the transition we made to connect with the city. However, we won't have the capital improvement costs of maintaining our lift station, lagoon, and main sewer line from the lift station to the lagoon.

Representative Kreidt: what is your bad debt and how do you collect that?
Alex Schweitzer: Yes, we do have bad debt because of serving indigent people. Because of state law, we do not automatically write debt off. We carry accounts receivables. We do collect. In some cases, an individual may inherit something so we'll try to collect that money

from them. In some cases they pay, privately. We have a collection agency that works with us. The total of that accounts receivable is in the millions.
Representative Kreidt: as long as the individual is still living, you are pursuing to collect that?
Alex Schweitzer: Yes. There are cases as well where an individual comes to us with $80,000 to pay out of their $100,000 bill. We make a decision whether or not to accept and oftentimes we do as this amount is better than nothing and then we write off the remainder of the bill.

Representative Nelson: back to the lagoon situation, will that be levied and be able to be utilized for something else?
Alex Schweitzer: we'll be looking at the mitigation of that with the health dept.

Representative Metcalf: regarding the collection agency you work with, what does your contract call for? Is it a variable amount of money that they can collect? What are the highs and lows?
Alex Schweitzer: most hospitals use third party collection agencies. We happen to use HSI which is a subsidiary of the ND hospital association. They, of course, keep a portion (25%) of what they collect. They're useful because otherwise you'd have to employ staff to do that sort of thing.
Representative Metcalf: what happens if they don't collect anything?
Alex Schweitzer: They get nothing. In some cases, after researching the situation, they find that the bill is virtually uncollectable so we may make a decision to write it off.

Vice Chairman Bellew: what is Joint Commission Certification (JCC), under professional fees and services?
Alex Schweitzer: JCC is our accreditation. We're deemed status hospital which means that we must be reviewed by an outside party. If we did not have JCC, the health dept would have to review us for our quality of care for the services that we provide. They're a private organization.

Representative Kaldor: what's the source of the other funds for the attorney fees for patient hearings?
Ken Schulz: when we set up our budget, we distribute our other funds in different depts. It's the same thing we spoke of before, third party payments. We don't collect anything specifically from the patient for legal fees.

Chairman Pollert: out of the $88,000 increase, where is that at in this spreadsheet (professional fees and services)?
Alex Schweitzer: patient medical services
Chairman Pollert: what do you mean by patient medical services?
Alex Schweitzer: Any medical care that needs to take place outside of NDSH as we cannot meet those needs such as surgery, optometry, etc.
Chairman Pollert: what is the Essentia Health –Consult Clinic?
Alex Schweitzer: That is to pay for a family practice doctor that does clinic work on the campus. We contract with a doctor to see our patients for medical concerns that are day to day and makes the decision to send them out for outside services, if necessary through consults.

Vice Chairman Bellew: what is the work activity contract?
Alex Schweitzer: $300,000 is paid to Progress Enterprises (work program for those with SMI). It's a vocational program to get them placed eventually into some useful kind of work. It's located in Jamestown (north end). They work with Human Services and are private, non-profit.

Alex Schweitzer proceeded to go over NDSH – Secured Services, labeled as attachment **THREE**. He stated that there are 76 beds and 64 patients at this time and staff are shared between traditional and secured services.

Chairman Pollert: your budget is based off of 76, but yet you are about 60? Are you seeing growth in that program?
Alex Schweitzer: The bed count is 76, but the budget is based on 85% occupancy just like traditional. Secure services is a very unpredictable area in that the way people come to us, it depends on whether the states attorney brings a petition to the district court to have them evaluated for admission as a sexually dangerous individual. A few things have to happen after that petition brought forward. We do a paper review and decide just from that the individual is not sexually dangerous or we bring them in for an evaluation and they may then be admitted. The prison sends us information about those leaving the prison that have a sex offense and potentially could be referred, but there are no guarantees that we'd get them because they'd have to meet the criteria to be sexually dangerous (tests help determine).
Chairman Pollert: what have your numbers been? Have they been religiously 55, 58...have they ever been 65?
Alex Schweitzer: Our highest occupancy has been 64. Remember, 5 of those individuals are guests at the state penitentiary (they are still ours), thus we have 59 residents at the NDSH. The 5 are being paid for through DOCR, not NDSH while they are at the penitentiary. The last 3 years, it's been stable (59-64).

Representative Metcalf: are your evaluations more sophisticated that you can basically come closer to keeping the right people in and the wrong people out? Have those people been re-evaluated?
Alex Schweitzer: Yes, that is exactly right. We are better trained. We continue to do research as far as how to treat these type of people. Yes, we do re-evaluate them as we are required by state law to re-evaluate them yearly. Remember, we've had 17 people leave. 15 of those individuals have been successful in the community and 2 went back to prison, for non sex related offenses. Evaluations are done by our evaluator and an outside evaluator (both psychologists).

Representative Wieland: These 5 individuals who are still part of your contingency but are in the penitentiary, you don't reimburse the penitentiary while they are there?
Alex Schweitzer: No, we do not.

Chairman Pollert: in doing the math, it's about $237 a day. We are trying to get per diem rates. Would that be correct?
Alex Schweitzer: Yes, $236.56 is the per diem. $67.66 is overhead head costs and the remainder is direct patient care cost.

I will go to the detailing and highlight changes. The increase in total salaries includes executive recommendation for state employees (large portion). We underfunded $900,000.

Representative Nelson: is the .51 FTE the other part of that pharmacy person?
Alex Schweitzer: That's actually a transfer of a nurse from the traditional services to secure services. It was an internal transfer.
Representative Nelson: in traditional services, that was .49.
Alex Schweitzer: We had a .51 position - we always have parts of positions that we pull in to use for that pharmacy position.
Representative Nelson: between the 2 facilities, you have an increase of 1 FTE?
Alex Schweitzer: The net effect is that 1 position is the tele pharmacy that we are requesting in this budget.

Representative Wieland: when the penitentiary remodeling work is completed, they are going to have a pharmacy located outside of the fence. Is it a possibility that the state hospital will be able to use that pharmacy?
Alex Schweitzer: Our pharmacists need to be onsite. They not only provide medications, but also do patient teaching, work with patients on their meds day to day. Are you talking about professional or purchasing of meds?
Representative Wieland: purchasing
Alex Schweitzer: We could look into that because we do purchase from the same group (Merinet).

Representative Nelson: JRCC is proposing to run the pharmacy from the state penitentiary to that and as we look for efficiencies, you are currently serving that facility?
Alex Schweitzer: We are not serving that facility. We have in the past, but they asked us not to serve them any longer. I followed up on the question you had during the overview with my pharmacist and that was correct. I asked if she knew the reason for that and she said she wasn't sure and that they were capable of providing that service.
Representative Nelson: are you able to provide some numbers as far as the efficiencies that could be garnered from you serving them?
Alex Schweitzer: Yes, I can get that for you.

Chairman Pollert: we're not going to be meeting a lot next week, but if there are schedules that we have requested, we can go over those during those times. Representative Kempenich has asked for information on the neighboring states (SD and MT) and the number of people in Medicaid and he states he has not received that information. He wanted to share it with the full committee.
Legislative Council: Representative Kempenich had asked our office to do research on other states and we have provided that to him. We didn't have any information on Medicaid clients. I did provide him (last week) information regarding legislative appropriations in other states for human service related activities. It's difficult to look at other states because other states have different agency structures.
Chairman Pollert: I better have the information that he got.
Legislative Council: I can get that to you.
Chairman Pollert: he had the questions during the overview of DHS in full appropriations meeting.

Brenda Weisz: we have some of the schedules that was requested during overview testimony like eligibles in MT and SD, so we can talk about when you want some of those schedules to come forward.

Chairman Pollert: what is the cost per day of traditional services at NDSH?
Alex Schweitzer: it depends on the unit as acuity of patients varies. **Brenda Weisz** provided information on the breakdown of per diem costs in this area for NDSH and Transitional Living Center, labeled as attachment **FOUR.**

Alex Schweitzer (continued with the detailing), total operating went up (5.5% increase). Professional services fees went up because by law, we're required to pay for the independent evaluators which are done along with the evaluations we do. The judge orders us a pay.

Vice Chairman Bellew: in going back to food and clothing, the food and clothing had a significant increase. Why is that?
Alex Schweitzer: in the second year, the DOCR will be charging us $3.08 per meal.
Vice Chairman Bellew: if you go right across there, you have $520,000 budgeted and you've only spent $153,000 for the first year and that adds up to $306,000.
Alex Schweitzer: We've only paid for ¾ of payments to DOCR so that would be higher...
Vice Chairman Bellew: so that's basically only 9 months
Alex Schweitzer: Yes, that's right.

Alex Schweitzer provided and went over information to assist in detailing of the North Dakota Developmental Center, labeled as attachment **FIVE.**

Chairman Pollert: go through what you did with FTE counts.
Alex Schweitzer: we went from 441.29 FTEs and reduced it by 40.53. The reason for this is that we will 95 individuals in the Developmental Center of July 1, 2011. Since we prepared the handout during overview, we're down to 103. We fully expect we will be at that level by the time July 1 rolls around.

Representative Nelson: the ones that have left since the overview, where do they go? Give us a brief description of where they go and what types of services they utilize.
Alex Schweitzer: They go all over the state. We match them up with providers. We are an ICF/MR so several go to ICF/MR in their communities. They go to independent supportive living arrangements, individualized apt setting; the services Tina Bay talked about when she overviewed the DD in DHS.
Representative Nelson: it has to get to a point where transitioning these individuals out gets more complicated.
Alex Schweitzer: Yes, it does. As these individuals get placed, the individuals are at higher needs. We have a transition task force that is made up of dept members, provider community, P and A, the ARC. We meet and discuss transitioning these individuals. Within that transition group, we have a centralized project committee that is actually looking at the individuals that we're talking about placing and working with community providers to actually help them and work on developing services in the community that will meet the needs of the individual. We're been doing this since 2005 when the legislature required us to start transitioning people.

Representative Nelson: to get to 67, this arrangement will be utilized?
Alex Schweitzer: Yes
Representative Nelson: so that's doable. The increase that we see in the DD providers is taken into account?
Alex Schweitzer: No, they are not. Chairman Pollert asked me to go over transitional living which I will go over now. 67 is the population goal for 2013. If you reduced the population of 67, you would have a reduction in the next budget request of 38 FTEs. The total salaries and benefit savings would be $2M. I will give you a history of transition. In 2005 this legislature allocated $50,000 for transition. We had a population of 140. In 2007, you allocated $1.1M. Our population then went to 126. In 2009, we had no appropriation and our population went to 103. There is nothing in the budget for transition at this point. There is a $6M OAR that we'd requested from the dept but did not get funded in the governor's budget. During the 09-11 biennium, we funded from Developmental Center savings (statewide cares program provides in home supports) to make sure that individuals are not re-admitted to DD Center or admitted to DD Center. We took 10 FTEs from our staff within the DD center to provide these services. From our savings, we funded 5 behavioral specialists. They provide behavioral supports for individuals with behaviors because that is a reason that these individuals would go back to the center. We opened an ISLA on campus (5.5 FTEs). This is an independent living arrangement for 3 individuals with sexual health issues. We funded a youth services program with 8 FTEs because we had 3 behavioral challenged youth that were not able to be placed in the community. This is a short term program and we've already placed 2 of these individuals. I spoke of the centralized project committee where we match up individuals with community providers. All of these programs prevent admissions and re-admissions to the DD Center.

Chairman Pollert: are the behavioral specialists traveling around the state or the NE area?
Alex Schweitzer: We have one located in Grafton, one located in Fargo, one in Minot, one in Jamestown (this position is open now but we are filling it), and one in Bismarck. In my opinion, there seems to be a rush in the transition process, but I think it's important we don't rush this thing due to quality of care issues.
Chairman Pollert: do you have the accommodations to follow the Olmstead decision?
Alex Schweitzer: Yes. We are transitioning as many people as we can and transitioning the campus like the Woodworth Iowa facility. Not every DD Center in the United States of America is closed. Some are doing it like us and putting people in ISLAs and making things more homelike for the remaining individuals. This is 2011 and perhaps there will be a change with providers and they will step and say we can serve these people. That will be fine as long as quality of care is met. We are not locked into one particular goal. We just need to work these goals bit by bit. It may be more difficult now as we have no transition money.
Chairman Pollert: truthfully you have money to float around with because if you go from 95 to 67, you do have an FTE savings so you don't really need money from us. There is a cost savings there at some point.
Brenda Weisz: the budget before you already has that money out because we got to 95. We don't have the money out to get to 67. Right now we are staffed to provide services to 95. You can't have the savings at the SAME time you are moving people out; the savings come after. To do another movement to 67, you are not going to see the direct savings because at the rate they move out and our ability to close areas and reduce staff at the DD Center won't come at the same ratio as you move people out. The savings will be seen 2

biennia later as you saw this biennium from 2 biennia ago. Right now we are in a holding pattern because there is not enough money to get to 67 in 11-13.

Representative Nelson: the 40 less FTEs in this budget are the result of moving from 125 to 95?
Alex Schweitzer: We have to dual fund. We have to fund the people in the DD Center as well as being able to do the community stuff. Some of the money could follow them, but it's difficult to fund projects if you aren't sure that the providers are going to get paid. Per diem cost at the Developmental Center is $651 and the per diem cost to maintain these individuals in the community is $410, so you are looking at $241 difference per day.

Representative Wieland: the main concern that I have is because of the facility itself, it's an inefficient setting for 100 people. It was likely much more efficient back 50 years ago. My concern is the efficiency of the building, not of the operation itself. When we get down to a point where we can look different possibilities and the possibility of a facility more or less in one building and not have to move people outside except to go outside to a courtyard or a lawn and the other amenities that people need. I should go up there again and take another look. I can visualize in my mind where we could have a facility that could take care of these folks almost in a community setting and do it in a more efficient manner if the facility was more efficient.
Alex Schweitzer: I agree from the standpoint of capital and building. We are open to options. If someday, it looked like the community could provide for everyone of these individuals and the result of that was that the DD Center closed, so be it. This session, we sold more land to the city. We did that because we were able to reduce an FTE. We don't want to or need to manage a whole lot of land. We have two buildings that have independent senior living in them. We are renting a lot of space on the campus. With the big boiler and heating plant, you are right. We are trying to address that as well.

Chairman Pollert: what do you figure is your cost per client to transition from the DD Center to a DD provider?
Alex Schweitzer: You'd have to have the cost of the $410 for that particular slot because you have to pay per day for that particular facility. Once those individuals leave, we would be able to start pooling those FTEs and we would come back with our next budget with a reduced budget. We have to double up for the 2 years (about $170,000 per client). If we had some funding, it would be a lot easier to do this. You are going to have short term pain for long term gain. I want to get to the efficiencies that Representative Wieland is speaking about.

Thank you for the opportunity to discuss the transition. I will proceed with the detailing.

Chairman Pollert: the 40.53 FTE, have they always been in the budget as paid positions?
Alex Schweitzer: Yes. Salary decrease is $1.5M. You add back the governor's increase for the 400 FTEs at 2.2. We are underfunding this budget at $738,000. The capital budget is going to decrease by $729,000 and the total operating has a slight increase of $20,000. The total expenses are down $2.2M. The travel increase is about having to transport individuals to appointments and to visit family members and there is increase in gas. The costs in bldg, grounds and vehicle supply are due to maintenance of buildings and infrastructure. Much of the decreases you see are due to decrease in residents and staff.

Representative Nelson: what is the increase in repairs about ($83,000)?
Alex Schweitzer: it is about the aging plant buildings and the associated repairs. Some of these buildings I would like to talk about eventually removing.

Chairman Pollert: can you go to operating fees?
Alex Schweitzer: Yes. Any questions about that?
Chairman Pollert: Please go through it.
Alex Schweitzer went through operating fees and services. Committee members interjected with questions throughout and questions and answers are as follows.

Chairman Pollert: where is the $400,000+ is coming from?
Alex Schweitzer: that is the increase in provider tax. Advertising is essentially recruitment for employees. Most of these are fairly standard. He went to professional fees and services.

Chairman Pollert: on your overview there is a $5.8M increase in general funds and $7.5M in federal funds. Is the $7.5 because of the transitioning out? Where does that come from in the federal funds?
Alex Schweitzer: there is an increase in federal funds because of the FMAP.
Chairman Pollert: you show a decrease of $8.7 of federal.
Alex Schweitzer: $7.5M is the federal fund decrease - other funds of $575,000 and the total of $2.2M. There is less general fund decrease because of the FMAP changes.

Representative Nelson: in going back to the ISLA information (projections given for upcoming biennium), there is a growth factor in there for transitions in that cost center of 8. I don't see that there in ICF/MR Adult. I know you did build in some transition in some of these areas.
Brenda Weisz: that growth is to get you to the starting point of 7/1/10 (this biennium) - getting you to our caseload for this biennium. When you look at 11-13, there's nothing for the growth for the next biennium.
Representative Nelson: the only way that we're accounting for the growth in the developmental center is if the utilization is overstated? If the numbers are right, then none of these people are paid for?
Brenda Weisz: We don't have any growth built in the budget for 11-13, other than the high school graduation. Let's say someone does not graduate from high school or continue on with life or have a placement in a community home that might free up a spot for a transition out of the DD Center.

Chairman Pollert informed DHS to come back on Monday March 21st to go over information that the committee requested during the detailing. He closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 21, 2011
15721

☐ Conference Committee

Committee Clerk Signature Julia Jeffe

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called House Appropriations Human Resources Division to order. Chairman Pollert opened hearing on SB 2012 to go over information (schedules: Health Care Reform FTEs, Dementia Care, ADRC, county grants funding sources, long term care information (CHIP, Medicaid, adult family foster care), FTEs for Cooper House, DD schedules, infant development unit) that were requested by the committee.

Chairman Pollert distributed information on Dementia Care Services Program, including outcomes of Dementia Care Services Program (provided by the UND Center for Rural Health) which he had been given last week to share with the committee. This information is labeled as attachment **ONE.**

Brenda Weisz provided and went over document (attachment **TWO**) about health care reform FTES (cost to continue salaries for the 2013-15 biennium), stating it's the only amount in the DHS budget related to health care reform.

Brenda Weisz distributed the minutes of the long-term care committee (attachment **THREE**) from September 28, 2010 (first two pages). On the second page is where the report is discussed and attached is the actual report (on the use of the funding for dementia care services program) submitted by UND School of Medicine and Health Sciences. There was a question that was asked on pg 2, second column towards the bottom (Senator Dever) and Brenda Weisz's response stating that DHS would be requesting funding of $1.2M from the general fund for the dementia care services program in its 2011-13 biennium base budget request which is the same level of funding as provided for the 2009-11 biennium.

Jan Engan: the ADRC concept evolved across the country beginning in 2003 as a partnership between CMS and the Administration on Aging. Central to this concept is the "no wrong door" approach making it easier for older adults, adults with disabilities and their

families to learn about choices they have as they look at long term care and supports and services. The ADRC link increase the ease and efficiency of connection people to available assistance. Jan Engan provided and presented information regarding ADRC: fact sheet: aging and disability resource link (how it works, background, key partners, funding/sustainability, goals and outcomes, and next steps) and an outline of how the ADRC works (seeking services with "no wrong door") which is labeled as attachment **FOUR.**

Representative Kreidt: wasn't there a matching grant that was supposedly coming down from the federal govt for the single point of entry for $900,000 with a $40,000 match from the state. Whatever happened to that? Is that still out there?
Brenda Weisz: We did not receive funding for the first ADRC grant that was in our budget two biennia ago, so those general funds were returned.
Representative Kreidt: was that a onetime situation? Was there an opportunity to apply for that?
Brenda Weisz: We did apply (100% federal funds) this biennium and went before the emergency commission. We did receive the grant, but no match was included.

Representative Wieland: in referring to attachment **FOUR**, these are the phone numbers I would have to remember to call if I thought my elderly grandmother needed assistance, for instance? Is there any easy number?
Jan Engan: it's the 1-800 number (1-800-366-6888). She went over the diagram as part of attachment **FOUR**, stating there are multiple ways to get connected to services in addition to the phone.
Representative Wieland: the grant money is used for training for individuals in the HSC? How many people are going to be able to be trained?
Jan Engan: Training is provided through the contract which will be replicated throughout the state to the various partners about the concept of ADRC and that could be your centers for independent living, County SS, network of senior service providers, assisted living, hospitals, anybody in your community who may have contact with older persons, family members or persons with disabilities where we may have clients in common or somebody new walks through their doors. We do the marketing of the program, provide them training how to access the program and essentially, it's on an ongoing basis.
Representative Wieland: who is doing the training?
Jan Engan: Currently, we are utilizing the staff at the HSC in Bismarck (region 7) where the pilot originated and we've expanded that to region 2 in Minot through the HSC.

Vice Chairman Bellew: how does ADRC differ from the Dementia Care Services Program?
Jan Engan: The Dementia care program is a specific direct service which we may or may not get a referral into the ADRC or we could have a client call in to the 1800 or through care choices on the internet and request information about Dementia care and be directed directly to them.
Vice Chairman Bellew: in referencing the fact sheet about ADRC, it seems like you are duplicating your effort here. Dementia Care program is through HSCs, right?
Jan Engan: No, it's not. That's through a separate contract with the ND/MN Alzheimer's Association to provide a direct care service. They're going out into the communities, counties, and providing, whether it's group or individual, training about Alzheimer's disease

and related dementia and they may or may not utilize the options counseling piece of the ADRC to hook up that family with some extended assistance in looking at other options. They're specifically focused on the one area. The ADRC does not do direct services, but the Dementia service care grant does do the direct services.
Vice Chairman Bellew: explain direct services to me.
A direct service is where an individual consumer gets something directly from a contracted agency. It could be a congregate meal, home delivered meal, additional training on how to deal with a care recipient who has wandering issues.

Debra McDermott provided and went over child welfare grant expenditures, labeled as attachment **FIVE.**

Chairman Pollert: are we at 55.36 on FMAP?
Brenda Weisz: 55.4 and it affects Medicaid and other parts of the dept (foster care, developmental center, HSC).
Chairman Pollert: Going down to 50 would be the worst case scenario, right? Do you have that dollar figure to drop?
Brenda Weisz: Yes, it would be the worst case scenario. Each 1 % drop in FMAP is equivalent to $8.2M of general fund need ($16.4M per biennium).

Maggie Anderson provided and went over adult family foster care information, comparison of Medicaid eligibles (with SD and MT), income levels for CHIP, Medicaid and CHIP income disregards and deductions, and surrounding state comparison information in regards to CHIP (labeled as attachment **SIX**).

Representative Wieland: under number 3 for clients receiving adult foster care (pg 1, attachment **SIX**), who makes the determination whether that facility is eligible for that amount of dollars?
Maggie Anderson: it goes back to that monthly rate worksheet so the case manager goes to the client's home to assess what their functional needs like how much personal care they might need and how much assistance they need with laundry, shopping, housekeeping. They go through the monthly rate worksheet and make points based on how severe their impairments may be that keep them from doing those activities on their own. Based on that worksheet, there is a formula. These are the cap amounts so they are not what everyone is receiving.
Representative Wieland: there is a foster home in the eastern part of the state that keeps saying that the maximum that the county will tell them that they are eligible for under Medicaid program is $16 per day which is not adequate to take care of someone. Why would they be getting that information?
Maggie Anderson: It is possible through the calculations of someone who had a minimal amount of need, their daily rate could be $16 and there have been situations where that determination has been made and the provider can still choose whether they are going to serve that client. I provided the maximums to you, but it is possible that their care could be $16 a day if they do not have significant care needs.

Chairman Pollert: as far as CHIPs program and universal healthcare, Representative Weisz stated that going to universal healthcare, you can't have a reduction in kids covered. Could you give me an explanation of what he was trying to tell me?

Maggie Anderson: In the passage of the healthcare reform bill, there was a piece called the Maintenance of Effort/Eligibility (MOE). This says that states must maintain their eligibility levels for adults in the Medicaid program through Jan 1, 2014 (which is when the exchanges are suppose to be up and running) and for children through September 2019. The difference in those two pieces is that the adult expansion happens Jan 1, 2014. The children's health insurance program was extended via the healthcare reform bill to 2019; however, it's only funded through 2015. In between 2015 and before it expires, a decision will need to be made as to what happens with the funding for the children's health insurance program. In between now and 2019, we are not able to reduce our eligibility levels for coverage for children. There have been some states struggling financially, who have submitted letters in request for reconsideration of that, but MOE is laid out that we cannot change eligibility.
Chairman Pollert: in healthcare reform, what does the children's health insurance go to?
Maggie Anderson: the healthcare reform bill doesn't call for a change to the eligibility levels. There would be no mandatory minimum across the board. We will be required to go to modified adjusted gross income for Medicaid determinations. There seems to be indication that states could continue forward with the methodology they're using today for CHIP, which for us would be net income, but all of that hasn't been determined yet. The difference between the 2015 where it's funded through and the reauthorized through 2019, there's a provision in the law that requires the secretary of health and human services to evaluate the state health insurance exchanges by the spring of 2015 and part of that needs to be to evaluate the extent of child only coverage in the exchanges. There is some thinking that, that evaluation that will happen in the spring of 2015 will determine how long any extension to the CHIP funding will happen after September 2015.

Representative Kreidt: Are some of the states that would be in financial stress between 2015-2019, being granted some waivers to opt out of some of these programs? I know right now there are over 1000 waivers that have been granted in regards to this act. Is that what's happening?
Maggie Anderson: There are a lot of different things happening. Arizona is the best example of that as they are in the forefront of asking for relief from their Medicaid enrollment and eligibility levels. The determination that was made is that part of the Arizona expansion that happened years ago was part of an 1115 demonstration waiver. The health and human services agency has said that you can't change your eligibility level but if that waiver expires, you are not obligated to renew the waiver. If states do not have an 1115 waiver and they've solely expanded Medicaid coverage through a state plan amendment, there are no flexibilities at this point that have been granted or discussed. The administration is offering a variety of other ways to reduce expenses, but they've stood fairly tall on the states not changing eligibility.

Nancy McKenzie provided and went over information (attachment **SEVEN**), starting with DHS psychiatrists and clinical nurse specialists for the human service centers across the state, including vacancies. Any vacancies are being filled with contract time and/or tele medicine. She then described the FTE that Cooper House is requesting, called Mental Health Technician which is a 24/7 position and covers 4.58 FTEs.

Representative Wieland: what was in the budget in the last biennium for Cooper House and how much is in the governor's budget now?

Brenda Weisz: it's about $358,000 for last time and $489,500 for the second position to add to that number.
Representative Wieland: what is the total?
Brenda Weisz: a little more than $850,000

Tina Bay provided a schedule of changes in DD grants from 09-11 appropriation to 11-13 executive budget and a breakdown of the changes. The information is labeled as attachment **EIGHT.** She then provided DD hourly wage comparisons without the wage increase (11-13 biennium), labeled as attachment **NINE.**

Chairman Pollert: when we get from the dept what the $.50 costs, it also includes the cost of the 33% of the fringe benefits that's covered as well, right?
Tina Bay: that's correct.

Tina Bay provided a breakdown of the 09/11 DD funding bucket allotments, labeled as attachment **TEN,** to include age limits, scores, total amounts in each bucket, and the number of eligible scores. In that last bucket (bucket 6), people could be eligible for 2 different categories (medically fragile or behavioral challenging), so it doesn't necessarily mean that 1100 people received funding from that bucket because they could be duplicated in that bucket.

Tina Bay provided information on Day Supports (attachment **ELEVEN**) and how the dept came to the rate they use as well as further information on family support services-in home support.

Vice Chairman Bellew: regarding the Autism spectrum disorder waiver, it says in your testimony that only goes through age 4. What do we do with autistic kids after age 4?
JoAnne Hoesel: this waiver is the first start for the state to target services to children and adults on the autism spectrum. If they autism and qualify for the regular DD waiver, then they could go into the regular DD waiver, but if we do have an individual that has Aspergers, for instance, and does not have a mental retardation, they could potentially receive services through the school system, but they would not be receiving services through a Medicaid waiver.
Vice Chairman Bellew: the autistic kids that go to the school system get services that are funded by the schools? Can they get any help from the state?
JoAnne Hoesel: At this point in time, there isn't targeted funding that goes to that group of people. They would potentially receive services through other existing systems that can often address some of their needs, but it isn't specific to autism spectrum disorder.
Vice Chairman Bellew: when would they come back onto the state rolls? After they get to a certain age? If the age is after they graduate from high school, then they'd go into DD, right?
JoAnne Hoesel: They would not be eligible for a waiver, so they would not receive Medicaid services through a DD waiver. They might receive some Medicaid services through the state plan, if they were eligible through the financial formula or had a disability, but we don't have targeted funding for that group of individuals if they do not qualify for developmental disabilities or have a mental retardation.

Chairman Pollert: is it a Senate bill that there's a $600,000 appropriation for autism and can you tell me what that bill is doing?
JoAnne Hoesel: It asks DHS to establish centers of achievement for individuals that have autism spectrum disorder. It would be through a request for proposal that we would work with an entity that would apply for that and we would then set up this center to make services for the group of individuals and that would be potentially serving youth that would not qualify for the existing DD waiver.
Chairman Pollert: what age group? From age 4 and up?
JoAnne Hoesel: I would have to review that. I do not remember if it had an age specified. Normally it would be up to age 21. It is SB 2268.

Brenda Weisz provided and went over infant development fee for service information, labeled as attachment **TWELVE.**

Chairman Pollert: Are the long term care personal allowances $50 or $55?
Brenda Weisz: We didn't increase that, so it's $50 for nursing homes. Last legislative session, the personal care allowance got moved for those other two groups which is $85 (DD and Basic Care). The nursing homes felt okay staying at the $50. The last time the nursing home was increased was from $40 to $50 in 1/1/2002.

Chairman Pollert stated that committee will be asking for amendments for SB 2012 next Monday (March 28) and closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 28, 2011
16044

☐ Conference Committee

Committee Clerk Signature Julia Hegle

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment), stating committee will be bringing forward amendments to Department of Human Services budget (DHS) today, discussing amendments tomorrow and voting on amendments/budget on Wednesday as a tentative schedule.

Chairman Pollert: any amendments from the committee?

Vice Chairman Bellew: I am proposing that we remove section six of the SB 2012 which keeps the lease rate at $12.50 which the Senate had put in (Prairie Hills Plaza). I am also proposing another amendment. The Senate increased the federal poverty level to 175% for CHIPS eligibility and I am proposing that we bring that level down to 160% which was the original level.
Chairman Pollert: will you be doing anything with the outreach?
Vice Chairman Bellew: I will keep the outreach where it is at.

Representative Nelson: I am proposing that we remove section seven from SB 2012 which is the $.50 an hour increase for developmental disability service providers. This is the $.50 that the Senate put in.

Chairman Pollert stated that committee members and Legislative Council can ask questions following proposed amendments for clarification. He stated that in depth discussion will take place tomorrow.

Chairman Pollert: I am proposing that in section eight, we remove the 7 FTEs that are dealing with Healthcare Reform thus we will remove section eight. The general fund is about $214,000. We had the information in a handout. I also will ask for an amendment that deals with section five, dealing with turn back. The agency wanted to keep the money in

their budget. I am proposing that we are going to pull that out and if we feel it's needed, it will be turned back in as a general fund. I believe that the agencies should not be keeping the turn back in their budget. It should be turn back and then general funds put back in.
Legislative Council: how much of that turn back do you want to put back in?
Chairman Pollert: $12.8M which is the current estimate

Representative Nelson: OAR 501 was capital improvements at the State Hospital ($161,000). I believe that wasn't funded in the executive budget for flooring at the State Hospital. Perhaps it isn't necessary?
Legislative Council: the OAR totaled $1.9M. The executive budget funded $1.8M. The Senate added in $161,840.
Representative Nelson: Okay, I am proposing that we remove the amount that the Senate added in for flooring at the State Hospital.

Representative Kreidt: in regards to HB 1169 (came over to the Senate with a fiscal note) and I'm going to turn it into a general fund appropriation. This is for the educational expenses for nursing facilities. I want to add, out of general funds, $56,423. With the bill passing, the dept expects to have some additional usage and that would cover if there are other individuals that would want to further their education. These monies can be used if there is a need for it. The return on this investment would be many times.
Legislative Council: in addition I will add the Medicaid match dollars (federal dollars) that go with those general fund dollars?
Representative Kreidt: Yes. I am proposing to remove the fringe benefits (general fund - $121,237) for the attorney that is being requested by the dept.
Representative Kaldor: was that a position an added position that is being requested?
Chairman Pollert: it dealt with administrative costs, but I don't think it funded the attorney.
Representative Kreidt: I will have to clarify that. I will bring that information forward tomorrow.
Legislative Council: would you like all the funding for the attorney removed? I believe the dept had added funding, perhaps to fully fund the position. The testimony said that the amount for the additional attorney hired (to add onto what was already in the budget) was $121,237 for salaries. Do you want just that amount taken out or do you want the funding to be removed for the entire position?
Representative Kreidt: let's just have the attorney expenses taken out.

Representative Wieland: there were several internal transfers in IT. I am proposing that the fifth FTE be removed which was for about $118,222.
Representative Kaldor: was that an additional FTE?
Representative Wieland: there were a total of 5 FTE added and I am asking for one of them to be removed.
Legislative Council: the information is on pg 3 of the overview for IT (the third bullet).

Representative Wieland: there were two separate study bills. One was a standalone and the other was included in another bill; both bills of which have been defeated. It has to do with the delivery of the human service delivery system. I am going to read one them here. I have two, but we haven't decided which one of the two to use because the wording is different, but they do the same thing. It would be *to study and develop a plan for restructuring administration and funding of all state and county social service programs.*

Chairman Pollert: is there a second study coming forward that we will have a discussion on tomorrow?
Representative Wieland: there were two studies originally in two other bills (that were defeated). This should be the only one that is coming. We will consider whether to use the wording that was in *02007* or that was in section seven.
Chairman Pollert: are you talking about a study that was being asked for by Vice Chairman Bellew?
Representative Wieland: yes
Representative Kaldor: are we going to get to see the two?
Representative Wieland: I will provide one to you today and bring the other one for tomorrow.
Chairman Pollert: the other one is dealing with the bill that Vice Chairman Bellew had. There is going to be 2-3 studies proposed and I will be asking the department to come forward to answer questions tomorrow as some of these studies might be already be being done. The Medicaid Advisory Council might be already talking about one of these studies.

Representative Kaldor: Senator Mathern brought forward a study to this committee a couple weeks ago about patient centered medical homes. He provided the committee with copies (*02003*)
Chairman Pollert: Yes, that is the other study that we are referring to.
Representative Wieland provided copies of the one that came out of the bill (attachment **ONE**). Tomorrow, the wording of the different studies will be discussed (*02003* and *02007* will be discussed).

Vice Chairman Bellew: I would like a report from the Dementia Care part of the legislation that's in the budget ($1.2M appropriation to Dementia Care), back to the Long Term Care committee during the interim on what they are doing with their money, how many employees they have, who gets the money, etc. I want a thorough report to look at the benefit of Dementia Care. I would like Dementia Care to report to the Department and the Department gives it to Legislative Management who then would get it to Health and Human Services or the Long Term Care committee.

Vice Chairman Bellew: the 302 and 303 OARs were funded in the governor's budget and I would like those removed. The 302 was the CD residential facility at SEHSC and the 303 was the residential adult crisis beds at WCHSC (added 4 beds). That would be two separate amendments.
Chairman Pollert: you can also reference WCHSC (pg 7 of the green sheet, number 12, attachment **TWO**) for clarification on these amendments. It shows on the OAR listing as well.

Representative Kreidt: NCHSC includes $1.4466M for an SMI stabilization unit (OAR 301) and I am proposing to have this removed (pg 6, number 9, attachment **TWO**).

Chairman Pollert: in mental health/substance abuse, there's a federal grant of $4.4M of onetime funding of which I want to allocate it out of that, $250,000 to SADD. I believe it can't go directly to SADD, but rather through an agency and then to SADD. I would like language in there for 1 for 1 matching from an outside party. My hope would be for $500,000 total for SADD. That refers to SB 2314 that was on the House floor.

Representative Kaldor: the amendment that I offered that day has language (you may want to run it through the advisory council) that delineates the purpose and the grants must go to organizations that fulfill that objective.
Chairman Pollert: I will take a look at that language and visit with DHS.

Representative Nelson: there was a $490,502 for an additional staff person at the Cooper House and I asked that be removed.
Legislative Council: it won't be on the green sheet (attachment **TWO**), but rather on the detailed testimony for SEHSC on pg 9.

Vice Chairman Bellew: in the past, we have underfunded salaries and I am proposing an amendment to underfund salaries in the dept. by $750,000.
Legislative Council: $750,000 from the general fund. In the past, we've worked with the dept to determine the divisions and where to underfund. Can we work with them this time?
Vice Chairman Bellew: Yes. In addition, I am proposing a $6.2M reduction in caseload utilization in Medical Services Division. I'll get into the details on that tomorrow. I think that's total funds; not just general funds.

Representative Kreidt: I am proposing amendment .02009 (attachment **THREE**). This deals with section nine, government nursing facility payment out of the healthcare trust fund. This would be a onetime grant which would be $200,000 taken out of that fund.
Chairman Pollert: this is coming out of IGT funds?
Representative Kreidt: that's correct.

Representative Wieland: I am one that is an amendment out of SB 2043 which is $1.75M to add into the agency funding (takes it out of the bill and puts it in there) – provided amendment to committee members. It has to do with the Oregon system. It's 50/50 (general/federal).
Chairman Pollert: that is the funding for the bill?
Representative Wieland: yes

Chairman Pollert: I am proposing an amendment dealing with the county eligibility system which deals with the counties and is on their OAR listing ($42M - $15M general). I am asking to get the system to start the IT process to get the groundwork done. We are going to meet in the special session and discuss healthcare reform. I feel that we need to start working in that direction. It's asking for $25,000 general funds ($250,000 total) – see attachment **FOUR.** This is on a 90/10 match. It'd take up to 44 months to get in place (it wouldn't be 90/10 for the duration).

Vice Chairman Bellew: last session, we rebased hospital physicians, dentists, ambulances and chiropractors. Through the testimony, we found out that physicians were rebased at 142% of Medicare. My understanding is that it was suppose to be at 100% of Medicare, but it was at 75% of costs, which is different from the Medicare rate. I am proposing to reduce the physicians back to 100% of Medicare. That will be about $39M total reduction in the budget, if it passes (see attachment **FIVE**).

Representative Nelson: in that same vein with physician rebasing that took place last session, this isn't meant to be piling on, but as another option for that particular cost center, I would propose that we would reduce the 3/3 rebasing for physicians this session. I believe that's $2,065,704, in the event that Vice Chairman Bellew's motion isn't passed.
Chairman Pollert: you are saying if the amendment for the $16M doesn't pass, is it your intent of taking away the inflator?
Representative Nelson: Yes.
Chairman Pollert: Do you know where the $2M is coming from?
Representative Nelson: that would be the 3/3 inflator that's proposed in the executive budget for Medicaid providers; just for physicians ($2,065,704 general funds - $4,700,204 total funds).
Chairman Pollert: Is it 104% of Medicare?
Vice Chairman Bellew: the information I got said it was 103% of Medicare, but I decided to go to 100% of Medicare.
Representative Kaldor: is that all general funds?
Vice Chairman Bellew: that is the FMAP rate so it would be 55-56% federal and 45-44% general.

Representative Nelson: I am proposing a reduction of 3 beds which would total $519,000 in the Secured Services area of the State Hospital.

Representative Wieland: under operating expense, I am proposing an amendment that the eight human service centers would reduce their operating by $100,000 and all other agencies in DHS to reduce by $375,000, for a total of $475,000 in all of the budgets

Representative Kreidt: I am proposing a $15,200,000 reduction in caseloads in the long term care section (NOT the DD portion; nursing homes, basic care).
Chairman Pollert: general or total?
Representative Kreidt: total funds.

Chairman Pollert: I am not recommending any caseload utilization reductions in the DD section, but I am asking for intent language. I am asking that any excess cost, caseload, in the DD portion be used for transition out of the Developmental Center into the communities. We've hit the caseload utilization in DD in the past. It's my intention not to do that this time. If there is any extra that is NOT used in caseload, it would be used in the transition process (95 to 67).
Representative Metcalf: do you have any idea what the funds would be in that particular instance?
Chairman Pollert: I am not asking for any funds. Let's say the caseload utilization has $1M that they aren't using, thus the $1M would be used to offset the costs to move from DD Center to the communities.

Vice Chairman Bellew: Lake Region Human Service Center added .7 FTE and I would like the funding for that removed.
Legislative Council: I don't see an increase at Lake Region for .7 FTE.
Representative Kaldor: it is not there.
Legislative Council: there was an increase in temporary salaries ($900,000) which represents a .7 FTE for a family caregiver and a .25 FTE for an SMI case manager.

Vice Chairman Bellew: Yes, that's it. I would like just the temp salaries related to .7 FTE to be removed.

Representative Metcalf: I would like add a specific amount of money for the transition purpose which would be adding $1.9M general fund and $2.4M federal funds, for a total of $4.3M
Chairman Pollert: is that an OAR?
Representative Metcalf: that is reduced from the original OAR ($4.7M) – 407

Representative Metcalf: I am asking for funding for two additional FTEs for the biennium ($314,453) for the Catholic Charities and the projects they work on (special needs adoption). Catholic Charities is asking for a 3% inflator increase for each year of the biennium, costing $73,401 (general funds), thus I am proposing to add this in. These would be two separate amendments.
Chairman Pollert: they aren't part of the 3/3?
Representative Wieland: it was left out.

Representative Metcalf: the caseload seems to be rising drastically in Catholic Charities and they are asking for 1 additional FTE to lower caseloads, which I am proposing we fund. I don't know exactly how Catholic Charities are paid. I believe it's a contract.
Chairman Pollert: what section is this part of?
Brenda Weisz, DHS: the first amendment (2 FTE – special needs, didn't have inflation as it's a performance based contract) is from the Child and Family Services area (CFS) and this amendment (to add 1 FTE) is for the DD Corporate Guardianship in the DD policy division ($141,814 - total funds)

Representative Metcalf: there are two other areas where there is a shortage. They are asking for $21,907 (general) increase for legal petitioning fees (Catholic Charities) which is dealing with guardianship. Also, I am requesting 15 additional guardianship slots be funded which would cost $67,342. This is in the DD section.

Representative Kaldor: I am proposing an amendment related to the rural health clinic payments and this is about rebasing as well. This would add general funds of $722,000 and total funds of $1.688M for rebasing rural health clinics to actual cost of providing services. This would be in Medical Services division (see attachment **SIX**).
Chairman Pollert: this is separate from HB 1152.

Representative Nelson: isn't this covered anywhere in Medical Services now?
Representative Kaldor: it was intended to be covered, but it was not. Hopefully we can get some clarification on this.
Maggie Anderson, DHS: In 2002, there was a federal law that was passed that required the dept to begin paying rural health clinics and federally qualified health centers (community health centers as referred to now) an encounter rate. At that time, the rate was set at cost and then based on the way that the federal law reads, that if you pay off of costs, then you inflate by what's called the Medicare Economic Index each year. Those costs are inflated by the Medicare Economic Index, but that index has not kept up with costs. Thus, Representative Kaldor is asking that we would rebase that encounter rate to cost.

Representative Nelson: how many of these areas do we reimburse at cost? How many areas of the Medical Services do we rebase at cost?
Maggie Anderson: within traditional medical services, there would be specific items, such as durable medical equipment where we pay acquisition cost as our fee for certain items. Other than that, things are paid off of a fee schedule and the fee schedule is not necessarily representative of cost. On the long term care side, we pay DD providers, basic care facilities, nursing facilities on allowable costs, based on our rate setting methodology. For instance, we set a fee schedule for dental services, and that fee schedule is not necessarily at cost.
Representative Nelson: Representative Kaldor is asking for rural health clinics to be reimbursed at cost (not allowable costs, but full cost).
Maggie Anderson: They would be rebased to cost and that is still based off of the Medicare cost reports and Medicare sets then what is allowed. The effort that was done to establish that number was based on Medicare cost reports because all of the rural health clinics still file Medicare cost reports. We used those allowed costs that Medicare allows.

Representative Kaldor: I am also proposing for the federal eligibility level for CHIP to be increased to 200%.
Legislative Council: I will look at the information given by Maggie Anderson about the different eligibility levels and the correlating costs and confer with the dept. to clarify costs.

Representative Wieland: there are 39 amendments.
Chairman Pollert: would you have this ready by tomorrow?
Legislative Council: Yes, I will have the amendment list ready as long as I can get a few things clarified by the department.

Chairman Pollert: we will be at the call at chair thus we will likely go in after the floor session tomorrow to do SB 2014 and have discussion of amendments from SB 2012. Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 29, 2011
16158

☐ Conference Committee

Committee Clerk Signature Julie Yeigle

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment) to discuss and vote on proposed amendments that were verbalized by committee members yesterday. Legislative Council provided a list of the amendments (attachment **ONE**).

Legislative Council: the amendments before you are by division i.e. Children and Family Services, Developmental Disabilities Division, thus they aren't listed by the order that they were proposed yesterday. The two amendments on pg 1, attachment **ONE**, that are department wide, will be allocated out to the divisions if adopted. At this time, I am just listing them as one amendment.

Representative Kaldor: Yesterday, I had indicated every amendment brought forth by the committee along with the member that brought them forward. The amendment list does not concur with that order. I am concerned about keeping track of where we are at.
Chairman Pollert: I will help keep track and check off the amendments off as we discuss them. We will go slowly.
Legislative Council offered to go over the amendments in the order that the committee proposed them yesterday.
Representative Nelson: generally what happens is when the narrative begins, the Chairman asks the person who proposed the amendments to explain the amendment and the rationale behind it. It is trackable.
Chairman Pollert: I will make sure all the amendments get heard and we will do just what Representative Nelson just stated.
Representative Kaldor: I will be asking a lot of questions because one of the frustrating things for me (I can't speak for Representative Metcalf) is that we spent about 2 weeks waiting, where I would have liked to have been a participant in the discussions about how these amendments were formulated. So since today is our day, it will take awhile.

Chairman Pollert: We will take however long it takes. We will start with number 1, pg 1 (attachment **ONE**).
Vice Chairman Bellew: Based on the vacant FTE list that we received, I think there's at least this much more that can be underfunded in salaries. It was based on a formula. Last session, we took $1.4M and we had X number of open FTEs, and this time there were about half that many, thus I took about half of what we did last session.
Representative Kaldor: since I am not familiar with that formula, did the dept, this particular budget cycle, follow the same procedure that they did last biennium so that this is a predictable amount of money. How do we know this?
Vice Chairman Bellew: I used the formula based on last biennium which is using the $1.4M as the base and underfunding the vacant FTEs.
Representative Kaldor: We know for a fact that they took that into consideration when they formulated the budget?
Vice Chairman Bellew: they did put underfunding of salaries in their line items. I don't think it was an adequate amount.
Chairman Pollert: if this is done, we had asked for the number of vacant FTE positions as of 12/31/10 and if I'm correct, it was 70+ vacant FTEs. I don't know if that came out in public testimony. We asked what their vacant FTEs were at crossover. I would suspect that you take that difference down which is what's been done in the past, and you bring it forward. I don't think there is a formula.
Representative Kaldor: when did they report the vacant FTE list to us?
Chairman Pollert: we had it at the beginning of the session. There should have been a report at the end of February.
Legislative Council: the vacant FTE report that Legislative Council put out was during the third week of session. We asked for all departments to provide their vacant FTEs as of 12/31. At that time, the Department of Human Services (DHS) had 70.65 vacant FTE. During detailing, DHS reported 48.05 vacant FTEs as of 2/21/11.
Representative Kaldor: how did that compare with our similar status last biennium when we were underfunding by $1.4M?
Chairman Pollert: do you have any figures on how you came up with your estimate on this amendment?
Vice Chairman Bellew: I'd have to find it.
Legislative Council: last session (it would have been HB 1012) DHS's vacant FTE count was 91.68 FTE (12/31/08).
Chairman Pollert: I would guess you would have taken the difference between the 70 and the 40 and then figured out a rough salary and then you either took the entire sum or a percentage of it. My figures state it would be roughly $1M.
Representative Kaldor: if I were to use a comparison between last biennium and this biennium, I come up with a little bit less than the $750,000, but based on the proportion that 48.05 represents of 91.68, it's even less. My concern is that, last biennium there's quite a difference between 91 and 48 and so the closer you get to 0 vacant FTE, the greater likelihood of underfunding salary line item, the greater impact you might have. It's not necessarily in the numbers.
Chairman Pollert: 85.7% (91vacant FTE from last biennium) times $1.4M equals $1.2M and this is a $750,000.
Representative Kaldor: that is exactly my concern which is why I want to find out how we do it.

Vice Chairman Bellew: I took that vacant FTE list (70.65) and divided it by $1.4M that we did last time and that equals $20,000. I multiplied that by the vacant FTE list as of 2/21/11 (48.05) and got $960,000. I thought that it was steep due to what they did within their budgets, so I reduced it to $750,000 for my proposal.

Roll call vote taken on number 1, pg 1, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Representative Wieland proposed number 2, pg 1(attachment **ONE**).
Chairman Pollert: as we detail the DHS budget, I indicate notes where the parts of the budget seem high and indicate in the particular section. For instance, I indicated that the travel expense is high by $50,000 in the Management and Administration section. This is just to explain how I keep track of things.
Representative Wieland: I make check marks as we go through the detailing, indicating the positive and negative changes. For instance, you take the previous year's travel, take year 1 (spend down sheet) and it shows that they haven't taken very much. I realize there is a lag, but you see where they haven't spent 50% in those cases. Thus most of the high costs are in travel, printing, repairs (in some cases), and that kind of thing. In going through these, we found where they were high and rounded it off. If I were to go back through and add it up, it would be considerably more than the $100,000 out of the eight human service centers, but I reduced it down.
Chairman Pollert: It's a cumulative total as you were going through the detail reports of what you wanted to bring forward?
Representative Wieland: Yes it was. We took out more last session, but they are getting more on target which is a good thing. The $375,000 from all the other division and that is also cumulative, but it isn't specified to one agency or human service center.
Chairman Pollert: you are saying of the operating expense and I know they can float between divisions or line items.

Roll call vote taken on number 2, pg 1, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Chairman Pollert: number 3, pg 1 (attachment **ONE**) is next up for discussion.
Representative Wieland: there are two of those where I was informed after we asked for the amendment that these are already been hired (the attorney and the IT FTE). Can we leave those until the end so we could do further research on that?
Legislative Council: The amendment pulls all the funding for those positions out (the attorney and IT FTE). The amount that was provided was just partial of the funding, so I worked with the department and got the correct amount, including the compensation package so there might be a few areas where you will see a slightly different number and I can help the committee with those if they have questions.
Chairman Pollert: Yes, we can delay those until the end.
Representative Kreidt: Yes, that's fine.

Chairman Pollert: number 5, pg 1, attachment **ONE.** This is just a start for the IT. In the special session, this will be addressed further. This gets them going as far as planning and implementation goes.

Roll call vote taken on number 5, pg 1, attachment **ONE** resulting in 7 yes, 0 no, 0 absent thus motion carried.

Vice Chairman Bellew: number 6, pg 1, attachment **ONE.** The explanation I got from the Senate for doing this wasn't adequate and no money was removed. I've heard that the cost increases that will take place in that building are fair so I thought we should remove that and let the dept pay the rental costs.

Roll call vote taken on number 6, pg 1, attachment **ONE** resulting in 7 yes, 0 no, 0 absent thus motion carried.

Chairman Pollert: number 7, pg 1, attachment **ONE.**
Legislative Council referred committee to pg 14 of attachment **ONE** to further explain this proposed amendment. There's an option A and B. Option A was an amendment that had been drafted and Option B was that section from a different bill.
Chairman Pollert: Representative Wieland and Vice Chairman Bellew both had proposed language for studies.
Representative Wieland: we think they basically say the same thing. In speaking with Representative Kaldor, it seemed like he liked option A. I would like option A as well.
Legislative Council: Option A is a required DHS study and states that DHS should present its findings to the legislative management. The legislative management would pick that up and assign it to an interim committee to receive.
Chairman Pollert: B is written the same way.
Legislative Council: Yes
Chairman Pollert: Option A is what we will vote on (committee confirmed by voice that wants to vote on Option A and disregard Option B - confirmed with Legislative Council that committee does not need to vote on Option B)

Roll call vote taken on number 7, pg 1 to include Option A on pg 14 (attachment **ONE**) resulting in 7 yes, 0 no, 0 absent thus motion carried.

Representative Kaldor: number 8, pg 1 to include language written on pg 15 (attachment **ONE**)
Chairman Pollert: I've been told that this patient centered medical homes is medical advisory committee that meets quarterly. I had a discussion with DHS. I was told that they are looking at this model in the advisory committee. They can certainly come forward if the committee would like.
Representative Kaldor: Yes, I would like this.
Chairman Pollert: I don't want us to have a second study if you are studying this through that advisory committee
Maggie Anderson, DHS: the medical advisory committee has identified medical home as a priority for work of the advisory committee. We actually have a sub-committee of the advisory committee who's developing and ND grown medical home (Medicaid population). There is a new state plan amendment available through the federal govt that allows that medical home to be used for the Medicaid population and allows us to include individuals with chronic medical conditions.
Representative Kaldor: will you be reporting during the interim to any of the interim committees on your findings?

Maggie Anderson: that did not happen, for instance, in the last interim. We do have the quarterly meetings and we have legislative representative on that committee from both the policy and appropriations side.
Chairman Pollert: would you like to have someone from the committee give an update to the appropriate committee in legislative management and that way they don't double up on the study?
Representative Kaldor: if this amendment were to go down, then I would like them to report to one of the appropriate committees in the interim. I suppose we could have an amendment that would require the medical advisory committee to report its findings to the interim human services committee or one of the budget committees.
Chairman Pollert: we could have that as language
Representative Nelson: this study is open ended and is not required by legislative management. If this study was amended into the bill and it was duplicative and they could use the advisory committee for that, would they have the latitude, in management, to require the reporting mechanism?
Legislative Council: the study is permissive so legislative management can decide to prioritize it not. If they decide to not prioritize and assign it to an interim committee, the chairman of legislative management would have the authority to add that as a particular study directive to a particular interim committee to have the dept and the advisory committee to report on patient centered learning.
Representative Nelson: There's two parts to this. This issue will obviously get studied one way or the other. The reporting mechanism can be added to this. The other aspect of this, is if we don't pass this, it is going to be amended onto a bill that I would just as soon see clean. I am talking about HB 1152 and it hasn't been voted on yet.
Representative Wieland: could we amend into this that it be reported. It does say that it should report its findings. If this does not pass, perhaps we could do a substitute amendment requiring it to be reported, so that it would be reported to the appropriate committee.
Representative Nelson: on that line on that last sentence it say the legislative management shall report any findings of any committee together with any legislation required to implement the recommendations to the 63rd legislative assembly.
Chairman Pollert: that would have to be separate language
Legislative Council: it would be much cleaner if the committee decided on study language and if you did not like it, we could go to the other option.
Representative Kaldor: I think it would be useful to retain this section for as long as we can, knowing that this bill will be in conference committee.

Roll call vote taken on number 7, pg 1 including written language on pg 15 (attachment **ONE)** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Vice Chairman Bellew proposed number 9, pg 1, attachment **ONE**.
Representative Kaldor: what do you mean by periodic?
Vice Chairman Bellew: quarterly or twice a year would be fine. They can do it whenever budget section meets.
Legislative Council: I worded this section in the way to say periodically and to allow the legislative management committee when they decide the interim structure, they will decide where they'd like this responsibility to lie (with which interim committee). With the word periodically, it allows that staff for whatever committee it gets assigned to, to determine,

with the department and the committee chairman, when the most appropriate time for that to come forward.
Representative Kreidt: that could be annually then.

Roll call vote taken on number 9, pg 1, attachment **ONE** resulting in 7 yes, 0 no, 0 absent thus motion carried.

Chairman Pollert: number 1, pg 2, attachment **ONE** – this is one of the sections that the healthcare reform FTEs are located in.
Representative Kaldor: was this FTE was already there or in the base budget?
Legislative Council: these were added in the executive budget
Chairman Pollert: All 7 of the healthcare reform FTEs are not on staff (one is in economic assistance policy program, one in child support program and five are in medical services). The department had handed out a sheet with the FTEs which explain the 7 FTEs and they add up to the $214,123.
Representative Kaldor: we've had much discussion about the November special session. I am concerned about the work that has to be done running up to November. If it moves forward and we are in a process of implementation, I am concerned that the dept will be behind.
Chairman Pollert: that is why I asked for this schedule.
Vice Chairman Bellew: I would like us to vote on all of the 7 FTEs for healthcare reform (1, 2, 6; pg 2, attachment **ONE**)
Representative Kaldor: these were in addition to existing FTEs and were not already in the dept?
Legislative Council: that is correct. These are new FTEs that were added in the executive budget.

Roll call vote taken on numbers 1, 2 and 6, pg 2, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Chairman Pollert explained numbers 3 (Option A) and 4 (Option B), both relating to federal poverty level for CHIPS eligibility
Vice Chairman Bellew: if the first one passes (number 3), does it automatically defeat the second one regarding CHIPS?
Representative Kaldor: I move we vote on Option B first (number 4, pg 2, attachment **ONE**)
Representative Kreidt: second
Representative Kaldor: We leveraged 4 times as much in federal dollars and this will be a significant help to ensure that we have children covered by healthcare. It's important for our state and healthcare in general. In spite of the fact that we use the net, we remain near the bottom of the states that are providing children's healthcare.

Roll call vote taken on number 4, pg 2, attachment **ONE** resulting in 2 yes, 5 no, 0 absent thus motion failed.

Vice Chairman Bellew: number 3 (Option A), pg 2, attachment **ONE.** We just increased that to 160% last session and with the outreach programs that are in this budget bill, I think

we are reaching the kids we need to reach at the 160% level, so that's why I am taking out what the Senate put back in. The outreach of $650,000 will be left intact.

Roll call vote taken on number 3 (Option A), pg 2, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Chairman Pollert: can you explain number 5, pg 2, attachment **ONE**?
Legislative Council: I added this to with the approval of the Chairman. During detailing, Maggie Anderson provided information regarding CHIPS and it did have a revised premium amount that they received from BCBS-ND that was slightly lower than they received at the time they put their budget together. This amendment reflects changes the amount budgeted for CHIPS to reflect that new revised premium amount which results in a savings of approximately $140,000 ($43,000 is from the general fund).
Chairman Pollert: this has nothing to do with Option A or B?
Legislative Council: that is correct and is the adjustment for the 160%.
Representative Kaldor: based on the premium reduction, we'd actually ensure more children at the Senate's level than they had originally estimated?
Legislative Council: the adjustment has to do with the amount of dollars (versus the number of children) that they dept pays to BCBS for the children that are enrolled. They've received a revised premium amount for BCBS and that is slightly lower than the amount used in the budget. We're holding the number of children constant and just adjusting the amount of the premium.
Representative Wieland: do we have to vote on this?
Legislative Council: yes

Roll call vote taken on number 5, pg 2, attachment **ONE** resulting in 7 yes, 0 no, 0 absent thus motion carried.

Vice Chairman Bellew: number 7, pg 2, attachment **ONE.** The traditional medical services includes inpatient hospital, outpatient hospital, physician services, drugs net rebase, healthy steps, premiums, dental, psychiatric treatment facilities, durable medical equipment, psychological services, ambulances, Indian Health Services and electronic health records. In inpatient hospital, I added up all the actual units of service and divided them out to get 5,005. In the budget they proposed 5,669 units of service. That should be a reduction of $3,475,237 in total funds. That will be at the Medicaid rate.
Chairman Pollert: what costs did you use in your estimations?
Vice Chairman Bellew: I used the budgeted cost on all my estimations (anything that the dept brought forward)
Chairman Pollert: you just looked at caseloads?
Vice Chairman Bellew: Yes. With outpatient hospital, I added them all together and averaged them, I got $174,667. They built their budget on $187,412. I increased that 5-6%. I reduced their budgetary amount by 4,000 units and that comes to $1,619,520 total funds. Next, I went to physician and at this point, I put a 0 at physicians and at drugs. The next one was healthy steps, the CHIPS program. Once again, I thought it was generous in increase for utilization. I reduced their number by 50. It came out to $328,000 total funds (rounded). Premiums and dental services were 0. Psychiatric residential treatment facilities was next. There again, I estimated that they budgeted 100 too many units (based on the numbers they gave us). I took 100 units at the cost they have there and that comes to

$894,336. The rest of them are 0. I added them up and got $6.3M and rounded it down to $6.2M
Chairman Pollert: last biennium, didn't we sometimes take out the high and low and take the average?
Vice Chairman Bellew: I took them all and did an average on all 16 months. I understand that the dept has to build their budget ahead of time and they can only use the figures that they have available at the time.
Chairman Pollert: for instance, under psychiatric residential, I got October as ruled out
Vice Chairman Bellew: I think I took that out
Chairman Pollert: basically it was the months on the graph that you used
Vice Chairman Bellew: yes

Roll call vote taken on number 7, pg 2, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Chairman Pollert: number 8, pg 2, attachment **ONE.**
Vice Chairman Bellew: in explaining option A (number 8), last session we rebased hospitals, physicians, ambulances, dentists, chiropractors, etc. but during conference committee last time, the physician rate was raised from 25% to 75% of cost. I was always under the assumption it was Medicare cost, however it was their actual billing expenses that it was raised to. Currently they are getting a reimbursement of 142% of Medicare costs and my amendment would bring them back down to 100% of Medicare.
Representative Nelson: it's Medicare *allowable cost* versus actual cost
Vice Chairman Bellew: Yes, that is right; I meant to say allowable cost.
Representative Nelson: that is a significant difference. Obviously there is a misunderstanding that took place. Those facilities that received this are across the board. That's your PPS hospitals and critical access hospitals and well over 80% are hospital based (the physicians). With this reduction, we affect hospitals across the state. I believe that Option B is a better way to more forward, but I'll wait for that.
Representative Kaldor: I hope we resist this amendment. This has a significant fiscal impact and it won't go unnoticed.
Chairman Pollert: I'm going to pull out all the numbers from last biennium because a lot of people don't realize how much of a cost happened last biennium. We had the ARRA funds in there so people weren't as informed as our section was. Hospital rebase on 100% of their reportable costs and physicians in the governor's budget were at 25%. The Senate put it up to 75%. On my part, I had a misunderstanding. With going to 100%, it puts at around 50% of physician's cost. I did have a figure of like 52% if it was based off of 103%.
Representative Wieland: I am disappointed that this wasn't brought forward to address the mistake that was made. There has been no discussion with any of the recipients. It wasn't intended and it isn't fair to the others. If we are going to have a substantial increase, it should have been across the board and not one area. I feel it needs to be adjusted.
Chairman Pollert: I should have asked more questions when the 75% came out. I would have never agreed to 75% of physician's cost if I would have known it would have been 142% of the Medicare.

Roll call vote taken on number 8 (Option A), pg 2, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion carried.

Vice Chairman Bellew: in that line item, do you have the federal and general funds reversed?
Chairman Pollert: is this an FMAP? Is the total right of the $39M?
Legislative Council: Yes, the total is right. Vice Chairman Bellew is correct thus the $17,448,925 is the general fund and $22,037,214 from federal funds.

Chairman Pollert: number 9 (Option B), pg 2, attachment **ONE.**
Representative Nelson: that would be to remove the 3% inflator that's in all the Medicaid provider budgets. Given the fact that is it a conference committee discussion point, I think it's appropriate that we can pass both of these.
Vice Chairman Bellew: we can discuss the 3/3 for physicians based on the one we just passed, right, in conference committee?
Chairman Pollert: I haven't seen anything on inflators yet so can the inflators discussion occur in the conference committee? This would reduce it down to Medicare at 100%. If we approve Representative Nelson's amendment, they are at 100% and the 3% inflator does not take effect, so we would be pulling them away from the 3%.
Representative Nelson: that is true. It's going to look even more punitive to physicians at that point.
Chairman Pollert: do we want to leave this until tomorrow morning so we get more information?
Legislative Council: by the strictest interpretation, perhaps it would be off the table in conference committee. You just made an amendment that affects Medicaid payments to physicians that can be interpreted in a broad sense, which would include inflationary factors.
Representative Kreidt: I would recommend we vote on this one.
Chairman Pollert: anything that comes up in discussion, no matter what topic, does that mean it's germane for discussion at conference committee?
Legislative Council: if we look at the rules for conference committees, they would state that the conference committees work out the differences between the two bills. Perhaps for appropriations that's different because we are talking about an entire budget for an agency, but typically they are instructed to look at the differences between the two bills.

Roll call vote taken on number 9 (Option B), pg 2, attachment **ONE** resulting in 4 yes, 3 no, 0 absent thus motion carried.

Chairman Pollert: number 10, pg 2, attachment **ONE**
Representative Kaldor: this was brought about after having discussion with rural healthcare clinics that may be associated with or working with a critical access hospital. Most of these clinics are operating at a loss and the concern is that we don't lose them. It was my understanding that there was some intention that this be included in the governor's budget (for some reason it wasn't in there) which is another reason why it was brought forward.
Representative Nelson: I don't remember this coming to us in overview or in public testimony.
Representative Kaldor: I learned of it after the overview.
Chairman Pollert: I've gotten e-mails on this as well. I understand what they're saying. One of the e-mails has an amendment requesting that critical access hospitals that operate

a rural health clinic be paid cost by the Medicaid program. Would that have changed any votes on HB 1152? I don't know.
Representative Kaldor: as I understand it, that might be part of the issue. While they are co-located, they are not related in how they are reimbursed. The clinic can't get subsidized by the critical access hospital for its deficiencies. In other words, they may be co-located or combined, but the reimbursement to the clinic cannot be balanced out by the critical access hospital.
Chairman Pollert: they are considered separate facilities
Representative Kaldor: yes
Representative Wieland: Are the clinics part of the rural hospitals? Do they own real-estate separate?
Representative Kaldor: I can't answer that with a firm response. I think that they are oftentimes associated where they might be part of the same structure or part of the same facility, but their reimbursement does not blend. You have a clinic with physicians that are reimbursed and you have the critical access hospitals that are reimbursed from Medicaid. It is my understanding that they were supposed to be rebased and this was not done, thus they are coming up short as a consequence. If they are associated with a critical access hospital, they can't use that hospital to balance off their shortfalls.
Representative Nelson: I always thought there was another funding formula (federal money) that funds for underinsured and low income. I feel uncomfortable passing a bill when no one came forth and explained the rural health clinic concept to us and made a case for the funding. Here is a situation where no one came to the table on either the senate of the house side and asked for something in an amendment.
Representative Kaldor: there are a lot of things we are doing in the budget for the first time without necessarily getting feedback from the participants. It did come to my attention after it had been dealt with in the Senate.
Representative Nelson: are you indicating that this was discussed in the Senate?
Representative Kaldor: No, it was discussed after
Representative Nelson: most of the things that are being proposed have included explanation. In my 3 sessions, I don't believe rural health clinics have ever come to the table.
Chairman Pollert: it seems like we did rebasing and now there is something else out there and did we miss something.
Representative Kaldor: I feel ill-equipped to explain all the ins and outs of this issue. Perhaps someone from the department can speak to this.
Chairman Pollert: you can certainly have someone come forward to provide general information.
Maggie Anderson, DHS: I will first address the question about the rebasing. When we were directed by the 07 legislative assembly to rebase the 5 provider types, rural health clinics was not included in that. Physician services were, but in Medicaid physicians in rural health clinics are two different Medicaid provider types and specialties. The federal govt dictates on how we pay rural health clinics. We have to pay them on an encounter. So, if someone goes into a physician practice and they have broken their arm, they pay us a CPT code for that service and we pay based on our fee schedule for that CPT code. It could be $500. If they go into a rural health clinic and they need a vaccine or they go into a rural health clinic and they've broken their arm, they receive the same encounter rate for that because they receive an encounter rate regardless of what the service. In the interim, the rural health clinics and the federally qualified health centers did approach the dept and

asked us if we could provide them information and assistance in looking at what it would cost to rebase their encounter rates to cost. We did assist them with that effort and provided that information to them. It was not included in the dept's base budget or as an optional adjustment request.
Chairman Pollert: it wasn't included in a bill anywhere either, right?
Maggie Anderson: No, it was not.

Roll call vote taken on number 10, pg 2, attachment **ONE** resulting in 5 yes, 2 no, 0 absent thus motion failed.

Chairman Pollert closed hearing on SB 2012 to consider discussing and voting on proposed amendments to SB 2012 tomorrow.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 30, 2011
16160

☐ Conference Committee

Committee Clerk Signature Julia Jeiser

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment), stating committee will continue discussing and voting on proposed amendments. The list of proposed amendments are labeled as attachment **ONE.**

Representative Nelson: number 11, pg 2, attachment **ONE.** It's important for all providers in the agency that the 3/3 inflator is included and that is more important than the $.50 increase for DD providers. It's a matter of prioritizing.
Representative Kaldor: the Senate added $.50. Was it an optional request in the budget?
Chairman Pollert: I don't see it on the OAR list (OAR list is labeled as attachment **TWO**).
Representative Wieland: It was on a request list from the providers. They actually wanted $1.46 plus 7.65% inflator.
Representative Kaldor: I don't think their request was unreasonable. This is an area where we certainly want to minimize turnover to the extent we can to ensure better care and it's seems as though we are always playing catch up in this area. There are some parts of the state where we absolutely can't compete. For that reason, I think this is one of those additions that the Senate made that is reasonable and smart. Regardless of the 3/3, I think we are still playing a bit of catch up in that area. I hope we resist this amendment.
Chairman Pollert: I will support this amendment. Last biennium, we had the dollar and 6/6 and in looking at the DHS budget, I think we need to slow down a bit.
Representative Kreidt: there is never a point where we are ever going to catch up in this industry and will always be catching up. It would be nice if we could, but there just aren't the dollars to do it.
Chairman Pollert: the legislature has done better than the average CPI and since 2005, the average on CPI, with what we've been giving for inflators, is better than what the CPI has averaged.
Representative Nelson: I agree with what Representative Kaldor said about the DD providers, however that same statement could be made for all Medicaid providers and

that's where this comes down to. If we could give everything to everybody, then they are the most deserving. It comes down to picking some winners and losers in this whole formula thing. If it comes at the expense of the inflator then somebody else is going to fall behind farther.
Representative Kaldor: I understand what you are saying and I understand that we've kept pace with CPI. The issue is that we've started at a low level in regards to pay (teachers, DD providers, etc.) in the state of ND. That's where we've been trying to play catch up. Our economy is changing, now, dramatically because the demand for workers, especially in the oil patch, is having an effect and that effect is reaching further across the state than it used to.
Representative Wieland: I intend to oppose this amendment. In a sense, I agree they are further behind. I do want to remind everyone that in the last session, the governor didn't have anything in there for increases and salary and this section came forth with a good package that really helped them. I got quite a few e-mails from people, stating that turnover was cut down to 20-25%. These employees take a special kind of person as they often don't get paid very much, but have a dedication from the heart.

Roll call vote taken on number 11, pg 2, attachment **ONE**, resulting in 4 yes, 3 no, 0 absent, thus motion carried.

Chairman Pollert: number 12, pg 2, attachment **ONE.** I think turn back should be thrown back into the general fund and then, if it's felt that we need to throw the money back in, that we do it through the general fund. There was language in section 5 of the bill (.02000) that we would need to delete.
Legislative Council: along with this amendment, we would be dealing section five, relating to carryover authority. In the amendment that will be drafted, we will reflect $12.8M of additional general fund revenue, representing the turn back coming in. We will be inserting a new section into the bill and that's the first section on pg 14 (attachment **ONE**).That relates to the general fund transfer to the budget stabilization fund. Federal regulations prohibit states from depositing any general fund dollars that are freed up due to the enhanced FMAP into a rainy day fund. Last session, the legislature put a similar section into the appropriation bill for DHS so they could prove to the federal govt, when they get audited, that none of the enhanced FMAP dollars went into a rainy day fund. We'd be inserting a similar section into the appropriation bill for this time.
Representative Kaldor: explain to me the net effect of this. Basically, we are putting an estimated number that would have carried forward in 13-15?
Legislative Council: in the executive budget, the governor reduced the dept's appropriation by $12.8M of general fund and then he allowed them to carryover what they anticipated would be unspent dollars from this biennium (09-11) in to 11-13 to use. We are reversing that. We are going to show revenue coming in of the expected turn back of $12.8M and then we are going to appropriate the $12.8M
Representative Kaldor: would it be possible for Office of Management and Budget to explain why it this was the appropriate thing to do? I know it has been done in other budgets.
Office of Management and Budget: It was done for the reason that we weren't allowed to put money into a rainy day fund. Since it was the stimulus money, replaced FMAP money, we felt it was appropriate to leave that money in the budget to use it for other medical

services and long term care. This way they could carry it over and continue to use it for those purposes in this next biennium.
Chairman Pollert: it is a philosophical difference between what the governor's budget shows and what this is. I much rather see turn back go back to the general fund and if it's needed, throw it back in. It's basically budget neutral.
Representative Kaldor: we are appropriating those dollars and not affecting any services.
Chairman Pollert: yes. This amendment includes the language on pg 14 (first section), attachment **ONE.**
Legislative Council: Yes it does.

Roll call vote taken on number 12, pg 2 and language in first section on pg 14, attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Representative Kreidt: number 13, pg 2, attachment **ONE.** HB 1169 was introduced last session and there were issues with the wording. We came forward with 1169 to correct that this time. This is in regards to educational funding for individuals in facilities to better themselves. We carried a fiscal note through policy and when it got to appropriations, we turned it into a general fund because the dept feels, with the change in the language; we might experience additional usage with individuals to go ahead and get some further education. It's appropriate to have the funding in this budget. I feel the return on the investment will be many times over.
Chairman Pollert: the funding mechanism in 1169 is not longer there as it's in this bill?
Representative Kreidt: there was never any money in 1169 as it was a policy.
Representative Kaldor confirmed that HB 1169 passed the Senate Human Services with a Do Pass, passed Senate floor and re-referred to Senate Appropriations .
Legislative Council: 1169 is in Senate Appropriations committee and I believe they are waiting to see if the money is added in this bill.

Roll call vote taken on number 13, pg 2, attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Representative Kreidt: number 14, pg 2, attachment **ONE.** It's money out of the community healthcare trust fund to go to a facility that is having problems with their bottom line. It's a small token to help this facility out.
Representative Kaldor: what is the status of the healthcare trust fund after this expenditure?
Representative Kreidt: after this one goes out, about $600,000 will be left in there. There was a $200,000 appropriation that went out last session to a project, which will likely not happen so that $200,000 will be coming back.
Chairman Pollert: didn't you have another bill that was being discussed before crossover with some IGT funds?
Representative Kreidt: Yes, I did, but that was cumulative. It should go back up to about $800,000
Representative Kaldor: is this kind of transfer going to be required next biennium?
Representative Kreidt: this is onetime
Representative Nelson: there are so many critical access hospitals that could use this infusion of cash. I understand McVille's situation that the IGT money would not have come into this state had it not been for those two community owned nursing facilities (Mcville and

Dunseith) and I know they are struggling. However, many are struggling. 24 of the 36 critical access hospitals are losing money. HB 1152 was introduced to do exactly what we are doing for one hospital and that changed to a different formula.

Roll call vote taken on number 14, pg 2, attachment **ONE**, resulting in 4 yes, 3 no, 0 absent, thus motion carried.

Representative Kreidt: number 15, pg 2, attachment **ONE.** From previous years, they have changed the formula for calculating costs. They use units; I go by census days – same thing. I used a higher number than what the dept is using right now. I used 63 total beds out there and reduced it by 100 (80 out of the caseloads). I'm anticipating, if1325 passes, we are going to see 20 beds come out of that. We've got the PACE program thus we'll lose nursing home beds. I used a number of 100 days and using 366 (next year – leap year) times 100 beds times the rate ($187) [recording error – about 3-4 seconds not recorded here] that gets you that amount.
Representative Kaldor: as a percentage, what reduction does that account for?
Representative Kreidt: we didn't put it in a percentage. Most of the turn back last time, came from this area.
Representative Wieland: 3.3% is the percentage I believe. I know that the state of ND is aging and more are expected to go into nursing homes, but it appears that is going the other way because of additional programs and people are staying in their homes longer. Do you expect that to continue to a point and then start going the other way or have we reached the maximum of nursing homes, in your opinion?
Representative Kreidt: I don't have a crystal ball to give you an answer, however I believe we are going to see facilities positioning themselves to where we will probably see a realistic number (in the next 2 years) in what we are going to need in long term care. Currently, beds for basic care are more in demand than they have ever been. Through the process, I felt that basic care numbers should stay where they are. Assisted living is very popular and continues to grow. If we wind up somewhere around the 6,000 number, that will be a number that will stay in place as we go in the future.
Representative Kaldor: this particular amendment includes all services, correct?
Representative Kreidt: Yes; there were a number of them that we left where they were, however, but I examined all the services. Out of all the programs, there were four and the rest were kept the way that the department had indicated when it brought the budgets forward. These include basic care, personal care, SPED, PACE, targeted case management, children's medical/fragile waiver, hospice waiver, technology waiver, ISLAs, ICF/MR, and day supports. The four I did make changes to include home and community based services waiver ($730,000 is a rounded number I used), nursing homes ($13M), expanded SPED ($35,000), children hospice waiver ($796,000)
Representative Kaldor: the children's hospice waiver anticipates 30 recipients, and you are proposing a 45% reduction. Are we going to run into a problem here?
Representative Kreidt: they can shuffle the money around if they run into a problem there. I feel these numbers are conservative that there should be no issues for all of the programs to continue running the way they are.
Chairman Pollert: in my notes, I indicated "kept in $1M for approximately 17 kids" and if I look at the 770 off the front total pg and then look at the detail...well, that's how I came up with my calculation.
Representative Kaldor: I was trying to recollect that explanation.

Chairman Pollert: I make notes as needed and ask the dept for clarification.

Roll call vote taken on number 15, pg 2, attachment **ONE**, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Representative Metcalf: number 16, pg 2, attachment **ONE**. This is an OAR (407) to transition people from the Developmental Center to the communities.
Chairman Pollert: this is related to another OAR, but you didn't use the total amount on the OAR sheets?
Representative Metcalf: Yes
Representative Kaldor: the OAR requested $2.7M general funds and you are putting in $1.9M?
Representative Metcalf: Yes
Representative Nelson: I agree that we have to provide transition funding for the DD center to get down to that 67. The other approach that makes sense is to leave the DD line alone (not taking any reductions in DD caseload utilization) throughout that whole cost center. I think there's an amendment and legislative intent that the money that is saved in caseload utilization would go toward that. It's addressed in two different areas. We'll end up doubling up if we pass this one, along with the other proposed amendment I mentioned.
Chairman Pollert: Next, it would be my intent to go down to the bottom of pg 3 in relation to this same issue, depending on how this vote goes. On the second option, there is language that I requested that is illustrated on pg 15, attachment **ONE.**
Representative Metcalf: we cannot allow the DD center to be shorted on this transition.
Representative Nelson: The DD Center has been able to lower their bed count without an identified motion like this and they have been able to do it within the budget. In the past we have taken from their caseload utilization, but the other option indicates we won't do that as the transition is a priority. We've done more to ensure that this time than we have in the past.
Chairman Pollert: 2 biennia ago, we took out $8.5M out of caseload utilization. We did not touch the DD caseload whatsoever for my proposed amendment.
Representative Metcalf: there was a determined need for this (OAR – 407). They have not let me down as far as any of these figures are concerned. I urge everybody to follow this motion.
Representative Kaldor: was the reduced caseload factored into the budget? Because if it was there will not be excess dollars for transition.
Vice Chairman Bellew: the OAR is a total of $6M. That is 1.5% of the total DD budget. I think they can find that amount in their existing budget without us adding.
Representative Metcalf: It is my understanding that this money is needed by the State Hospital. I realize that they intertwine these budgets and I don't exactly know how they do this. The State Hospital is responsible for making these transitions.
Vice Chairman Bellew: I got my figures from the total DD grant line item. That is part of the transition out of the state hospital in Grafton.
Chairman Pollert: It's not in the governor's budget, but yet their testimony says their goal is to go to 67 so you could look at that and question the figures.
Representative Kaldor: that's my question. Was the budget based on lower case utilization already? Is that why the OAR is there?
Office of Management and Budget: the agency's goal is to get down to 67 people, but due to prioritization of the funding that they had already put into their budget, we weren't

able to add additional funding for that, so we were encouraging them to continue to try to transition people within their means.
Chairman Pollert: if they see budget savings in DD Center, they could use that money as well, even though there is a reduction of salaries.
Representative Nelson: if the money isn't realized in caseload utilization, would the transition still take place and they go to a deficiency appropriation?
Chairman Pollert: that would be a decision by the agency. If there isn't any money from the caseload utilization, the dept could still look at their overall budget and decide whether they want to want to transition out of the DD center (if there is money elsewhere).
Representative Nelson: they have flexibility within their total budget to do this, even outside of the DD line?
Chairman Pollert: Yes. We aren't telling them to use money from different areas, but they could do that.
Representative Nelson: there is a provision that if the money isn't there, the transition wouldn't stop. At the worst case scenario, they would go into a deficient situation and the transition would continue.
Legislative Council: this goal of transitioning to a certain number is outside of statue, so it would depend on the dept if they wanted to continue to reach that goal and get there with no funding and risk coming in for a deficiency appropriation.
Representative Nelson: they would have the discretion to make that decision internally, but it wouldn't be required by statue?
Legislative Council: yes
Chairman Pollert: they were making those decisions last biennium to get down to 95 because we didn't allocate any dollars to go down from the DD Center.
Brenda Weisz: In our DD caseload last biennium, we built in the transition of 17 individuals which is why we were able to do the transition.
Chairman Pollert: there is caseload for transitioning in these numbers this biennium?
Brenda Weisz: No. If you look at the spend downs that were handed out this time, we're walking you through the last year of the biennium to show you what we got and that is what you are seeing for the last year of the current biennium, the 8 that are being transitioned. Last biennium, 9 were transitioned the first year and 8 the second year. If you look at our budget that's before you for 11-13, there are no transitions built into our DD caseload. This is the reason the OAR was developed.
Chairman Pollert: Did we hit on DD caseload last biennium?
Brenda Weisz: Yes, you did make an adjustment.
Chairman Pollert: You had into your budget last time, but House Appropriations Human Resources Division did reduce DD caseload, even though you still had it in your budget, so we kind of had a double-double there. We reduced it more than $2M. You still had it in your budget so you still got it done.
Brenda Weisz: there was delay in the transitioning. It balanced out.
Chairman Pollert: we are talking $2M here, so we aren't hitting DD at all as far as caseload utilization so if those numbers are there, you could possibly do that again with the legislative intent language and go toward the caseload.
Brenda Weisz: We appreciate that you have not hit the DD caseload. We built our budget with the intention that all of those that would be in the community would be in the community as we presented to you, so we don't build our budget with fluff. If something changes, we could then look at the possibility of doing that. We already have the intent language in our bill; section three.

Representative Kaldor: there might be a little bit of a timing issue and making the transition. If it's in the budget, you can plan for it, and if it's not, you don't know.
Brenda Weisz: Let's just say that we only have a DD budget; no other parts. We would have to start the biennium and serve our clients in the community and wait and see. We would have to go for awhile and see what would happen and see what our clientele does before we would be able to see if we could do a transition. The OAR would allow us to move with a transition sooner than later.
Chairman Pollert: I know there is a timing issue because you aren't going to want to transition out until you have a better feel regarding your budget.
Representative Kaldor: in the OAR, the general fund request leverages those federal dollars. If you find that your caseload is down and you are able to utilize those dollars for transitioning, are you still able to leverage those federal dollars based on whatever amount you can put into it?
Brenda Weisz: Yes
Representative Metcalf: These are people that we are talking about; not dollars. I've heard that if you can't transition, then you can carry it forward which means people will stay there in the DD Center and not be moved out. I would hope we can look at this as a need of service to the people that are in that DD Center. If I were restricted to my movements based on living in that developmental center, I would not be the happiest person in the world. The Olmstead Act basically says you will transition these people out. I understand you feel that you have other methods to get this accomplished, but I hope there is no delay with the transition.

Roll call vote taken on number 16, pg 2-3, attachment **ONE**, resulting in 2 yes, 5 no, 0 absent, thus motion failed.

Chairman Pollert: number 8, pg 3 including language from pg 15, attachment **ONE.** He went over the language.

Roll call vote taken on number 8, pg 3 including language from pg 15, attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Chairman Pollert adjourned meeting with plan to reconvene later in the morning after full appropriations committee meets.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 30, 2011
16185

☐ Conference Committee

Committee Clerk Signature Julia Hejfe

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment) to continue discussing and voting on proposed amendments. List of amendments is labeled attachment **ONE**.

Representative Metcalf: number 1, pg 3, attachment **ONE.** Catholic Charities does not have FTEs as we know them. They have contract with the Department of Human Services (DHS) and with that contract they are given so much money and with that money, they are authorized to spend it. They said they need additional money to hire additional staff.
Vice Chairman Bellew questioned the difference in the proposed amendment and the testimony given from Developmental Disabilities.
Legislative Council: you are talking about two different sections. Representative Metcalf is discussing the one in the Children and Family Services division and Vice Chairman Bellew is referring to Developmental Disabilities (DD) division. Catholic Charities had two distinct testimonies that they provided during public testimony. One related to special needs adoption (current proposed amendment) and the other related to DD and guardianship.
Chairman Pollert: My understanding is these are set price contracts. With this amendment, are we trying to re-negotiate?
Representative Metcalf: Yes. They are trying to get this added to their contract that they have.
Representative Nelson: I don't see this on the OAR. Was this presented to Office of Management and Budget in the discussion of the budget for DHS?
Office of Management and Budget: It was not an OAR.
Chairman Pollert: there wouldn't have been anything from the department on this issue and the information we got came from public testimony.
Representative Nelson: Is the baseline level with last biennium? Is there any kind of inflationary increase in this budget as compared to last time?
Representative Kaldor: according to the testimony, it's the same as the 09-11 biennium.
Chairman Pollert: wouldn't there have had to been a re-negotiation every 2 years?

Brenda Weisz, DHS: The service that we are talking about (AKS contract) was RFP (Catholic Charities won the award) and we have a renewal option on the RFP. I am not sure if it's negotiated or renewed at our option at the same level. That is where the negotiations would take place.
Chairman Pollert: there would have been a negotiated price on the RFP at this time?
Brenda Weisz: If our renewal options we may renew as our budget was at a hold even.

Roll call vote taken on number 1, pg 3, attachment **ONE,** resulting in 2 yes, 5 no, 0 absent thus motion failed

Representative Metcalf: number 2, pg 3, attachment **ONE.** This is an inflationary adjustment for the contracted employees for special needs adoption.
Chairman Pollert: if the 3/3 inflators that we have in the budget are not included, it's a performance contract?
Brenda Weisz: when we look at our contracts, the whole inflationary concept comes from starting with the grants. They get paid a fee for service in all our granting schedules (long term care, medical care). There are contracts that are paid a daily fee (corporate guardianship) and those we put an inflationary factor one, like daily fees and the county contracts. Since this was a performance based and it's a rather new concept that started a couple biennia ago, we don't have an inflation factor on a performance based contract.
Chairman Pollert: these are contracted rates that were set up when the contract was originally RFPd out?
Representative Nelson: if we are going to compare apples to apples, how many approximately of these performance based contracts that are out there, don't provide a 3% inflator for their workers?
Brenda Weisz: there's not a whole lot.
Chairman Pollert: it seems like when we had rebasing on rural clinics yesterday, you question when you see something that's not rebased. You can get this information to us at another time.
Brenda Weisz: we pay on a pay point. It's difficult to inflate that. We need to go back and look at the contract and as we do adoption, etc., we should be looking at whether those pay points should be adjusted. That's what we need to do when we build our future budget. That's the perspective and thought process when putting inflation. When you look at a fee that you pay for Catholic Charity, doctor, hospital, dentist, and look at inflation, you have a basic fee. You're not looking at an outcome and then you inflate that forward. We don't have many contracts that are performance based in this fashion like 1, 2, or 3.
Representative Kaldor: how frequently do we do these RFPs?
Brenda Weisz: Generally speaking, we do an RFP and we try to put in 2 renewal options for a 2 year period. You'd get a vendor for a 6 year period. We are exercising our second renewal so this will be their 6th year and then it will be up for RFP the next time around.
Representative Kaldor: when they're developing their proposal, that's a consideration that the service provider should be considering in that proposal (when submit their response) how costs change over that 6 year period.
Brenda Weisz: Yes and then we analyze that and rank it.
Representative Kaldor: in an RFP, do we request consideration for inflation or do we have any kind of flag...if someone were to submit a proposal to the dept and it doesn't include any inflation whatsoever, is that something that would trigger a red flag that this is something that needs to be discussed? Is it included in the RFP?

Brenda Weisz: when we did this 4 years ago, there wasn't anything in the RFP at that time and that was the very first of its kind that we did with a performance based. The AKS contract was paid differently at that time. The reason we did a performance outcome contract was to get a handle on the process and on the cost. We have learned what it takes and what we can do differently. In our next RFP, there will be differences from what we have learned.
Representative Metcalf: there are three more concerning these RFPs. If these 3 aren't listed in the contract that you have right now, is there any way of getting them additional funds for the work that they've expended or is this something that they are just going to have to eat up or cut back until they get a new contract?
Brenda Weisz: For the 3, we did reprioritize internally within the dept and the executive budget does include additional $141,814 additional money for the corporate guardianship contract. This is a contract that has inflation as they have a daily rate. As far as coming and doing that at this point in time, when it comes to additional petitioning, what we have done in the past is we've wait to see the rollup in that contract. If the number of wards hasn't come on as the contract states, we've used that rollup in the contract to pay for additional petitioning. According to their testimony, they are saying that they don't feel that that's going to be available.
Chairman Pollert: you mentioned the $141,814. Did you say this amount is in the budget right now and is funded?
Brenda Weisz: Essentially, they needed two and this is the other piece that they are bringing forward in public testimony. They did come to us during the biennium and we talked about it in detailing that we did add it and he had in his testimony that we did provide the 141,814 this biennium and continued it by reprioritizing into our next budget. The Catholic Charities still needs an additional 141,814. There are times where we have had to make adjustments. We do work with Catholic Charities in their adoption contract throughout the biennium too if there are circumstances that occur during the biennium within that contract.
Chairman Pollert: you did do an allocation increase, but they are asking for another?
Brenda Weisz: Yes, it's related to an accreditation review that they had with caseload standards.

Roll call vote taken on number 2, pg 3, attachment **ONE**, resulting in 2 yes, 5 no, 0 absent thus motion failed

Representative Wieland: number 3, pg 3, attachment **ONE**. SB 2043 deals with the changing of how we look at money that's provided to individuals (4500). SB 2043 is a standalone bill that has $1.775M in it. This amendment takes the money out of the bill and puts the money into the department (amendment is labeled as attachment **TWO**). The amendment is to pull the section of appropriations out of SB 2043. This will come up in full appropriations.
Legislative Council: SB 2043 was discussed yesterday when Rep. Weisz was before full appropriations committee
Due to Vice Chairman Bellew's request, Representative Wieland reviewed contents of SB 2043 (attachment **THREE**).
Vice Chairman Bellew: how are you going to determine which ones to assess?
JoAnne Hoesel, DHS: The consultant would assist us in identifying how best to identify the individuals that would give a true representation of the whole DD population (high need, low

need) so that the new rate process can be applied and be reflective of true costs that the providers incur as they provide services. It could be by provider, by so many in an area – the consultant would guide us in that.
Chairman Pollert: this would be a start as it contains just about a third of the caseload?
Representative Wieland: Yes that's correct
Vice Chairman Bellew: this process won't start taking place until June of next year because of the MMIS delay?
Representative Wieland: we can't institute the program until after MMIS is actually operational.
JoAnne Hoesel: We have extended the process. We won't actually change the IT system until MMIS is available. We will be modeling the impact of the new reimbursement system on those individuals that are assessed with a new assessment tool called the SIS (Support Intensity Scale). We will be able to make any adjustments in the rate setting to make sure that it truly reflects cost. We'll have a negotiation process with the providers. Once the MMIS is ready to go, the IT transition will be made to reflect what we've learned through the modeling process and the development phase.
Vice Chairman Bellew: are you going to be able to do it within your current limits?
JoAnne Hoesel: the development phase is onetime costs that, through the consultant and new assessment, will change the process. This has no impact on cost of services and is an administrative function change. At this point, there is enough money in the system for services. This is the consultant and the new assessment to make the switch over.
Chairman Pollert: you had brought forward a schedule of what you felt were the costs and where the savings start showing up.
JoAnne Hoesel: the savings start in year 5 - once you get all of the individuals assessed and in the new process.
Chairman Pollert: there would have to be more money appropriated for the other 3000 people coming into the next biennium for the assessment.
JoAnne Hoesel: Correct, there will be some additional consulting and the IT transition.
Representative Wieland: it would also involve the SIS which would be for the other 3000 people as well. / I've made a list of why this is a good system and why we should be doing it and have come up with 10 reasons. I have them available for anyone who wants to see them. Because of the way this things work, we should see elimination of handling of paperwork because at the current time, paperwork is being handled 9 times before payments are made.
Vice Chairman Bellew: You have a line item under DD called your bucket funding. Could the money go away?
Brenda Weisz: I don't think it will be separated out as bucket money because it will be a prospective rate setting system. You won't see bucket money. It'll be a different payment mechanism.
Vice Chairman Bellew: could the dollar amount go away?
Brenda Weisz: No. We are going to be spreading it out because we are doing it over three biennia now as you are doing fewer people. It makes sense to spread it out like we are doing. The first fiscal note you saw on this was bigger and now it's smaller and we are going to spread it out and do fewer people and do the pilot over 3 biennia. The savings might come a little later than 5 years because we are doing the analysis over 3 biennia.

Roll call vote taken on no. 3, pg 3, attachment **ONE** including amendment .02010 (attachment **TWO**), resulting in 6 yes, 1 no, 0 absent, thus motion carried.

Chairman Pollert adjourned to reconvene on SB 2012 tomorrow morning after floor session.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
March 31, 2011
16247

☐ Conference Committee

Committee Clerk Signature Julia Jeffe

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment) to continue discussing and voting on proposed amendments. The list of the amendments are labeled as attachment **ONE**.

Representative Metcalf: number 4, pg 3, attachment **ONE.** The caseloads are increasing in number and severity, especially in our youth. This could be related to drug and alcohol abuse. The caseloads are above the nation average; nearly double at 1 FTE to 38 cases versus the nation average of 1 FTE to 20 caseloads. These FTEs are considered the same FTEs as they would in the govt operation. They are contracted. The average social worker working for Catholic Charities in guardianship currently works about 56-58 hours a week, with no extra compensation as they are on contract. I hope we can add the extra FTE that they have requested.
Chairman Pollert: HB 1199 is a guardianship bill. There's a study in that bill.
Legislative Council: When HB 1199 left the House was a study of guardianship services for vulnerable adults in the state. That bill has since been amended in the Senate and is currently in Senate appropriations as it includes an appropriation for guardianship program enhancements of $64,000 from the general fund.
Chairman Pollert: What is the $64,000 for?
Legislative Council: the bill states that it is for guardianship program enhancements.
Chairman Pollert: is the study still in the bill?
Legislative Council: No, the study is not.
Chairman Pollert: I had a discussion with Rep. Weisz (Human Services Chair). He stated when the bill was in the House, he had a discussion with the Judicial Branch of govt and he was told that there needs to be a comprehensive study on the guardianship statewide and the study needs to be done before you do anything else. Before you start sticking appropriations in, you better know what you have a direction on. It reminds me of the Autism bill and they talked about what direction they wanted to go.

Representative Metcalf: I agree that there needs to be a study. However, do we need to put the employees at a disadvantage while the study is being done? Nothing will be done in the next two years while the study is being done. This is a matter of fairness as these individuals are overworked. We need this extra worker to lower their caseload. This extra FTE would lower the caseload from 38 to 34, which is still a lot.
Representative Nelson: I'm assuming this is a performance based contract?
Brenda Weisz: No, this is a daily fee contract. We pay an amount per day per ward under this contract.
Representative Nelson: How often is that negotiated?
Brenda Weisz: We inflate for the daily fee, the 3/3.
Representative Nelson: OAR 408 talks about guardianship program enhancements. What were you considering in that?
Brenda Weisz: That OAR relates to what came forward as HB 1199. 1199 is for a different population group that what Representative Metcalf's amendment addresses (the Developmental Disabilities (DD) population). 1199 was for the SMI and the vulnerable adult population. Right now there is $40,000 in the dept's budget to establish a guardianship for 16 individuals. Currently, for that population, there isn't a guardianship fee like there is for the DD guardianship, so it adds $500 a year guardianship fee for that population.
Representative Nelson: so, you didn't offer anything other than the 3/3 inflator, despite reviewing the high caseloads?
Brenda Weisz: This time around, compared to other biennia, the dept took a different approach, as far as its OARs. Many biennia before, you would see an OAR list that maybe was sometimes two pages long because we would incorporate the requests of providers. This time, when we did our strategic planning and our stakeholders meetings, we incorporated the message that the budget was hold even and that the governor's budget request was to include 3% savings. The approach that our executive director and cabinet took is that we would put forward the requests from our stakeholders meetings and the priorities of the dept. We did not bring forward any priorities of providers out there and did communicate that to them and let them know that they need to come forward through public testimony with what their needs might be. We treated all providers consistently with that.
Chairman Pollert: is that $67,342 related to what's over in the Senate right now (no. 6, pg 3, attachment **ONE**)?
Brenda Weisz: No, it is not. The 3 here are related to the DD population and HB 1199 relates to a different population that is treated inconsistently from this population, which is why that bill was introduced and had the funding as it does. There's not currently a fee tied with that.
Representative Wieland: In this case, the dept pays the provider on a case by case basis?
Brenda Weisz: We pay a daily rate (corporate guardianship daily fee) per ward (individual). If the $141,814 was funded, it would go into the calculation and we would convert that into a fee and increase the daily rate.
Chairman Pollert: I would recommend that Brenda describe them all at the same time (all 3 of the amendments proposed by Representative Metcalf: numbers 4, 5, and 6, pg 3, attachment **ONE**).
Brenda Weisz: they are all tied to the same concept.
Representative Wieland: they might in fact be getting paid for working extra hours beyond the 40?

Brenda Weisz: I don't know they do their payroll. I know how they present the budget to us and then the budget is broken down into a daily fee and it takes their cost divided by the wards, divided by the days and that's how we pay the contract.
Representative Metcalf: in speaking with the individual that supervises all these people, I can guarantee that these workers are putting in 50-60 hours per week. They don't seem to be complaining about it. They do wish they would get another individual on there so they wouldn't have to put so many hours in. Out of this daily rate, all expenses for that individual are being paid. If they have to travel from Fargo, ND to Hillsboro, that expense is being paid out of Catholic Charities.
Brenda Weisz: $5.88 is the daily rate per individual that we serve. The petitioning cost is separate from the daily rate. We do have a piece of the contract that is set aside for petitioning.
Representative Wieland: I understand working 50-80 hours a week and not getting compensated. I worked in real-estate and I get that. 70 hours a week is no big deal.
Representative Metcalf: I put in 80-90 hours a week when I was on the farm and never got paid for any of it. We all have our own stories. As long as the petitioning costs are brought up, I will talk about it. There is a request for an increase in the petitioning costs of $21,970. However, the petitioning costs have just about doubled and that appears to be the way things are running. If they don't get this increase, it will come right out of their funds.
Chairman Pollert: the petitioning costs are by the court. Have those rates gone up?
Brenda Weisz: In the current contract, we have $29,750. The costs for petitioning have been more than what is in the contract. For each individual petition, I don't know specifically how much the petitioning costs are.
Chairman Pollert: You've had to rob from Peter to pay Paul?
Brenda Weisz: Yes
Representative Metcalf: these cases are getting more complex. Being more complex the legal industry is going to be charging more the work they have to do in order to accomplish what we are asking of them. That is something that needs to be done.

Chairman Pollert: any questions on number 6, pg 3?
Representative Metcalf: right now, they've got 104 slots that they are working for. With the history of the guardianship requirements, they anticipate in the next 2 years, that they will be going up an additional 15 slots. They only get paid by what they do. There is cost, outside of that $67,342, that we could be charged if those slots are filled. If those slots are not filled, that cost is going to go down.
Representative Wieland: I've indicated to the individual that spoke to Representative Metcalf that I can't support increasing staff at this time. I need to be assured that we are at least doing the study. Do we have that in here somewhere?
Chairman Pollert: hang on with that question. We'll get back to it. Do they have to petition you for each biennium to come forward if they think there is more caseload coming forward? How did they come up with the dollar amount?
Brenda Weisz: It's not a grant. It's a contract where we just purchase a service at a daily rate and for many biennia, we've had 414 wards. That contract has been steady and it's been going up. They anticipate it to go up 15 more slots, which is the basis for this request. This is the first time in many biennia, that they've verbalized exceeding the 414 that we've served.

Chairman Pollert: would they have talked to you earlier, before your budget was to get in, whether you should have increased the budget for that particular item or not and you decided not to put it in the budget?
Brenda Weisz: they did talk to us earlier when we were developing the budget, but back to the concept of how we dealt with provider requests this biennium as we treated all providers equally and ask all provider requests go through legislation that they sought or through public testimony. Regarding the study, when 1199 came forward, the study was really to only look at that vulnerable population, not the DD population, but the concern was the older adults and the SMI. The guardianship for the DD world has been well established since the lawsuit and that has been ongoing and operating without much intervention. What's been newer and caused concern in the community which was the reason for the study and the bill was for a different population group where it was for the SMI and older adults. Regarding the basis for OAR, a couple of biennia ago, we did have a bill come forward to provide guardianship services for the vulnerable and SMI and that fiscal not came forward at about $800,000+ and then $40,000 was put in our budget. We've noticed a need for establishment of guardianship for that population. I believe that study focused on that population.
Representative Metcalf: Catholic Charities admits that they are a charitable group and do not expect to make money on this. They are losing money. DHS is not paying them enough to cover their costs. In speaking to the supervisor, he stated they may have to drop guardianship all together. We need to be asking ourselves if we are helping our people and I feel we have a responsibility to provide the basic needs to our fellow humans, taking into account disadvantages that others have, that you and I don't have to deal with. For instance, there was a newspaper article the other day about a man who committed suicide who struggled with alcoholism and drugs. He just got married in November. We need to be helping others out. Catholic Charities isn't asking for too much and are just trying to prevent going down in the hole more than they have to.

Roll call vote taken on number 4, pg 3, attachment **ONE**, resulting in 2 yes, 5 no, 0 absent, thus motion failed.

Roll call vote taken on number 5, pg 3, attachment **ONE**, resulting in 6 yes, 1 no, 0 absent, thus motion carried.

Roll call vote taken on number 6, pg 3, attachment **ONE**, resulting in 2 yes, 5 no, 0 absent, thus motion failed.

Chairman Pollert: number 7, pg 3, and language on pg 15 attachment **ONE.**
Representative Kaldor: this is basically to replace SB 2314.
Chairman Pollert: I carried that to the floor with a DNP. That's coming out of $4.4M prevention grant.

Roll call vote taken on number 7, pg 3 and language on pg 15, attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Chairman Pollert: number 8, pg 3 and language on pgs 15 and 16 (includes Option A and Option B). Legislative Council, what is the difference between the options?

Representative Kaldor: I can explain this. This didn't get discussed the day we were bringing up amendments, but Chairman Pollert gave me permission to submit it. The intent is to study the Qualified Service Provider system. My interpretation is that Option A has optional study that may or may not happen while Option B requires a mandatory report to be required by DHS to the legislative management. I would support Option B.
Vice Chairman Bellew: Has there ever been a study on QSPs and what they've been paid, etc.?
Legislative Council: I am not aware of something recently, but I will research to see if legislative management has done a study regarding QSPs.
Representative Wieland: this was a section that was added after we had the discussion of putting in amendments.
Representative Kaldor: Yes.
Chairman Pollert: there was actually a letter in e-mail form regarding QSPs that we had received recently. I realize there was a problem in the western part of the state with St. Joseph's but I haven't had anybody come forward about St. Joseph's, so does that tell me that the services are being provided by a different group of QSPs? Every hospital and how they deliver the QSP services are different and am at a quandary as to why my e-mails weren't filled indicating there is a problem. I know there must be a local problem. I even spoke with legislators from that area and they haven't heard anything either.
Representative Kaldor: we did have public testimony related to this. They are being affected by issues, fiscal and quality of care. I think it would be appropriate for us to take a look at this during the interim.
Chairman Pollert: do we have to vote on both?
Legislative Council: since Representative Kaldor has a preference for Option B that could be the option that the committee votes on.
Representative Kaldor: I would move option B
Chairman Pollert: I would prefer option A
Vice Chairman Bellew: I prefer option A. I would like to see the report if it gets chosen to an interim committee instead of to the assembly.
Representative Kaldor: it would be reported to the legislative management during 2011-12, so that's the language that we used, so that is would go to an appropriate committee.
Legislative Council: that's correct. Option A is typical legislative management studies.
Chairman Pollert: if it's selected, it'll go to an interim committee and then the findings would be discussed with the interim committee and the interim committee would decide if they want some...
Representative Kaldor: Okay, I move option A, number 9, pg 3, attachment **ONE.** I don't think option B requires that interim committee make a recommendation.
Chairman Pollert: It wouldn't have to. Anybody can bring legislation forward during the interim committee and then have a vote on whether they want to come forward to.
Representative Metcalf: my preference is option B as there is a better chance it will be surveyed if it's put in DHS versus the legislative management.
Vice Chairman Bellew: I rather see legislative management do it, even though DHS will give them all the information.
Chairman Pollert had Option B withdrawn (with Representative Kaldor's permission)

Roll call vote taken on number 4, pg 3 and language on pg 15-16 (option A) attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Representative Nelson: number 1, pg 4, attachment **ONE.** This amendment would bring it back to what the executive budget recommended in OAR 501.

Roll call vote taken on number 1, pg 4, attachment **ONE**, resulting in 7 yes, 0 no, 0 absent, thus motion carried.

Representative Nelson: number 2, pg 4, attachment **ONE.** We looked at the caseload reduction area and we thought that there were possibly 3 beds that could be removed. They funded it at 85% of the bed capacity originally and half of the increase that was anticipated totals $519,000 which was the basis for this particular amendment.
Representative Metcalf: I hope we understand that they maintain that particular unit at 85%, however at times they are up to 100%. They have taken it upon themselves to reduce their costs because they don't have that cost when they are at 85%. Are we telling them to maintain at 82% with removing the 3 beds? This is the wrong way to go.
Representative Kaldor: I would concur with Representative Metcalf that this could put them in a potential bad situation and should be defeated.
Chairman Pollert: I believe they have a capacity of 76 and then 85% of the workload would be 65 and they currently have 59. It's your thought that the numbers could comfortably be at 62.
Representative Nelson: that's what the consensus was.
Representative Kaldor: the consensus of whom?
Representative Nelson: ummm...my two eyes...
Chairman Pollert: Representative Nelson had talked to me about it. The budget is based on 65 and they've been constant at 59, so what happens with the other money? Would it be excess? I get phone calls about once a month stating that individuals feel there are too many employees out there. If they go to 63, would they have the funds to switch the repair costs in their line item over there? Nothing was taken out of the state hospital's budget as far as travel expense, operating expense, etc.
Representative Metcalf: basically it seems that we are grasping for straws when we are trying to come up with these figures and I would ask that Alex come forward to give us the exact figures as far as the history of occupancy (highs and lows) and current occupancy.
Alex Schweitzer: The highest capacity has been 64. We have 59 in house and 5 in prison that are ours. Thus as soon as they complete their sentence, they are coming back to the State Hospital. We staff 65 beds which is 85%. There is a two year period here thus you have to consider there could be admissions. We get referrals. We are only talking about in house right now and need to consider the possibility of admissions.
Chairman Pollert: do you know for sure that you will get the 5 that are coming out of the prison?
Alex Schweitzer: I don't know if I will get all 5 back, but they will gradually start coming back into the program over the next 3-4 years. It will depend on when they complete their sentence. We will get them all back in the next 5 years.
Chairman Pollert: do you plan to be releasing any of the 59?
Alex Schweitzer: That is a possibility. There is one person for sure that will be released in the next year (stage 5). He is the only stage 5. There are unknowns due to results of the yearly evaluations that are required to take place which could lead a person going back to court and the judge could look at their case and could say the individual may no longer met criteria for being sexually dangerous thus release could occur. We staff according to our best guess estimate. We get about 3 letters a month from the prison psychologist who

essentially provides names of individuals who will be potentially discharged from the prison and we are sending a referral to the local state's attorney and then it's up to the local stat's attorney to make a determination of whether they should be evaluated. We are looking at 5 staff with this $500,000 (direct care staff).
Chairman Pollert: are the staff just on so we are paying for FTEs that aren't working if the capacity does go above 59 or 61?
Alex Schweitzer: I could go into the specifics on the staffing which would take much more time than we have this morning. For every 2 staff members that are hired, you have to have 3 to cover shifts. That's at 85%. You still staff to the 85%. You have to do that because if we reach that point, what do I do if I don't have the 5 staff members? Yes, there is possibly some downtime. The point is I can't predict admissions and discharges. These direct care staff deal with very difficult patients; not clinical staff. Any less staff is going to be a problem.
Representative Metcalf: do you anticipate people come back in?
Alex Schweitzer: Yes, we do, as I stated above. I underfunded this budget by $900,000 to make up for the issue that you talked about in terms of the staff not sitting around. This adds to the underfund.
Representative Kaldor: in the event that an individual is referred to you and you are at maximum capacity, what takes place as a result, in the referral process? I'm talking about if you have 76 beds full.
Alex Schweitzer: we would have to add beds into that unit. If a judge orders someone to the state hospital sex offender program, we have to take them.

Representative Nelson: I am going to offer a substitute motion. Instead of the decrease in the funding relating to the reduction of 3 beds in the secured services area, I would move to nix that and decrease $250,000 in the operating line item instead.
Representative Wieland: second
Representative Nelson: even though we are asking for some efficiencies in the overall operations, it does give the state hospital the flexibility to respond to the needs in this area, if that presents itself. Hopefully that would allow the freedom to respond to a number of situations and yet, there would be somewhat of a savings (over half would be restored to this potential reduction).
Chairman Pollert: as far as your motion, can the state hospital float monies between traditional and secure services?
Representative Nelson: yes, that would be my intention. They would be less restricted with this motion.

Roll call vote taken on substitute motion to number 2, pg 4, attachment **ONE** which would decrease $250,000 in the ND State Hospital operating line item, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Representative Kreidt: number 1, pg 7, attachment **ONE.** That was on the OAR list (301 – 3rd priority).
Representative Kaldor: this was funded in the governor's budget.
Chairman Pollert: it was part of the $6.1M of the psychiatric hospital inpatient program (the terminology I am using).
Representative Kaldor: as I read the testimony on this, the governor's budget included this funding to fill a capacity gap for individuals with serious mental illness. In this region, it

would provide the ability to meet immediate supervision needs. It would reduce the need for local hospitalization or transport to the state hospital. I commend Governor Dalrymple for including this in his recommendation. I think this is a very serious and growing issue. It is important to the region and to the hospital and state hospital who are called upon to meet those needs in these events. I am not sure of the reason for this. Was it because it was an optional OAR? I believe it is a proper priority.
Chairman Pollert: I think the number 1 objective was for the 4092 days for the psychiatric inpatient and I support that part of the governor's budget. I am not convinced of the need for the SMI beds for NC or to go from the 10 to 14 beds in the WC region or the chemical dependency beds for SE region. That will be the basis of my support for the upcoming amendments to reduce funding for the regions I just specified, thus I won't comment on the other two.
Representative Kaldor: in this region of the state, it does serve counties that are experiencing a significant social change. This change has to do with the oil boom, influx of population from areas all over the country that are working in that region. I suspect, over the next two years, we will continue to hear more stories such as the man who suicided in Stanley from that region of the state. I hope that we're not ignoring the impact that this is having in that region of the state. We can afford to do this and it's important that we do.
Representative Nelson: Representative Kaldor is right, however we are not ignoring the needs as the director's priority was the inpatient psychiatric care (hospital) which is what I am supporting as well. We do need to prioritize. The approach that this amendment indicates is that we're not going to be able to do all of it in this biennium in every region. I know we will readdress this at some point in time.

Roll call vote taken on number 1, pg 7, attachment **ONE**, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Vice Chairman Bellew: number 1, pg 8, attachment **ONE.** I wasn't convinced of the necessity of it.
Representative Kaldor: this is for the family caregiver adult protective services program. Had it been funded before?
Vice Chairman Bellew: I don't remember the testimony.
Representative Kaldor: Office of Management and Budget, do you know if it had been funded before or at in part in the previous biennium?
Office of Management and Budget: I don't know.
Legislative Council: LRHSC has used temporary salaries in previous biennia. I don't know if they have used this in this particular program.
Representative Kaldor: have we funded in the past a family care giver adult protective services program in the LR Center?
Chairman Pollert: they probably funded it, but they probably have permanent FTEs on that. Perhaps they think their caseload is to the point of adding a .7 FTE.

Roll call vote taken on number 1, pg 8, attachment **ONE**, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Vice Chairman Bellew: number 1, pg 12, attachment **ONE.** It is about prioritizing. The dept said that the psychiatric hospital rates was their number 1 priority, so I thought I'd give them their number 1 and talk about the rest.

Representative Kaldor: this goes from 10 to 14 beds. It's based on an expected increase in need. Again, we are talking about adult crisis situations. We are in an area of the state where they have influx of people from all over the country and they're experiencing significant changes as a consequence. This is not the place to cut and is an appropriate priority.

Roll call vote taken on number 1, pg 12, attachment **ONE**, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Vice Chairman Bellew: number 1, pg 10, attachment **ONE.** This request is for the same reasons as I indicated before.
Representative Wieland: in this incidence, this is a request for a facility they don't have. The hospitals have been doing a lot of this and they are at or above their capacity and are claiming now they can't take any additional folks. I have been getting multiple requests from law enforcement in this area to keep this in. We have increased population in this area as well. We get a lot of resettlement folks. For instance, there are 28 different dialects in my school district. There are different individuals from other areas with different culture and social changes and standards. If we find at the end of the 2 years that the demand is down, then we can reduce or remove it.
Representative Kaldor: I concur. Cass County is the place where a lot of problems end up. It is the largest city in the state. The trend lines are increasing and the needs are increasing. We are balancing our budget on the backs of those who are least able to deal with this. It has an effect on the social fabric of our communities and law enforcement and one of the things that we have been proud of in ND is that these are good communities to live in. This all contributes to that. I would hope that we would oppose the amendment.
Representative Metcalf: there is a definite need for taking care of our new citizens that come in from other countries. I would recommend that we keep this money available.
Representative Nelson: in 2 years, will this potentially be a better situation? I don't think we can look forward to that. What we are funding inpatient amounts to half of the days that are being uncompensated now. We are not meeting that full need in inpatient. Part of the problem is, is that once they're stabilized and released, where do they go? This is the residential piece and Southeast provides the treatment. I think that at the end of the day, this is necessary in every one of these major cities to have this treatment take place and provides a place for these individuals to reside so they aren't in people's backyards and in the streets. This will help to slow this revolving door and provide some savings to the State Hospital, the hospitals that are providing uncompensated services now, and the counties. Where do they end up when they relapse – county jail, state penitentiary, etc. It's outside the human service area and extends into the corrections area and a loss of life. I think this is critical. During the West Central testimony, it was stated, that in some cases, they have bought bus tickets who have been released in this region of the state and sent to Fargo and to what – to the streets. There's no place else for them to go. I'm going to support Representative Wieland with this and oppose this.
Vice Chairman Bellew: to respond to the statement that Fargo doesn't have anything like this, I want to state that in their testimony, it says they started an 8 bed short term substance abuse residential facility. They established that in August 2010. They want more money to continue that. They established this last biennium without an appropriation so why can't they do it this biennium without an appropriation? It looks like they are already doing it.

Roll call vote taken on number 1, pg 10, attachment **ONE**, resulting in 3 yes, 4 no, 0 absent, thus motion failed.

Representative Nelson: number 2, pg 10, attachment **ONE.** I think the priority we made with the last vote, I am more comfortable with the residential facility than adding additional staff to the Cooper House. The commitment we made last session is intact.
Vice Chairman Bellew: Cooper House, with the new funding, would be $813,000. This only reduces the funding by $350,400. Can you explain that?
Representative Nelson: some of the funding was added to complete the FTE that we authorized last session and this is the total value of the second FTE. Some of the funding that you are referring to was to fund that FTE.
Legislative Council: the dept did add $148,102 to fully fund the one staff for the Cooper House. They had added a total of $498,502. $148,102 of that was to fully fund the one staff for Cooper House so the remainder of that was the $350,400 which you see, which would be for the second staff.

Vice Chairman Bellew: I'd make a substitute motion on this and pull all the Cooper House funding, which would amount to $813,862 (verified by Office of Management and Budget and Legislative Council)
Chairman Pollert: Vice Chairman Bellew is looking at the grants sheet item.
Representative Kreidt: second
Vice Chairman Bellew: Cooper House is for the city of Fargo. We just allowed the 15 beds for the substance abuse residential facility. They started an 8 bed short term this past August. I don't believe that the state should be funding a staff for the Cooper House at this time and believe it should be a city of Fargo responsibility.
Representative Wieland: what is the cost for the first group of positions (4-5 people, illustrated as one staff as it's a 24/7 staff)?
Chairman Pollert: $463,462 would be for the first staff (Legislative Council confirmed this). The second group would be for $350,400.
Representative Wieland: I would like to comment that there is a difference between these two positions.
Representative Nelson: The city of Fargo would be responsible for making up the position's shortfall is what Vice Chairman Bellew said. The legislative assembly made a commitment to the Cooper House last session regarding this one position and I think it's important that we meet the original commitment. This money does provide a place for people to live. It provides a place for law enforcement to be aware of for these individuals and can respond to situations sooner because of the Cooper House. It saves the state and the county money because of decreased detox costs and as well as correctional costs. These people need services somewhere. The state and local subdivisions get to be the payer of that service. We are looking at this with blinders that if we cut the funding, the problem goes away.
Representative Kaldor: Lt. Vettle testified in support of Cooper House and the additional staff. I know him personally and he and I have had conversations about this outside of the legislative process. This burden will be borne one way or the other; whether it's Cooper House, police stations, sheriff's department, or the detox centers. Based on testimony, this seems like a successful program. In many respects, we will reduce the burden on taxpayers, generally, and afford some possibility (in a small sense) rehabilitation and hope

to help these people get on their feet. This is a very difficult population. Lt. Vettle stated that if they aren't in Cooper House, they will be in your backyard. They are going to be someplace. I think we need to leave this money in.
Vice Chairman Bellew: this is not to close Cooper House. This funding is a guard for Cooper House that I am proposing to remove. It is simply saying that the state shouldn't put money into this.
Representative Kaldor: This is not solely a guard. They describe the position as someone at the door, however the staff is moving throughout the house, meeting with and talking to those that are inhabiting the house and in many cases, intervening in some tough situations that can occur. It's security and assistance to everyone there. Yes, you are saying that you aren't wanting to close it, but rather that this isn't a state priority. However, I would suggest that this is a very good state interest. We are funding other programs that are trying to address similar circumstances. If this works, I think it is worth our investment as a state.
Chairman Pollert: I am going to support Vice Chairman Bellew. I believe this is a local issue and not a state issue.

Roll call vote taken on substitute motion to number 2, pg 10, attachment **ONE** of removing all of the funding to Cooper House for both FTE positions to total $813,862, resulting in 3 yes, 4 no, 0 absent, thus motion failed.

Representative Kreidt: I make a motion to re-instate the $350,400 and vote on that
Representative Wieland: second

Chairman Pollert: we are back to the original amendment that was asked for (number 2, pg 10, attachment **ONE**). If this amendment passes, it would fully fund the first FTE (the $148,102 with what was appropriated for that FTE position last year), but does not fund the second FTE.

Roll call vote taken on number 2, pg 10, attachment **ONE**, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Chairman Pollert: we will now go back to the numbers 3 and 4 on pg 1, attachment **ONE.** We'll start with number 3, pg 1.
Representative Kreidt: I'm going to change removing the entire position of the attorney and leave the attorney position there, but I still want to remove the general fund dollars. I think the dept can find that amount ($102,000) within its budget if they want to continue to have that attorney work for the department. That is my substitute motion to the original proposed amendment.
Representative Wieland: second
Chairman Pollert: the negative FTE position is taken away and DHS will have to find the $102,300 in their operating budget.
Representative Nelson: how would that reflect in the estimated income and total line item? Would they be wiped out?
Legislative Council: yes, for this particular change, I would remove that decrease you see in the estimated income of $82,157. The new total for this particular change would be the negative $102,300 of general fund dollars.

Representative Wieland: I intend to make the same type of motion for the IT position (number 4). They are already in existence and already working, so if they want to continue to have that position, then they could find it out of operating.
Chairman Pollert: we will deal with number 3, pg 1, attachment **ONE** first.

Roll call vote taken on substitute motion on number 3, pg 1, attachment **ONE**, illustrating removal of general fund dollars of $102,300 for the attorney position, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Representative Wieland: I would make a similar motion for the information technology position that the position would remain, but the funding would be removed.
Legislative Council: the related change would be the $120,473.
Representative Nelson: second

Roll call vote taken on substitute motion to number 4, pg 1, attachment **ONE**, to remove general fund dollars related to IT position of $120,473, but to keep IT position in budget. This resulted in 5 yes, 2 no, 0 absent, thus motion carried.

Chairman Pollert: any other amendments?
Representative Kaldor: I have a proposed amendment which was already drafted by Senator Mathern (attachment **TWO**). I feel a duty to introduce the amendment (.02004), even though I know how it's going to go (distributed copies of amendment to committee members). The amendment will fund OAR 703 (the healthcare reform grant IMD Demo) which is the Medicaid Emergency Psychiatric Demonstration Project. I move amendment .02004
Representative Metcalf: second
Chairman Pollert: from discussion with lobbyists, the first choice was inpatient psychiatric hospital and this was one of their objectives.
Representative Kaldor: Yes. I want to put it on the table. It's $1,140,306 general funds and $1,440,156 federal funds for a total of $2,580,462. I thought about simply bringing this forward to the full appropriations committee, but thought it would be more straight up if I brought it to the division. The impetus for this is related to the testimony. This is a demonstration project to try to expand the number of options available in communities by establishing a 3 year demonstration project. It will allow states to cover patients in non-governmental free standing psychiatric hospitals and receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms and improve the efficiency and cost effectiveness on inpatient psychiatric care.
Representative Nelson: was this proposed amendment offered in the Senate?
Representative Kaldor: I do not know.
Legislative Council: the amendment was offered in the Senate on the floor and in the Senate appropriations committee and it was defeated in both.
Chairman Pollert: I plan on opposing this. We have to prioritize and we cannot fund everything.

Roll call vote taken on amendment .02004 (attachment **TWO**), resulting in 2 yes, 5 no, 0 absent, thus motion failed.

Chairman Pollert: I will keep in touch with Roxanne (Legislative Council) about getting these amendments drafted, thus we will either reconvene to vote on amendments and the bill on Friday (April 1) or Monday (April 4). The committee will be at the call of the chair. Chairman Pollert closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Human Resources Division
Roughrider Room, State Capitol

SB 2012
April 4, 2011
16282

☐ Conference Committee

Committee Clerk Signature Julia Hejtfje

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Pollert called hearing to order. Clerk took role and quorum declared. Chairman Pollert opened hearing on SB 2012 (.02000-First Engrossment). Legislative Council provided attachment **ONE**, which illustrates a comprehensive list of proposed amendments that committee had discussed and voted on last week. Legislative Council prepared amendments in proper form, ready for full appropriations committee.

Chairman Pollert: do you want to have time to look through this or should Legislative Council walk through them, page by page?
Representative Wieland: I would like Legislative Council to walk through them.
Chairman Pollert: Roxanne Woeste (Legislative Council), you can go through these and the committee members will ask questions throughout the explanation.

Legislative Council started going through attachment **ONE.** I'd like to start with an explanation on pg 5; statement of purpose of amendment. The first few pages are all the amendment instructions for the bill. Beginning on pg 5, you'll see the changes specific by the division that's in the bill. First for management, there are two divisions within management (administration-support and information technology services). In the middle of pg 5, you can see we reduced funding for salaries and wages due to the underfund (admin-support). We reduced funding for operating expenses and this one is specifically indicated as the department wide reduction which was the $375,000 for all the divisions, expect for the human service centers and it was $100,000 at the human service centers. That's allocation that affects admin support. The next is for the attorney position (operating expenses – division-specific reduction). She went through the information technology services. The division-specific for operating expenses is related to the FTE in IT support. That is the number changes for that first division management. She went through the top part of pg 6 (other changes affecting Management programs or multiple programs of the department), stating the actual language that will be inserted is located on pg 3. Further illustrating pg 6, she informed committee of the seven FTEs related to healthcare reform

that committee proposed to remove, which are part of three different sections (economic assistance (one), child support program (one) and medical services (five) and went through the proposed dollar changes under these sections up to the bottom of pg 6, remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160% of the federal poverty level to 175% of the federal poverty level.
Representative Kaldor: on the form we went through last week with all of the proposed amendments on it (attachment **TWO**), the number indicated was $5M.
Legislative Council: that number is an error. This number is the correct number ($567,367).
Chairman Pollert: Yes, I questioned this and researched this number as well and yes, it is the $567,367.

Legislative Council continued going through Medical Services Program (pg 7) and Long-Term Care Program (Pg 7).

Vice Chairman Bellew: did we not want to put language in here so that $12.8M would not go into the budget stabilization fund?
Legislative Council: the language is in here and is located on pg 2, new section 5. I realize there are questions in regards to the turn back and the general fund revenue. That is not specifically reflected here. Revenue will be reflected when this amendment is officially adopted in committee and the bill has received a do pass as amended motion. Revenue will be reflected next time we update budget status.
Chairman Pollert: when I look on the 2nd pg where it says grand total general fund, it shows $908,640,874. I did those figures, compared to the governor's budget that was a reduction of the governor's budget $19.3M and the Senate version of $25M. If the physician's services was taken off of here, that means we reduced the governor's budget by $2M. I knew that wasn't correct. When I piecemealed it out and went through all my numbers, then my general question was how the $12.8M shows up.

Legislative Council continued to go through attachment **ONE**, pg 7, continuing with Long Term care and adding funding for HB 1169. That bill has come out of Senate appropriations with a Do Pass and I believe it was passed on the floor on Friday April 1. She went though Aging Services Program, Children and Family Services Program, Mental Health and Substance Abuse Program, Developmental Disabilities Division (moved to pg 8), Vocational Rehabilitation. Following these sections which illustrate the dollar changes in the Program and Policy program, she indicated the other changes affecting Program and Policy programs are located on pg 3 of the amendment. The first one is relating to risk behavior prevention grants, section 9. Section 10 is the legislative intent regarding DD grants (allowing the dept to use dollars that are unexpended appropriation authority for transitioning from DD Center into communities). Section 11 is a study related to QSPs. She continued to go through the dollar changes under State Hospital (pg 8), Developmental Center (pg 9), and illustrated the specific changes within the Human Service Centers, starting with Northwest Human Service Center on pg 9, North Central Human Service Center on pg 10, Lake Region Human Service Center on pg 10, Northeast Human Service Center on pg 10, Southeast Human Service Center on pg 11, South Central Human Service Center on pg 11, West Central Human Service Center on pg 11, and Badlands Human Service on pg 11-12. She stated she would be happy to answer any questions on the amendment.

Chairman Pollert: management program was a reduction of $403,988 (pg 5) and program and policy was a reduction of $35M. If you add back the $56423, the $887,500 for retrospective to prospective and the $21,970, that comes to $965,043. You take the reductions of the State Hospital of $411,840, the reduction of the Human Service Centers of $2.842M; you get total reductions of $37,839,480. You take out the $12.8M of turn back and you get a figure of $25,039,480 which corresponds to the figure back on pg 2, on the grand total general fund from the Senate version, those two numbers actually match up for me. I'm hearing Legislative Council say that the $12.8M will work its way through depending on how our motions go this morning.
Legislative Council: Yes.
Chairman Pollert: does the committee understand what I was thinking in that those numbers don't add up until you work with the $12.8? Are there any further questions with that?
Representative Nelson: do the House changes in that second to last column ($25M) include the $19M of physician reimbursement? Let's surmise that there are reductions to the reductions in the physician reimbursement.
Chairman Pollert: Before the turn back of $37,839,480 (general funds), if you take the physician's rebasing away of $17,448,925, you would get a figure of $20,390,555. Without the physician's amendment ($17.4M – not the $2M of the 3/3), but keeping the 3/3, you get $20M. That $20M doesn't add up on the second pg to the $908,064,874 until you get that turn back into there.
Representative Nelson: assuming that, that would be the case under that scenario, that $20M is taking the physicians back to 142% of Medicare, but not giving them the 3/3 inflator.
Chairman Pollert: Yes, you are right.
Representative Nelson: Is that a scenario you are looking at?
Chairman Pollert: I am not saying anything right now. I had to backtrack those numbers up. Any further questions?
Representative Kaldor: these amendments appear to reflect what we had discussed last week and voted on (attachment **TWO**). The underfunding on salaries was spread throughout so it took me awhile to get it sorted out. Right now, as it stands, we have increased the appropriation from the general fund, but the revenue won't be reflected until we pass this out.
Legislative Council: that is correct. Appropriation bills deal with the appropriation side of the budget. Revenue is tracked differently by our dept. We start with the executive budget, revenue forecast, we make adjustments to that as bills are passed by the house and the senate. Because this bill does have a revenue impact, the $12.8M of general fund revenue will be reflected when we do budget status update.
Representative Kaldor: in the governor's budget, they allowed them to carry those funds into the 11-13 biennium. They were not reflected in revenue or a balance to expend for 09-11.
Legislative Council: that is correct.
Chairman Pollert: how is the $12.8M show up? Will we see the grand total general fund be down further or will we see the $12.8 show up some place else?
Legislative Council: the $12.8M of additional general fund revenue does not appear specific in this amendment. It is something that we will adjust in our general fund tracking for the week when this amendment is adopted. Because you removed that section of the

bill, allowing the dept to carryover unexpended general fund dollars, now the dept is required to return turn back any unused general fund dollars. Currently that estimate is $12.8M so our staff will reflect an additional $12.8M of general fund dollars and general fund revenue. Typically appropriations don't deal with general fund revenue adjustments, but it's not specific to the bill. You won't see a specific line. You're not going to see it in the bill when we incorporate these amendments.
Chairman Pollert: overall, statewide, we'll see the $12.8, but $908M on pg 2 is still going to be intact, even though it's not indicative.
Legislative Council: correct. The $908M is the general fund appropriation amount for the DHS for House version of the bill. We don't net revenue in appropriations; we keep them separate.
Representative Kaldor: that $908M does reflect the $12.8M
Legislative Council: correct. It includes the $12.8 that's added. Each week when we update budget status and we provide you with now a 3 pg summary, there are some detailed budget status reports and one of those reports shows revenue changes and this week after this amendment is adopted, you'll see a $12.8M general fund revenue positive adjustment.

Vice Chairman Bellew: I'll move to adopt amendment .02011 (11.8152.02011)
Representative Kreidt: second

Roll call vote taken to adopt amendment .02011, resulting in 5 yes, 2 no, 0 absent, thus motion carried

Vice Chairman Bellew: I will move SB 2012 Do Pass as Amended
Representative Kreidt: second

Representative Kaldor: I will be voting against the budget. I think we need to be prepared to discuss these amendments on the floor because there will be questions.
Chairman Pollert: It's never been any different. I realize there are areas of controversy which I am aware of and will be prepared to discuss.

Roll call vote taken for a Do Pass as Amended on SB 2012, resulting in 5 yes, 2 no, 0 absent, thus motion carried.

Chairman Pollert was assigned to carry the bill.

Chairman Pollert: I appreciate all the hard work; both from the industry and from the agency. There are no other bills in our section. We will meet in full appropriations today at 10 am. I will adjourn unless we need to be called back in for division work which will be at the call of the chair. **Chairman Pollert** closed hearing on SB 2012.

2011 HOUSE STANDING COMMITTEE MINUTES

House Appropriations Committee
Roughrider Room, State Capitol

SB 2012
4/4/11
16290

☐ Conference Committee

Committee Clerk Signature Julia Jeiser

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to provide an appropriation for defraying the expenses of the department of human services; to provide an exemption; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program.

Minutes:

Chairman Delzer: Called the committee to order. Roll was called and a quorum was declared. We'll start with SB 2012.

Representative Pollert: For discussion purposes, I move amendment .02011 (attachment **ONE**).

Representative Bellew: Second.

Representative Pollert explained the amendment (attachment **ONE**), starting on pg 2. The department figured there would be $12.8M of turn back. The original version was intended to keep the turn back in the budget. We pulled it out and you will see later, when I go through the amendments, there will be a $12.8M increase to the general fund. There's always language in there so that it doesn't affect the budget stabilization fund.

Chairman Delzer: It will show as an added expenditure for next time's general fund cost, but it shows up as turn back extra revenue for this biennium.

Representative Pollert: In the revenue reports. I might need to explain that in a little further detail when I go back to what the effect is to the total general funds. From there I'm going to go to pg 5 of the amendments. The Senate added about 5.5 or 6 million to SB 2012. They had reduced $10,000 on their budget, but added back in $5.5-6M. $.50 to DD which is about $5M and they put CHIPS from 160% to 175% federal eligibility level for poverty. The HR (House Appropriations Human Resources Division) pulled out the $.50 to the DD salary and pulled out the CHIPS and went back to what we are currently at, 160%. Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover will be the entire way through the management subdivisions (i.e. Child Support Program, Medical Services Program, etc.), amounting to $750,000. HR also removed $375,000 in general funds of operating expense which could be phones, travel,

printing, etc. Thus, the $31,930 under general fund in administration-support is part of the $750,000 and the operating expense department wide of $16,275 in administration-support is part of the $375,000. You'll see in the human service centers sections, there are $100,000 department wide as well that was taken out for operating expense.

The reduced funding for operating expenses was for the expenses for an attorney that was hired; it was just an operating expense reduction. You'll see that going all the way through. On the bottom of page 5, the other changes were to add funding for activities relating to the eligibility system replacement project. That's dealing with the computer eligibility system. We had the amendment passed that would start the IT work. They have to be able to be system ready in 2014 if health reform goes forward. This sets the planning stages for IT, starts that in motion. That will have to be an issue further discussed when we come back for special session during redistricting and health reform.

Top of page 6, the Senate had removed office space lease. We in the House took that out, because we found out there was no one that had the space they needed to lease of that magnitude in size. We added sections for studies (top of pg 6, language on pg 3) and a report.

(moved on to pg 6, Program and Policy subdivision). There were seven FTEs related to healthcare reform and HR removed these. That amounted to about $213,000. Anything related to health care reform was pulled out of SB 2012. The Senate added CHIPs to 175% and we pulled it back to 160%, but we left the dollars for the outreach program in. Going to page 7, reduce funding for CHIP, that had nothing to do with the 160%, it had to do with lower premiums. Next, we looked at caseload utilization in two areas (Medical Services and Long-Term Care). The first one is under Medical Services for $2.739M. We went through numbers (the bulk was inpatient hospital) to determine this. Next is reduce funding for Medicaid payments to physicians to 100% of the Medicare rate. The $17M general funds and the $39.4M total funds equates to about 102.48% of Medicare (it's not actually 100%). Last biennium, the governor's budget was at 25% of physician's actual cost and 100% of allocated costs for hospitals. At the end of the biennium, the Senate put physicians at 75% of their actual costs and hospitals stayed at 100%. We found that information out that, that equated to 142% of the Medicare rate. This amendment puts it at around 50% of physician's costs.

The entire budget has a 3/3 inflator and there's only one place we played with the inflator, and that was here with the physicians. The reason we did that is we know when we get to conference we wanted to make sure we have the discussion on physician services and the inflator. There are a number of us who didn't agree with 142% of Medicare. It wasn't our intention of the section to do 142% down to 102.48%, but we wanted to make sure in conference committee that we had a discussion of physician services as well as the inflator.

Vice Chairman Kempenich: I have a question about the physicians, if it had worked out from what was intended last session, where would we be at on that inflationary scale for physicians? Are we above that or is this bringing it back down to where we should be at?

Chairman Delzer: You mean at the 25%?

Vice Chairman Kempenich: The 50% is still higher than what it would have been on a normal attrition is it went through.

Chairman Delzer: The 25% would have been less than the 100% of the Medicare costs; 50% is 100%.

Representative Pollert: The $200,000 it comes out of IGT funds going to a nursing home, which is part of the hospital in District 23. They were one of the originals that made it possible for us to get to $98M of IGT funds.

Chairman Delzer: What are they going to use that for?

Representative Kreidt: The hospital is having some difficulty with their bottom line and this particular facility would be able to firm it up to a breakeven point of operation on the hospital side, with the $200,000. They originally were one of the facilities that generated the IGT funds in the beginning and it's a government owned facility. We felt it was appropriate.

Chairman Delzer: That's the one at McVille. The only other one was at Dunseith.

Representative Kreidt: Correct. They are just a nursing facility.

Representative Pollert: The next is dealing with the turn back. The $12.8M is the estimated turn back, section 5, pg 2. HB 1169 dealt with education expenditures for the nursing homes. The funding portion is the $56,423 that was taken out of 1169 and added into 2012 (general fund money). We took a look at long term case load. Basically, the biggest bulk (90%) come from nursing home utilization rates - the negative $6.7M ($15.2M total). (continued on to Aging Services Program, Children and Family Services Program, Mental Health and Substance Abuse Program, DD Council, DD Division, and Vocational Rehab). If you add all those numbers up and subtract the reduction, that comes to 37,839,480. This is the amount that is the reductions in program and policy that we had did without the $12.8M of turn back. I bring that up for discussion purposes.

Representative Skarphol: On page 7 where it says decrease funding for long-term care to reduce projected caseload/utilization rates; is that a reduction in the increase, or an actual reduction?

Representative Pollert: A reduction in the increase. It's projected caseloads that the dept came forward to us and we took a look at caseloads of everything (basic care, nursing homes, etc.).

Representative Skarphol: Farther up on the page, I'm assuming when you get up to the $17M with regard to the 100% of the Medicare rate, that's actually potentially a reduction?

Representative Pollert: That would be a reduction to the budget, yes.

Representative Skarphol: The balance of these is more or less reductions in increases? (recording error – missed seconds in recording)

Representative Nelson: In that particular area, the inflator was given to nursing homes. The translation in that is that there were 100 beds that were overestimated of the usage across the state. There are 100 less people that will need those beds. In the physician, that's a totally different thing. That is taking the inflator away, plus the reimbursement. We did not change the actual units of coverage for physicians, but we did for nursing homes, so it is an apples to oranges comparison.

Chairman Delzer: Over the last 2-3 biennia, the actual bed usage in nursing home has been on the decline.

Representative Pollert: That is correct. We as a section did not play with the costs; we just looked at the utilization numbers. Last biennium, there was an average of $.85 to nursing homes for pay. QSPs and DD were given $1. Also added onto that, was a 6/6 inflator. It was about $80M general funds added last time. It has to be reflected in this budget. When you add what we did for rebasing to hospitals, physicians, all the dollar increase (recording error – missed seconds of recording).

(continued with State Hospital, middle of page 8) In the governor's budget there was $1.8M for capital expenditures. $1.5M was for phase 3 of their backup generator and then it was $300,000 for the Horizons building. They had requested $1.961840. Senate added the remainder in and we took it out as we figured the State Hospital could live without the replacement of some of the flooring. I will back up to middle of pg 8. SB 2314 dealt with SADD. I stated on the Floor we would be adding language (pg 3, section 9, attachment **ONE**) and funding to SB 2012. This is the area that says 'a section is added to provide that the department utilize $250,000 of federal funds appropriated...' They have a onetime $4.4M federal grant coming in of which $250,000 of that will be used to go towards SADD. It's asking for matching from an outside entity. They told us if they could get one-time funding of $500,000, they could make it work, so this is part of it. $250,000 out of 2012 to federal grants and then an outside party would be looking for the other matching $1 for $1. (continued going over top of pg 8 under other changes affecting Program and Policy programs). 'A section is added to provide legislative intent regarding developmental disabilities grants' (pg 3, section 9, attachment **ONE**). In the last 2 biennia, we have looked at 3 areas of caseload utilization; medical services, long-term care, and DD. We did not take money out of the DD caseload, like we did to the other two areas, because during the sections within the detailing, there was no money allocated to transfer people from the Developmental Center to the community DD setting. We did not hit any caseload utilization. We thought some of those numbers might be a little high, so we said we would not go after those caseloads, but instead stated that it is the intent of the legislative assembly that any unexpended appropriation authority or extra dollars from not reaching caseload, to use for transition. Additionally, any extra money from Developmental Center should be used for transition as well.

(going to page 9, Human Service Centers) Every human service center has a reduction for the vacant FTE positions of the $750,000. The primary issue that DHS is advocating for is psychiatric inpatient hospital treatment which was $6.1M. We kept in the 4932 days that goes to the big 6 plus 1 (Trinity for psychiatric contract was not getting reimbursed - $3.5M). Due to us prioritizing and keeping this in, we pulled out the $1.4M for seriously

mentally ill (SMI) beds in Minot, .7 FTE at Lake Region in Devils Lake, cost to move from 10 to 14 SMI beds at West Center in Bismarck. We kept in the $939,000 for CD beds at SE in Fargo and the $300,000+ in Badlands.

Chairman Delzer: These were all new initiatives over and above what we were paying for psychiatric services?

Representative Pollert: Correct. Those services were being offered for the last couple of biennia at the big 6 plus 1 (hospitals) with no reimbursement, thus the $6.1M reimburses them.

Chairman Delzer: They had a contract for X amount of dollars and they were expending more than that contract?

Representative Pollert: Correct.

Chairman Delzer: This makes them totally whole on that contract?

Representative Nelson: It does not. For one, it may cover about half of the uncompensated days. I haven't seen all the numbers with the other hospitals.

Representative Pollert: That was the amount that was put in the governor's budget for the 4932 days. That wasn't the amount that the big 6 plus 1 wanted, but rather what was agreed upon in the budget.

Chairman Delzer: Out of those numbers of days, are they all Medicaid eligible or are these all over and above the Medicaid?

Representative Pollert: It's not only Medicaid eligible.

(top of page 11) Cooper House, last biennium, was authorized for one staff. We funded the remainder for the first staff, but did not fund their request for a second staff (24/7 position, consists of 4-5 FTE).

That explains the amendments. If I go back to page 2 and you look at the grand total general fund, it went from $646.3M to $908.0M. It's a 40.5% increase in general fund spending, but you take away $171M of FMAP (we have to fund) and you get to a 12.6% increase to the budget. The $908M equates to $19,298,784 below the governor's budget. It's $25M below the Senate version. They reduced 40 FTEs at the Developmental Center. There's a reduction of 27 total FTEs. Most of the FTEs pulled are 85-90% federal fund.

Chairman Delzer: On the long term care, we've gotten code someplace that says long term care is rebased every three years. Was it rebased last biennium?

Representative Pollert: There is no rebasing in SB 2012.

Chairman Delzer: The next will be 2013.

Representative Pollert: The budget shows a 38.7% general fund increase, but you have to take away the $171M of FMAP and it comes out to 12.6% increase in the general funds.

Chairman Delzer: Questions by the committee?

Vice Chairman Kempenich: Has there ever been a discussion about our enrollment, how we compare to other states as far as getting into the system?

Representative Pollert: We did get some information about the total numbers in Montana and South Dakota; we never know what apples to apples and oranges to oranges are. It would take a study of some sort before we would decide to do something like that. I can't, intellectually, be able to tell you the differences.

Chairman Delzer: I know in the past we were always considered one of the lower states on Medicaid, but I don't know if that's still the case, with our economic situation compared to the rest of the nation. There is nothing in here that studies that?

Representative Pollert: No, there is not.

Representative Williams: On page 4, section 12, supplemental payment from the health care trust fund to the city of McVille for $200,000. It states a city with a population less than 500 with a hospital will qualify. Is this a unique circumstance? Was it presented to the governor, or the Senate?

Representative Kreidt: Back when the ITG funds first originated, there were two government owned facilities used to generate the $98 million that came into the state; McVille being one of them. Those monies have now dried up. The only money that continues to come into this fund comes from loans given to other facilities. There is a 25 year payback on those loans, so there is roughly one million that comes into this fund during the biennium. At the beginning of the session, there was $1.3M was paid back into that fund. There was a point when there was more money and each entity received a onetime adjustment in salaries. This money is generated by nursing facilities across the state that participated in the program. The fund still is alive. The $200,000 that was appropriated went to McVille and it goes to the hospital. They're running a deficit of a little over $200,000. This money is a way to firm this hospital up because they did originally make this happen, we wouldn't have had these funds without this facility and one other facility (that facility did not have a hospital). It's a onetime only to them.

Chairman Delzer: That was in 1999. It was the difference between what a government owned entity could charge the federal government for the difference between Medicare rates and Medicaid rates and it had to be run through them. Those two particular facilities received a certain share of that money that they were allowed to keep while that was going on. Page 22 in your trust fund book has the trust fund and it levels about $800,000. You say this is a onetime deal, but does this do anything to keep them open or are they going to be coming back and asking us again?

Representative Kreidt: It is a onetime deal. It wouldn't stop any facility from coming and asking for money out of the health care trust fund, but those dollars will be limited. The

reason we used a $200,000 amount this time is because there is a facility that received a $200,000 grant last session, and they are turning that money back in. It is a recycling of that money, otherwise this probably wouldn't have happened.

Vice Chairman Kempenich: When was the last time we looked at our social services utilization for instance? I'm concerned with comments I'm hearing about less federal support, but our numbers keep going up.

Representative Pollert: Are you asking for language on the study to do a certain part of the Medicaid population?

Chairman Delzer: If you have an interest on that, you should consider putting language together and offering that to the conference committee.

Representative Nelson: In response to Rep. William's question, this issue was addressed in HB 1152, which in its original version would have granted funding to all critical access hospitals. That was changed to provide supplemental payment levels for lab and anesthesia coverage which of course, in McVille, didn't do much for them. That bill came out of that particular district that McVille resides in.

Chairman Delzer: Further discussion?

Representative Pollert: It wasn't 80 million of the 6 & 6 of the rebasing and salary pass throughs; it is $68.5M. The rebasing was almost $25M total general funds. The QSPs, DD raises and the long-term care facilities was $13.5M. The 6 & 6 cost almost $30.5M. The 3 & 3 this biennium is going to be $23.5M. That continues to add to the budget every time we move.

Chairman Delzer: Further discussion on the motion to amend?

Representative Kroeber: On page 8, state hospital ($250,000), reduce funding for operating expenses, it says division specific reduction; what divisions were reduced?

Representative Pollert: We looked at caseload utilization of sex offenders. We thought they had room to go down 3 (76 is capacity, they budget at 85% which is 65, they are currently at 59). Through discussion, we found out that 5 were coming back from the penitentiary. A substitute motion was made to reduce their operating expenses by $250,000. The director of the state hospital said he was fine with that.

Representative Kaldor: We spent a lot of time on these amendments and there are quite a number of them. I'm going to discuss a few sections of this amendment, in terms of their affect. There are good and bad points with any amendment. The Senate did add $.50 to the DD providers' hourly rate ($5M general fund impact). That was not in the governor's budget. That's an area where we have turnover and concerns with competitive pay rates. If we pass the reduction in Medicaid payments to physicians, there will be much discussion in conference committee. Hospitals represent about 80% of the physicians that are paid through hospitals and while, last session, there are fairly significant increases they have budgeted at least for normal reimbursement and this is going to be a significant reduction

($40M impact). It's about a 39% reduction from current reimbursement levels. The Senate moved the CHIP level from 160 – 175% of federal poverty level. That has a $1.8M impact. I believe we should support the 175%. I wanted to bring attention to what the governor did in his budget, relating to SMI, which I think is very appropriate. We removed SMI beds in NCHSC and while this in Minot, it serves areas in the oil rig. The other one related to this is adding 4 beds for residential adult crisis in WCHSC which the section removed. At the SEHSC, we removed a 24/7 position at Cooper House. Cooper House is a state issue and assist those with chronic homelessness and addiction. I commend DHS for their budget presentation and their work. We underfunded the pay plan as well as operating expenses. They had already reduced their FTE count by over 20 FTEs in total and they had reassigned several FTEs to match up with the demands in other parts of the human services budget. I understand that we have $12.8M of turn back and we probably will have turn back in the next biennium, but I think the Human Services Dept did an excellent job of accounting for what was actually needed. I'm concerned about the way in which we calculated caseload utilization. The dept came in with very good material on how they estimated caseload utilization. We used a different methodology. We basically averaged everything they gave us to come up with our numbers. I don't know which is right. I hope we're right, however underfunding caseload utilization could be a problem if caseload changes go the wrong direction. I wanted to point those out for the benefit of the committee. I'll be opposing the amendments that are proposed.

Chairman Delzer: called for voice vote for amendment .02011 (attachment **ONE**) and amendment carries by voice vote.

Representative Pollert: I move Do Pass as Amended on SB 2012.

Representative Bellew: Second.

Chairman Delzer: Discussion?

Representative Pollert: We realize there are things going in conference committee that will need to get ironed out. We had good discussion in section. I have concern on the cost to continue with DHS and when we add. To comment on the salary raise for DD providers, we thought that if we raise for DD, what about the QSPs and everybody else? We thought if DD was going to get a raise, then the inflators would take a hit.

Chairman Delzer: Just for a point of reference, back in 99 when we were dealing with pay raises for DDs, a dime was about $600,000 at that time. That's how much things have moved forward. Did you discuss what is apt to be the cost to continue for next biennium, when you add the 3 & 3 in?

Representative Pollert: We didn't ask for the cost to continue. The 3 & 3 is going to be $23.5M. The caseload utilization is going to be $36M. The benefit package will be $14M. Those continue to add up to the $68M we added last biennium. With the dollar raises, the 6 & 6, all add up. We will be over $1 billion next biennium.

Roll call vote taken on Do Pass as Amended on SB 2012, resulting in 17 yes, 3 no, 1 absent, thus motion carried. Representative Pollert assigned as carrier of the bill.

Chairman Delzer closed hearing on SB 2012.

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - House changes:				
Departmentwide				
1) Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($750,000)	$0	($750,000)
2) Reduce funding for operating expenses by $100,000 from the general fund for the human service centers and $375,000 from the general fund for all other divisions		(475,000)	0	(475,000)
Administration - Support				
3) Remove attorney position and related funding included in the department's base budget	(1.00)	(102,300)	(82,157)	(184,457)
Information Technology Services				
4) Remove provider outreach and information system training position and relating funding included in the department's base budget	(1.00)	(120,473)	(64,586)	(185,059)
5) Add funding for activities relating to the eligibility system replacement project		25,000	225,000	250,000
Total House changes - Management	(2.00)	($1,447,773)	($146,743)	($1,594,516)
House version - Management Subdivision	114.10	$30,073,689	$47,391,669	$77,465,358

Other changes affecting Management programs or multiple programs of the department:

6) Remove Section 6 of the engrossed bill relating to office space lease limitation. This section was added by the Senate.

7) Add a section relating to a study of the human services delivery system or a study of administration and funding of state and county social services programs.

8) Add a section relating to a Legislative Management study of patient-centered medical homes.

9) Add a section providing for a report to Legislative Management on the dementia care services program.

Date: 3/29/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number No 1, pg 1, attachment ONE

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

-Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover ($750,000)

Motion Carried

Date: 3/29/11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number No. 2, pg 1, attachment ONE

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 2, pg. 1, attachment ONE

Motion carried

Date: 3/29/11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number No. 5, pg 1, attachment ONE

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Add funding for activities relating to the eligibility system replacement project

Motion carried

Date: 3/29/11
Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number No. 6, pg 1, attachment ONE

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

See above

Motion carried

Date: 3/29/11
Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 7, pg 1, attachment ONE (Voted on Option A)

Motion carried

department shall present its findings, the proposed plan, and any legislative changes necessary to implement that plan to the legislative management.

PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY

SECTION _. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MAANGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation would result in North Dakotans experiencing health care savings and improved medical results as well as whether implementation would impact North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

DEMENTIA CARE SERVICES PROGRAM

SECTION _. - REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services must periodically report to Legislative Management regarding the status of the dementia care services program. The reports should include information as to budgeted and actual program expenditures, program services, and program outcomes.

RISK BEHAVIOR PREVENTION EFFORTS

SECTION _ - RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENT. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of Section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts for the biennium beginning July 1, 2011, and ending June 2013. The department shall require an entity receiving a grant under this section to provide one dollar of matching funds for each dollar of state funds provided.

DEVELOPMENTAL DISABILITIES GRANTS

SECTION _. - LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

QUALIFIED SERVICE PROVIDERS

Option A

SECTION _. - LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and

Date: 3/29/11
Roll Call Vote # 6

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 7, pg 1 and language on pg 15 (attachment ONE)

Motion carried

Date: 3/29/11
Roll Call Vote # 7

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 9, pg 1, attachment ONE

Motion carried

	PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
	Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
	Program and Policy - House changes:				
	Economic Assistance Policy Program				
1)	Remove position and funding added in the executive budget relating to health care reform	(1.00)	($17,805)	$0	($17,805)
	Child Support Program				
2)	Remove position and funding added in the executive budget relating to health care reform	(1.00)	(62,714)	(121,742)	(184,456)
	Medical Services Program				
3)	Option A - Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		(5,021,489)	(6,342,560)	(11,364,049)
4)	Option B - Provide funding to increase eligibility for the state children's health insurance program from 175 percent of the federal poverty level as provided for by the Senate to 200 percent of the federal poverty level	1.00	4,832,046	15,648,196	20,480,242
5)	Reduce funding for the state children's health insurance program to reflect a revised premium amount		(42,989)	(95,928)	(138,917)
6)	Remove positions and funding added in the executive budget relating to health care reform	(5.00)	(144,988)	(183,846)	(328,834)
7)	Decrease funding for medical services to reduce projected caseload/utilization rates		(2,739,780)	(3,460,220)	(6,200,000)
8)	Option A - Reduce funding for Medicaid payments to physicians to 100 percent of the Medicare rate		(22,037,214)	(17,448,925)	(39,486,139)
9)	Option B - Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians		(2,065,704)	(2,634,500)	(4,700,204)
10)	Provide funding for rebasing rural health clinics to cost		722,000	966,000	1,688,000
	Long Term Care Program				
11)	Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011		(5,021,489)	(6,342,560)	(11,364,049)
12)	Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority; requires the department to turnback any unexpended general fund authority from the 2009-11 biennium; and appropriates funds from the general fund for the 2011-13 biennium.		12,800,000	0	12,800,000
13)	Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates		56,423	70,085	126,508
14)	Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program		0	200,000	200,000
15)	Decrease funding for long-term care to reduce projected caseload/utilization rates		(6,716,880)	(8,483,120)	(15,200,000)
16)	Add funding for developmental disabilities grants to transition individuals from the		1,900,000	2,400,000	4,300,000

Date: 3/29/11
Roll Call Vote # 8

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, 2, 6, pg 2, attachment ONE
[Removal of the 7 FTE related to Health Care Reform implementation]
Motion Carried

Date: 3/29/11
Roll Call Vote # 9

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wiedland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 4 (Option B), pg 2, attachment ONE

Motion Failed

Date: 3/29/11
Roll Call Vote # 10

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 3 (option A), pg 2, attachment ONE

Motion carried

Date: 3/29/11
Roll Call Vote # 11

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 5, pg 2, attachment ONE

Motion Carried

Date: 3/29/11
Roll Call Vote # 12

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 7, pg 2, attachment ONE

Motion carried

Date: 3/29/11
Roll Call Vote # 13

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 8 (Option A), pg 2, attachment ONE

Motion carried

Date: 3/29/11
Roll Call Vote # 14

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 4 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 9 (Option B) pg. 2, attachment ONE

Motion Carried

Date: 3/29/11
Roll Call Vote # 15

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wiedland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 10, Pg 2, attachment ONE

Motion Failed

Date: 3/30/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland		✓			

Total (Yes) 4 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 11, pg 2, attachment ONE

Motion carried

Date: 3/30/11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 12, pg 2, attachment ONE

Motion carried

Date: 3/30/11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 13, pg 2, attachment one

Motion carried

Date: 3/30/11
Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 14, pg 2, attachment ONE

Motion carried

Date: 3/30/11
Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 15, pg 2, attachment ONE

Motion carried

Date: 3/30/11
Roll Call Vote # 6

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wiedland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 16, Pg 2, attachment ONE

Motion failed

Development Center to the community				
Aging Services Program				
No changes			0	
Children and Family Services Program				
1) Increase funding for special needs adoption contract services to allow for an increase of two additional staff for the program		314,453	0	314,453
2) Increase funding to provide a 3 percent per year inflationary adjustment for the special needs adoption contract		73,401	0	73,401
Mental Health and Substance Abuse Program				
No changes			0	
Developmental Disabilities Council				
No changes			0	
Developmental Disabilities Division				
3) Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043		887,500	887,500	1,775,000
4) Increase funding for corporate guardianship services to allow for the increase of one additional staff to lower caseloads		141,814	0	141,814
5) Increase funding for petitioning costs for indigent people with developmental disabilities		21,970	0	21,970
6) Increase funding to provide for 15 additional guardianship slots		67,342	0	67,342
Vocational Rehabilitation				
No changes			0	
Total House changes - Program and Policy	(6.00)	($22,054,103)	($24,941,620)	($46,995,723)
House version - Program and policy subdivision	368.50	$714,993,846	$1,493,149,066	$2,208,142,912

Other changes affecting Program and Policy programs:

7) Add a section to provide that the department utilize $250,000 of federal funds appropriated to the mental health and substance abuse division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts.

8) Add a section to provide legislative intent regarding developmental disabilities grants.

9) Add a section to provide for a Legislative Management study of the state's qualified service provider system or a section to provide that the department is to report to the Legislative Management and the 2013 Legislative Assembly on the status of the qualified service provider system

Date: 3/30/11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 8, pg 3; pg 15, attachment ONE

Motion Carried

Date: 3/30/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 2, pg 3, attachment ONE

Motion failed

Date: 3/30/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 3, attachment ONE

Motion failed

Date: 3/30/11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 6 No 1

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 3, pg 3, attachment ONE

Date: 3/31/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 4, pg 3, attachment ONE

Motion Failed

Date: 3/3/11
Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 6 No 1

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 5, pg 3, attachment ONE

Motion Carried

Date: 3/31/11
Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 6, pg 3, attachment ONE

Motion failed

Date: 3/31/11
Roll Call Vote # 4

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 7, pg 3, attachment ONE

Motion carried

department shall present its findings, the proposed plan, and any legislative changes necessary to implement that plan to the legislative management.

PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY

SECTION _. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MAANGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation would result in North Dakotans experiencing health care savings and improved medical results as well as whether implementation would impact North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

DEMENTIA CARE SERVICES PROGRAM

SECTION _. - REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services must periodically report to Legislative Management regarding the status of the dementia care services program. The reports should include information as to budgeted and actual program expenditures, program services, and program outcomes.

RISK BEHAVIOR PREVENTION EFFORTS

SECTION _ - RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENT. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of Section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts for the biennium beginning July 1, 2011, and ending June 2013. The department shall require an entity receiving a grant under this section to provide one dollar of matching funds for each dollar of state funds provided.

DEVELOPMENTAL DISABILITIES GRANTS

SECTION _. - LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

QUALIFIED SERVICE PROVIDERS

Option A

SECTION _. - LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and

evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

Option B

SECTION _. - QUALIFIED SERVICE PROVIDER SYSTEM - REPORTS. The department of human services shall report to the Legislative Management during the 2011-12 interim and to the sixty-third legislative assembly on the status of the qualified service provider system. The report must include information on appropriateness of payments to qualified service providers and the necessity of increasing the payment levels.

Date: 3/31/11
Roll Call Vote # 5

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 9, (option A - pg 15-16), attachment ONE

Motion carried

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - House changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects.		($161,840)	$0	($161,840)
Decrease funding relating to the reduction of 3 beds in the secured services unit		($519,000)	$0	($519,000)
Total House changes - State Hospital	0.00	($680,840)	$0	($680,840)
House version - State Hospital	467.51	$52,807,797	$20,146,403	$72,954,200

Other changes affecting the State Hospital:

None

Date: 3/31/11
Roll Call Vote # 6

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 7 No 0

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 4, attachment ONE

Motion Carried

Date: 3/31/11
Roll Call Vote # 7

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert			Rep. Lee Kaldor		
Vice Chairman Larry Bellew			Rep. Ralph Metcalf		
Rep. Gary Kreidt					
Rep. Jon Nelson					
Rep. Alon Wieland					

Total (Yes) 7 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 4, attachment ONE

Motion Carried

Date: 3/31/11
Roll Call Vote # 8

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Nelson Seconded By Rep. Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

substitute motion to No. 2, pg 4, attachment ONE that states DECREASE $250,000 in State Hospital operating line

Motion carried

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mental ill		($1,444,661)	$0	($1,444,661)
			0	
Total House changes - North Central Human Service Center	0.00	($1,444,661)	$0	($1,444,661)
House version - North Central Human Service Center	117.78	$11,965,366	$9,023,857	$20,989,223

Date: 3/31/11
Roll Call Vote # 9

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 7, attachment ONE

Motion carried

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - House changes:				
Reduce funding for temporary salaries		($37,930)	($52,047)	($89,977)
			0	
			0	
Total House changes - Lake Region Human Service Center	0.00	($37,930)	($52,047)	($89,977)
House version - Lake Region Human Service Center	60.00	$6,844,260	$4,483,994	$11,328,254

Date: 3/31/11
Roll Call Vote # 10

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 8, attachment ONE

Motion carried

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - House changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds		($309,128)	$0	($309,128)
			0	
Total House changes - West Central Human Service Center	0.00	($309,128)	$0	($309,128)
House version - West Central Human Service Center	135.30	$13,800,404	$12,630,961	$26,431,365

Date: 3/31/11
Roll Call Vote # 12

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Poliert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 12, attachment ONE

Motion Carried

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for chemical dependency residential services		($939,159)	$0	($939,159)
Remove funding added in the department's base budget for additional staff at the Cooper House		(350,400)	0	(350,400)
			0	
Total House changes - Southeast Human Service Center	0.00	($1,289,559)	$0	($1,289,559)
House version - Southeast Human Service Center	182.15	$20,896,174	$16,278,987	$37,175,161

Date: 3/31/11
Roll Call Vote # 12

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 3 No 4

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 1, pg 1 Q, attachment ONE

Motion Failed

Date: 3/31/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Bellew Seconded By Rep. Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson		✓			
Rep. Alon Wieland		✓			

Total (Yes) 3 No 4

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Substitute Motion on No. 2, 19.10, attachment ONE which would REMOVE all the funding to Cooper House ($813,862)

Motion Failed

Date: 3/31/11
Roll Call Vote # 15

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Kreidt Seconded By Rep. Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No. 2, pg 10, attachment ONE

Motion carried

Date: 3/31/11
Roll Call Vote # 16

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House **Appropriations Human Resources Division** **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep Kreid Seconded By Rep. Wieland

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

substitute motion to no. 3, pg 1, attachment ONE, stating to REMOVE $102,300 of general fund dollars and kept attorney position in. Motion carried

Date: 3/31/11
Roll Call Vote # 19

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Wieland Seconded By Rep. Nelson

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Substitute Motion to No. 4, pg 1, attachment one to remove funding related to IT position of $120,473, but to keep remainder of Motion carried funding in budget

- Attachment TWO - Rep. Kaldor
- March 31, 2011

11.8152.02004
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
Senator Mathern
March 4, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	328,874,163	1,629,516,486
Total all funds	$1,870,492,778	$387,226,319	$2,257,719,097
Less estimated income	1,381,801,240	137,729,602	1,519,530,842
Total general fund	$488,691,538	$249,496,717	$738,188,255"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$287,895,144	$934,244,660
Grand total special funds	1,549,066,932	143,644,024	1,692,710,956
Grand total all funds	$2,195,416,448	$431,539,168	$2,626,955,616"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	47,538,412	0	47,538,412
General fund	$31,521,462	$31,521,462	$0	$31,521,462
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,686	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	$0	$53,488,637
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	$0	$4,958,832
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	4,536,041	0	4,536,041

General fund	$6,882,190	$6,882,190	$0	$6,882,190
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	$0	$13,209,723
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	$0	$22,185,733
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	$0	$9,343,547
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	$0	$14,109,532
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	$0	$6,529,292
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	$2,580,462	$2,626,955,616
Less estimated income	1,683,661,250	1,691,270,800	1,440,156	1,692,710,956
General fund	$927,363,658	$933,104,354	$1,140,306	$934,244,660

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes	House Version
Salaries and wages	$50,346,211	$50,346,211		$50,346,211
Operating expenses	90,850,363	90,850,363		90,850,363
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	2,580,462	1,629,516,486
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,686	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
FTE	374.50	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of House Changes

	Adds Funding for Demonstration Grant[1]	Total House Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	2,580,462	2,580,462
Total all funds	$2,580,462	$2,580,462
Less estimated income	1,440,156	1,440,156
General fund	$1,140,306	$1,140,306
FTE	0.00	0.00

[1] This amendment adds funding of $2,580,462, of which $1,140,306 is from the general fund and $1,440,156 is from federal funds, for a competitive institution for mental disease demonstration grant available through federal health care reform.

Date: 3/31/11
Roll Call Vote # 18

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division **Committee**

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Kaldor Seconded By Rep. Metcalf

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert		✓	Rep. Lee Kaldor	✓	
Vice Chairman Larry Bellew		✓	Rep. Ralph Metcalf	✓	
Rep. Gary Kreidt		✓			
Rep. Jon Nelson		✓			
Rep. Alon Wiedland		✓			

Total (Yes) 2 No 5

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

.02004 - Attachment TWO

Motion Failed

11.8152.02011
Title.03000
Fiscal No. 5

Prepared by the Legislative Council staff for
House Appropriations - Human Resources
April 1, 2011

VK 4/4/11 1 of 2

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 1, line 2, remove "and to amend and"

Page 1, remove line 3

Page 1, line 4, replace "children's health insurance program" with "to provide for legislative management studies; and to provide for a department of human services study"

Page 1, replace lines 16 through 21 with:

"Salaries and wages	$14,231,353	$2,226,715	$16,458,068
Operating expenses	46,548,787	15,735,631	62,284,418
Capital assets	0	138,400	138,400
Total all funds	$60,780,140	$18,100,746	$78,880,886
Less estimated income	34,477,817	13,285,595	47,763,412
Total general fund	$26,302,323	$4,815,151	$31,117,474"

Page 2, replace lines 3 through 10 with:

"Salaries and wages	$41,389,716	$8,330,668	$49,720,384
Operating expenses	75,461,417	16,961,863	92,423,280
Capital assets	8,580	(8,580)	0
Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	260,496,543	1,561,138,866
Total all funds	$1,870,492,778	$319,795,789	$2,190,288,567
Less estimated income	1,381,801,240	92,820,911	1,474,622,151
Total general fund	$488,691,538	$226,974,878	$715,666,416"

Page 2, replace lines 15 through 27 with:

"Northwest human service center	$8,452,001	$222,567	$8,674,568
North central human service center	19,208,018	1,694,208	20,902,226
Lake region human service center	10,886,645	357,661	11,244,306
Northeast human service center	25,768,431	2,321,019	28,089,450
Southeast human service center	30,139,636	7,868,498	38,008,134

South central human service center	15,567,495	1,291,516	16,859,011
West central human service center	24,683,076	1,669,367	26,352,443
Badlands human service center	10,857,338	850,716	11,708,054
State hospital	65,641,609	7,581,591	73,223,200
Developmental center	52,939,281	(1,130,034)	51,809,247
Total all funds	$264,143,530	$22,727,109	$286,870,639
Less estimated income	132,787,875	(7,198,220)	125,589,655
Total general fund	$131,355,655	$29,925,329	$161,280,984"

Page 3, replace lines 3 through 6 with:

"Grand total general fund	$646,349,516	$261,715,358	$908,064,874
Grand total special funds	1,549,066,932	98,908,286	1,647,975,218
Grand total all funds	$2,195,416,448	$360,623,644	$2,556,040,092
Full-time equivalent positions	2,216.88	(27.53)	2,189.35"

Page 3, after line 15, insert:

"Supplemental payment	0	200,000"

Page 3, replace lines 17 through 20 with:

"State hospital capital projects	0	1,800,000
Total all funds	$92,329,503	$2,519,175
Less estimated income	88,033,205	719,175
Total general fund	$4,296,298	$1,800,000"

Page 4, remove lines 9 through 30

Page 5, replace lines 1 through 23 with:

"SECTION 5. GENERAL FUND TRANSFER TO BUDGET SECTION STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and

ending June 30, 2013, including $25,516,808 for inflationary increases for human services providers.

SECTION 6. DEPARTMENT OF HUMAN SERVICES STUDY - HUMAN SERVICES DELIVERY SYSTEM. During the 2011-12 interim, the department of human services shall review, study, and develop various plans for restructuring the human services delivery system in this state. The review and study must consider the requirements imposed on the department of human services by federal agencies under federal law, federal regulations, program state plans, and program waivers for the administration of and receipt of payment under federal programs. One of the plans for restructuring must provide for the creation of administrative units that are authorized to deliver all of the economic assistance and therapeutic social services programs and services that are currently being provided or authorized to be provided by counties and regional human service centers. The administrative units must have a direct relationship with the department of human services in administering federal programs in the state and must be locally administered. Before August 1, 2012, the department shall present its findings and plans to the legislative management.

SECTION 7. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation would result in North Dakotans experiencing health care savings and improved medical results as well as whether implementation would impact North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 8. REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services shall periodically report to the legislative management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes.

SECTION 9. RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENTS. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall require an entity receiving a grant under this section to provide one dollar of matching funds for each dollar of state funds provided.

SECTION 10. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

SECTION 11. LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with

any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 12. SUPPLEMENTAL PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $200,000 from the health care trust fund which the department shall provide as a one-time grant to the hospital in a city with a population of less than five hundred according to the 2000 census which also has a government nursing facility that participated in the intergovernmental transfer payment program."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886
Less estimated income	47,538,412	47,538,412	225,000	47,763,412
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	($64,850,068)	$2,190,288,567
Less estimated income	1,510,481,136	1,518,090,686	(43,468,535)	1,474,622,151
General fund	$731,469,093	$737,047,949	($21,381,533)	$715,666,416
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	($74,500)	$8,674,568
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	($74,500)	$4,884,332
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	($1,531,658)	$20,902,226
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	($1,531,658)	$11,878,369
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	($173,925)	$11,244,306
Less estimated income	4,536,041	4,536,041	(52,047)	4,483,994
General fund	$6,882,190	$6,882,190	($121,878)	$6,760,312
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	($93,159)	$28,089,450
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	($93,159)	$13,116,564
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	($456,586)	$38,008,134
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	($456,586)	$21,729,147
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	($94,688)	$16,859,011
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	($94,688)	$9,248,859
DHS - West Central HSC				

Total all funds	$26,740,493	$26,740,493	($388,050)	$26,352,443
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	($388,050)	$13,721,482
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	($81,600)	$11,708,054
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	($81,600)	$6,447,692
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	($68,335,062)	$2,556,040,092
Less estimated income	1,683,661,250	1,691,270,800	(43,295,582)	1,647,975,218
General fund	$927,363,658	$933,104,354	($25,039,480)	$908,064,874

Senate Bill No. 2012 - DHS - Management - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
Salaries and wages	$16,513,336	$16,513,336	$55,268	$16,458,068
Operating expenses	62,408,138	62,408,138	(123,720)	62,284,418
Capital assets	138,400	138,400		138,400
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886
Less estimated income	47,538,412	47,538,412	225,000	47,763,412
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474
FTE	116.10	116.10	0.00	116.10

1

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - House changes:				
Administration - Support				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($31,930)	$0	($31,930)
Reduce funding for operating expenses (departmentwide reduction)		(16,275)	0	(16,275)
Reduce funding for operating expenses (division-specific reduction)		(102,300)	0	(102,300)
Information Technology Services				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(23,338)	0	(23,338)
Reduce funding for operating expenses (departmentwide reduction)		(134,672)	0	(134,672)
Reduce funding for operating expenses (division-specific reduction)		(120,473)	0	(120,473)
Add funding for activities relating to the eligibility system replacement project		25,000	225,000	250,000
Total House changes - Management	0.00	($403,988)	$225,000	($178,988)

House version - Management Subdivision	116.10	$31,117,474	$47,763,412	$78,880,886

Other changes affecting Management programs or multiple programs of the department:

Section 6 of the engrossed bill is removed relating to office space lease limitation. This section was added by the Senate.

A section is added relating to a study of the human services delivery system.

A section is added relating to a Legislative Management study of patient-centered medical homes.

A section is added providing for a report to the Legislative Management on the dementia care services program.

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
Salaries and wages	$50,346,211	$50,346,211	($625,827)	$49,720,384
Operating expenses	90,850,363	90,850,363	1,572,917	92,423,280
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	(65,797,158)	1,561,138,866
Total all funds	$2,241,950,229	$2,255,138,635	($64,850,068)	$2,190,288,567
Less estimated income	1,510,481,136	1,518,090,686	(43,468,535)	1,474,622,151
General fund	$731,469,093	$737,047,949	($21,381,533)	$715,666,416
FTE	374.50	374.50	(7.00)	367.50

1

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
Program and Policy - House changes:				
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($12,054)	$0	($12,054)
Remove position and funding added in the executive budget relating to health care reform	(1.00)	(17,805)	0	(17,805)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(36,574)	0	(36,574)
Remove position and funding added in the executive budget relating to health care reform	(1.00)	(62,714)	(121,742)	(184,456)
Medical Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(24,105)	0	(24,105)
Reduce funding for operating expenses (departmentwide reduction)		(180,116)	0	(180,116)
Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty		(567,367)	(1,266,990)	(1,834,357)

level to 175 percent of the federal poverty level				
Reduce funding for the state children's health insurance program to reflect a revised premium amount		(42,989)	(95,928)	(138,917)
Remove positions and funding added in the executive budget relating to health care reform	(5.00)	(144,988)	(183,846)	(328,834)
Decrease funding for medical services to reduce projected caseload/utilization rates		(2,739,780)	(3,460,220)	(6,200,000)
Reduce funding for Medicaid payments to physicians to 100 percent of the Medicare rate		(17,448,925)	(22,037,214)	(39,486,139)
Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians		(2,065,704)	(2,634,500)	(4,700,204)
Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program		0	200,000	200,000
Long-Term Care Program				
Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011		(5,021,489)	(6,342,560)	(11,364,049)
Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority; requires the department to turn back any unexpended general fund authority from the 2009-11 biennium; and appropriates funds from the general fund for the 2011-13 biennium.		12,800,000	0	12,800,000
Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates		56,423	70,085	126,508
Decrease funding for long-term care to reduce projected caseload/utilization rates		(6,716,880)	(8,483,120)	(15,200,000)
Aging Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(5,263)	0	(5,263)
Reduce funding for operating expenses (departmentwide reduction)		(17,231)	0	(17,231)
Children and Family Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(5,697)	0	(5,697)
Mental Health and Substance Abuse Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(6,240)	0	(6,240)
Reduce funding for operating expenses (departmentwide reduction)		(26,706)	0	(26,706)
Developmental Disabilities Council				
No changes		0	0	0
Developmental Disabilities Division				
Reduce funding for salaries and wages for anticipated savings from vacant positions		(2,804)	0	(2,804)

and employee turnover				
Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043		887,500	887,500	1,775,000
Increase funding for petitioning costs for indigent people with developmental disabilities		21,970	0	21,970
Vocational Rehabilitation				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(1,995)	0	(1,995)
Total House changes - Program and Policy	(7.00)	($21,381,533)	($43,468,535)	($64,850,068)
House version - Program and policy subdivision	367.50	$715,666,416	$1,474,622,151	$2,190,288,567

Other changes affecting Program and Policy programs:

A section is added to provide that the department utilize $250,000 of federal funds appropriated to the mental health and substance abuse division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts.

A section is added to provide legislative intent regarding developmental disabilities grants.

A section is added to provide for a Legislative Management study of the state's qualified service provider system.

Senate Bill No. 2012 - DHS - State Hospital - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
State Hospital	$73,473,200	$73,635,040	($411,840)	$73,223,200
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797
FTE	467.51	467.51	0.00	467.51

1

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - House changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects.		($161,840)	$0	($161,840)
Reduce funding for operating expenses (division-specific reduction)		(250,000)	0	(250,000)
Total House changes - State Hospital	0.00	($411,840)	$0	($411,840)
House version - State Hospital	467.51	$53,076,797	$20,146,403	$73,223,200

Senate Bill No. 2012 - DHS - Developmental Center - House Action

The House did not change the Senate version for the Developmental Center.

Senate Bill No. 2012 - Human Service Centers - General Fund Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	4,958,832	4,958,832	(74,500)	4,884,332
DHS - North Central HSC	13,410,027	13,410,027	(1,531,658)	11,878,369
DHS - Lake Region HSC	6,882,190	6,882,190	(121,878)	6,760,312
DHS - Northeast HSC	13,209,723	13,209,723	(93,159)	13,116,564
DHS - Southeast HSC	22,185,733	22,185,733	(456,586)	21,729,147
DHS - South Central HSC	9,343,547	9,343,547	(94,688)	9,248,859
DHS - West Central HSC	14,109,532	14,109,532	(388,050)	13,721,482
DHS - Badlands HSC	6,529,292	6,529,292	(81,600)	6,447,692
Total general fund	$90,628,876	$90,628,876	($2,842,119)	$87,786,757

Senate Bill No. 2012 - Human Service Centers - Other Funds Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	3,790,236	3,790,236		3,790,236
DHS - North Central HSC	9,023,857	9,023,857		9,023,857
DHS - Lake Region HSC	4,536,041	4,536,041	(52,047)	4,483,994
DHS - Northeast HSC	14,972,886	14,972,886		14,972,886
DHS - Southeast HSC	16,278,987	16,278,987		16,278,987
DHS - South Central HSC	7,610,152	7,610,152		7,610,152
DHS - West Central HSC	12,630,961	12,630,961		12,630,961
DHS - Badlands HSC	5,260,362	5,260,362		5,260,362
Total other funds	$74,103,482	$74,103,482	($52,047)	$74,051,435

Senate Bill No. 2012 - Human Service Centers - All Funds Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	8,749,068	8,749,068	(74,500)	8,674,568
DHS - North Central HSC	22,433,884	22,433,884	(1,531,658)	20,902,226
DHS - Lake Region HSC	11,418,231	11,418,231	(173,925)	11,244,306
DHS - Northeast HSC	28,182,609	28,182,609	(93,159)	28,089,450
DHS - Southeast HSC	38,464,720	38,464,720	(456,586)	38,008,134
DHS - South Central HSC	16,953,699	16,953,699	(94,688)	16,859,011
DHS - West Central HSC	26,740,493	26,740,493	(388,050)	26,352,443
DHS - Badlands HSC	11,789,654	11,789,654	(81,600)	11,708,054
Total all funds	$164,732,358	$164,732,358	($2,894,166)	$161,838,192
FTE	837.48	837.48	0.00	837.48

[1]

NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($74,500)	$0	($74,500)

Total House changes - Northwest Human Service Center	0.00	($74,500)	$0	($74,500)
House version - Northwest Human Service Center	45.75	$4,884,332	$3,790,236	$8,674,568

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mentally ill		($1,444,661)	$0	($1,444,661)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(70,740)	0	(70,740)
Reduce funding for operating expenses (departmentwide reduction)		(16,257)	0	(16,257)
Total House changes - North Central Human Service Center	0.00	($1,531,658)	$0	($1,531,658)
House version - North Central Human Service Center	117.78	$11,878,369	$9,023,857	$20,902,226

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - House changes:				
Reduce funding for temporary salaries		($37,930)	($52,047)	($89,977)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(75,320)	0	(75,320)
Reduce funding for operating expenses (departmentwide reduction)		(8,628)	0	(8,628)
Total House changes - Lake Region Human Service Center	0.00	($121,878)	($52,047)	($173,925)
House version - Lake Region Human Service Center	60.00	$6,760,312	$4,483,994	$11,244,306

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($72,720)	$0	($72,720)
Reduce funding for operating expenses (departmentwide reduction)		(20,439)	0	(20,439)
Total House changes - Northeast Human Service Center	0.00	($93,159)	$0	($93,159)
House version - Northeast Human Service Center	138.30	$13,116,564	$14,972,886	$28,089,450

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - House changes:				
Remove funding added in the department's base budget for additional staff at the Cooper House		($350,400)	$0	($350,400)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(92,100)	0	(92,100)
Reduce funding for operating expenses (departmentwide reduction)		(14,086)	0	(14,086)
Total House changes - Southeast Human Service Center	0.00	($456,586)	$0	($456,586)
House version - Southeast Human Service Center	182.15	$21,729,147	$16,278,987	$38,008,134

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($84,020)	$0	($84,020)
Reduce funding for operating expenses (departmentwide reduction)		(10,668)	0	(10,668)
Total House changes - South Central Human Service Center	0.00	($94,688)	$0	($94,688)
House version - South Central Human Service Center	85.50	$9,248,859	$7,610,152	$16,859,011

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - House changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds		($309,128)	$0	($309,128)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(61,420)	0	(61,420)
Reduce funding for operating expenses (departmentwide reduction)		(17,502)	0	(17,502)
Total House changes - West Central Human Service Center	0.00	($388,050)	$0	($388,050)
House version - West Central Human Service Center	135.30	$13,721,482	$12,630,961	$26,352,443

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	72.70	$6,529,292	$5,260,362	$11,789,654

Badlands Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($69,180)	$0	($69,180)
Reduce funding for operating expenses (departmentwide reduction)		(12,420)	0	(12,420)
Total House changes - Badlands Human Service Center	0.00	($81,600)	$0	($81,600)
House version - Badlands Human Service Center	72.70	$6,447,692	$5,260,362	$11,708,054

Date: 4/4/11
Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8152.02011

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Bellew Seconded By Rep. Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wieland	✓				

Total (Yes) 5 No 2

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

see attachment ONE

Motion carried

Date: 4/4/11
Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Human Resources Division Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Bellew Seconded By Rep. Kreidt

Representatives	Yes	No	Representatives	Yes	No
Chairman Chet Pollert	✓		Rep. Lee Kaldor		✓
Vice Chairman Larry Bellew	✓		Rep. Ralph Metcalf		✓
Rep. Gary Kreidt	✓				
Rep. Jon Nelson	✓				
Rep. Alon Wiedland	✓				

Total (Yes) 5 No 2

Absent 0

Floor Assignment Chairman (Rep.) Chet Pollert to full appropriations committee

If the vote is on an amendment, briefly indicate intent:

Date: 4/4
Roll Call Vote #: 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Committee

Legislative Council Amendment Number .02011

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Pollert Seconded By Rep. Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer			Representative Nelson		
Vice Chairman Kempenich			Representative Wieland		
Representative Pollert					
Representative Skarphol					
Representative Thoreson			Representative Glassheim		
Representative Bellew			Representative Kaldor		
Representative Brandenburg			Representative Kroeber		
Representative Dahl			Representative Metcalf		
Representative Dosch			Representative Williams		
Representative Hawken					
Representative Klein					
Representative Kreidt					
Representative Martinson					
Representative Monson					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice vote carries

Date: 4/4
Roll Call Vote #: 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2012

House Appropriations Committee

Legislative Council Amendment Number .02011

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Pollert Seconded By Rep. Bellew

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X		Representative Nelson	X	
Vice Chairman Kempenich	X		Representative Wieland	X	
Representative Pollert	X				
Representative Skarphol	X				
Representative Thoreson	X		Representative Glassheim	X	
Representative Bellew	X		Representative Kaldor		X
Representative Brandenburg	X		Representative Kroeber		X
Representative Dahl			Representative Metcalf		X
Representative Dosch	X		Representative Williams	X	
Representative Hawken	X				
Representative Klein	X				
Representative Kreidt	X				
Representative Martinson	X				
Representative Monson	X				

Total (Yes) 17 No 3

Absent 1

Floor Assignment Rep. Pollert

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2012, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (17 YEAS, 3 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2012 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "and to amend and"

Page 1, remove line 3

Page 1, line 4, replace "children's health insurance program" with "to provide for legislative management studies; and to provide for a department of human services study"

Page 1, replace lines 16 through 21 with:

"Salaries and wages	$14,231,353	$2,226,715	$16,458,068
Operating expenses	46,548,787	15,735,631	62,284,418
Capital assets	0	138,400	138,400
Total all funds	$60,780,140	$18,100,746	$78,880,886
Less estimated income	34,477,817	13,285,595	47,763,412
Total general fund	$26,302,323	$4,815,151	$31,117,474"

Page 2, replace lines 3 through 10 with:

"Salaries and wages	$41,389,716	$8,330,668	$49,720,384
Operating expenses	75,461,417	16,961,863	92,423,280
Capital assets	8,580	(8,580)	0
Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	260,496,543	1,561,138,866
Total all funds	$1,870,492,778	$319,795,789	$2,190,288,567
Less estimated income	1,381,801,240	92,820,911	1,474,622,151
Total general fund	$488,691,538	$226,974,878	$715,666,416"

Page 2, replace lines 15 through 27 with:

"Northwest human service center	$8,452,001	$222,567	$8,674,568
North central human service center	19,208,018	1,694,208	20,902,226
Lake region human service center	10,886,645	357,661	11,244,306
Northeast human service center	25,768,431	2,321,019	28,089,450
Southeast human service center	30,139,636	7,868,498	38,008,134
South central human service center	15,567,495	1,291,516	16,859,011
West central human service center	24,683,076	1,669,367	26,352,443

Badlands human service center	10,857,338	850,716	11,708,054
State hospital	65,641,609	7,581,591	73,223,200
Developmental center	52,939,281	(1,130,034)	51,809,247
Total all funds	$264,143,530	$22,727,109	$286,870,639
Less estimated income	132,787,875	(7,198,220)	125,589,655
Total general fund	$131,355,655	$29,925,329	$161,280,984"

Page 3, replace lines 3 through 6 with:

"Grand total general fund	$646,349,516	$261,715,358	$908,064,874
Grand total special funds	1,549,066,932	98,908,286	1,647,975,218
Grand total all funds	$2,195,416,448	$360,623,644	$2,556,040,092
Full-time equivalent positions	2,216.88	(27.53)	2,189.35"

Page 3, after line 15, insert:

"Supplemental payment	0	200,000"

Page 3, replace lines 17 through 20 with:

"State hospital capital projects	0	1,800,000
Total all funds	$92,329,503	$2,519,175
Less estimated income	88,033,205	719,175
Total general fund	$4,296,298	$1,800,000"

Page 4, remove lines 9 through 30

Page 5, replace lines 1 through 23 with:

"SECTION 5. GENERAL FUND TRANSFER TO BUDGET SECTION STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and ending June 30, 2013, including $25,516,808 for inflationary increases for human services providers.

SECTION 6. DEPARTMENT OF HUMAN SERVICES STUDY - HUMAN SERVICES DELIVERY SYSTEM. During the 2011-12 interim, the department of human services shall review, study, and develop various plans for restructuring the human services delivery system in this state. The review and study must consider the requirements imposed on the department of human services by federal agencies

under federal law, federal regulations, program state plans, and program waivers for the administration of and receipt of payment under federal programs. One of the plans for restructuring must provide for the creation of administrative units that are authorized to deliver all of the economic assistance and therapeutic social services programs and services that are currently being provided or authorized to be provided by counties and regional human service centers. The administrative units must have a direct relationship with the department of human services in administering federal programs in the state and must be locally administered. Before August 1, 2012, the department shall present its findings and plans to the legislative management.

SECTION 7. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation would result in North Dakotans experiencing health care savings and improved medical results as well as whether implementation would impact North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 8. REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services shall periodically report to the legislative management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes.

SECTION 9. RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENTS. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall require an entity receiving a grant under this section to provide one dollar of matching funds for each dollar of state funds provided.

SECTION 10. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

SECTION 11. LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 12. SUPPLEMENTAL PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $200,000 from the health care trust fund which the department shall provide as a one-time grant to the hospital in a city with a population of less than five hundred according to the 2000 census which also has a government nursing facility that participated in the intergovernmental transfer payment program."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886
Less estimated income	47,538,412	47,538,412	225,000	47,763,412
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	($64,850,068)	$2,190,288,567
Less estimated income	1,510,481,136	1,518,090,686	(43,468,535)	1,474,622,151
General fund	$731,469,093	$737,047,949	($21,381,533)	$715,666,416
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	($74,500)	$8,674,568
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	($74,500)	$4,884,332
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	($1,531,658)	$20,902,226
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	($1,531,658)	$11,878,369
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	($173,925)	$11,244,306
Less estimated income	4,536,041	4,536,041	(52,047)	4,483,994
General fund	$6,882,190	$6,882,190	($121,878)	$6,760,312
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	($93,159)	$28,089,450
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	($93,159)	$13,116,564
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	($456,586)	$38,008,134
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	($456,586)	$21,729,147
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	($94,688)	$16,859,011
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	($94,688)	$9,248,859
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	($388,050)	$26,352,443
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	($388,050)	$13,721,482
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	($81,600)	$11,708,054
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	($81,600)	$6,447,692
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	($68,335,062)	$2,556,040,092
Less estimated income	1,683,661,250	1,691,270,800	(43,295,582)	1,647,975,218
General fund	$927,363,658	$933,104,354	($25,039,480)	$908,064,874

Senate Bill No. 2012 - DHS - Management - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
Salaries and wages	$16,513,336	$16,513,336	$55,268	$16,458,068
Operating expenses	62,408,138	62,408,138	(123,720)	62,284,418
Capital assets	138,400	138,400		138,400
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886

Less estimated income	47,538,412	47,538,412	225,000	47,763,412
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474
FTE	116.10	116.10	0.00	116.10

1

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - House changes:				
Administration - Support				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($31,930)	$0	($31,930)
Reduce funding for operating expenses (departmentwide reduction)		(16,275)	0	(16,275)
Reduce funding for operating expenses (division-specific reduction)		(102,300)	0	(102,300)
Information Technology Services				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(23,338)	0	(23,338)
Reduce funding for operating expenses (departmentwide reduction)		(134,672)	0	(134,672)
Reduce funding for operating expenses (division-specific reduction)		(120,473)	0	(120,473)
Add funding for activities relating to the eligibility system replacement project		25,000	225,000	250,000
Total House changes - Management	0.00	($403,988)	$225,000	($178,988)
House version - Management Subdivision	116.10	$31,117,474	$47,763,412	$78,880,886

Other changes affecting Management programs or multiple programs of the department:

Section 6 of the engrossed bill is removed relating to office space lease limitation. This section was added by the Senate.

A section is added relating to a study of the human services delivery system.

A section is added relating to a Legislative Management study of patient-centered medical homes.

A section is added providing for a report to the Legislative Management on the dementia care services program.

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
Salaries and wages	$50,346,211	$50,346,211	($625,827)	$49,720,384
Operating expenses	90,850,363	90,850,363	1,572,917	92,423,280
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	(65,797,158)	1,561,138,866

Total all funds	$2,241,950,229	$2,255,138,635	($64,850,068)	$2,190,288,567
Less estimated income	1,510,481,136	1,518,090,686	(43,468,535)	1,474,622,151
General fund	$731,469,093	$737,047,949	($21,381,533)	$715,666,416
FTE	374.50	374.50	(7.00)	367.50

1

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
Program and Policy - House changes:				
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($12,054)	$0	($12,054)
Remove position and funding added in the executive budget relating to health care reform	(1.00)	(17,805)	0	(17,805)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(36,574)	0	(36,574)
Remove position and funding added in the executive budget relating to health care reform	(1.00)	(62,714)	(121,742)	(184,456)
Medical Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(24,105)	0	(24,105)
Reduce funding for operating expenses (departmentwide reduction)		(180,116)	0	(180,116)
Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		(567,367)	(1,266,990)	(1,834,357)
Reduce funding for the state children's health insurance program to reflect a revised premium amount		(42,989)	(95,928)	(138,917)
Remove positions and funding added in the executive budget relating to health care reform	(5.00)	(144,988)	(183,846)	(328,834)
Decrease funding for medical services to reduce projected caseload/utilization rates		(2,739,780)	(3,460,220)	(6,200,000)
Reduce funding for Medicaid payments to physicians to 100 percent of the Medicare rate		(17,448,925)	(22,037,214)	(39,486,139)
Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians		(2,065,704)	(2,634,500)	(4,700,204)
Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program		0	200,000	200,000

Long-Term Care Program				
Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011		(5,021,489)	(6,342,560)	(11,364,049)
Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority; requires the department to turn back any unexpended general fund authority from the 2009-11 biennium; and appropriates funds from the general fund for the 2011-13 biennium.		12,800,000	0	12,800,000
Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates		56,423	70,085	126,508
Decrease funding for long-term care to reduce projected caseload/utilization rates		(6,716,880)	(8,483,120)	(15,200,000)
Aging Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(5,263)	0	(5,263)
Reduce funding for operating expenses (departmentwide reduction)		(17,231)	0	(17,231)
Children and Family Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(5,697)	0	(5,697)
Mental Health and Substance Abuse Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(6,240)	0	(6,240)
Reduce funding for operating expenses (departmentwide reduction)		(26,706)	0	(26,706)
Developmental Disabilities Council				
No changes		0	0	0
Developmental Disabilities Division				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(2,804)	0	(2,804)
Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043		887,500	887,500	1,775,000
Increase funding for petitioning costs for indigent people with developmental disabilities		21,970	0	21,970
Vocational Rehabilitation				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(1,995)	0	(1,995)
Total House changes - Program and Policy	(7.00)	($21,381,533)	($43,468,535)	($64,850,068)
House version - Program and policy subdivision	367.50	$715,666,416	$1,474,622,151	$2,190,288,567

Other changes affecting Program and Policy programs:

A section is added to provide that the department utilize $250,000 of federal funds appropriated to the mental health and substance abuse division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts.

A section is added to provide legislative intent regarding developmental disabilities grants.

A section is added to provide for a Legislative Management study of the state's qualified service provider system.

Senate Bill No. 2012 - DHS - State Hospital - House Action

	Executive Budget	Senate Version	House Changes[1]	House Version
State Hospital	$73,473,200	$73,635,040	($411,840)	$73,223,200
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797
FTE	467.51	467.51	0.00	467.51

1

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - House changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects.		($161,840)	$0	($161,840)
Reduce funding for operating expenses (division-specific reduction)		(250,000)	0	(250,000)
Total House changes - State Hospital	0.00	($411,840)	$0	($411,840)
House version - State Hospital	467.51	$53,076,797	$20,146,403	$73,223,200

Senate Bill No. 2012 - DHS - Developmental Center - House Action

The House did not change the Senate version for the Developmental Center.

Senate Bill No. 2012 - Human Service Centers - General Fund Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	4,958,832	4,958,832	(74,500)	4,884,332
DHS - North Central HSC	13,410,027	13,410,027	(1,531,658)	11,878,369
DHS - Lake Region HSC	6,882,190	6,882,190	(121,878)	6,760,312
DHS - Northeast HSC	13,209,723	13,209,723	(93,159)	13,116,564
DHS - Southeast HSC	22,185,733	22,185,733	(456,586)	21,729,147
DHS - South Central HSC	9,343,547	9,343,547	(94,688)	9,248,859
DHS - West Central HSC	14,109,532	14,109,532	(388,050)	13,721,482
DHS - Badlands HSC	6,529,292	6,529,292	(81,600)	6,447,692
Total general fund	$90,628,876	$90,628,876	($2,842,119)	$87,786,757

Senate Bill No. 2012 - Human Service Centers - Other Funds Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	3,790,236	3,790,236		3,790,236
DHS - North Central HSC	9,023,857	9,023,857		9,023,857
DHS - Lake Region HSC	4,536,041	4,536,041	(52,047)	4,483,994
DHS - Northeast HSC	14,972,886	14,972,886		14,972,886
DHS - Southeast HSC	16,278,987	16,278,987		16,278,987
DHS - South Central HSC	7,610,152	7,610,152		7,610,152
DHS - West Central HSC	12,630,961	12,630,961		12,630,961
DHS - Badlands HSC	5,260,362	5,260,362		5,260,362
Total other funds	$74,103,482	$74,103,482	($52,047)	$74,051,435

Senate Bill No. 2012 - Human Service Centers - All Funds Summary

	Executive Budget	Senate Version	House Changes[1]	House Version
DHS - Northwest HSC	8,749,068	8,749,068	(74,500)	8,674,568
DHS - North Central HSC	22,433,884	22,433,884	(1,531,658)	20,902,226
DHS - Lake Region HSC	11,418,231	11,418,231	(173,925)	11,244,306
DHS - Northeast HSC	28,182,609	28,182,609	(93,159)	28,089,450
DHS - Southeast HSC	38,464,720	38,464,720	(456,586)	38,008,134
DHS - South Central HSC	16,953,699	16,953,699	(94,688)	16,859,011
DHS - West Central HSC	26,740,493	26,740,493	(388,050)	26,352,443
DHS - Badlands HSC	11,789,654	11,789,654	(81,600)	11,708,054
Total all funds	$164,732,358	$164,732,358	($2,894,166)	$161,838,192
FTE	837.48	837.48	0.00	837.48

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NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($74,500)	$0	($74,500)
Total House changes - Northwest Human Service Center	0.00	($74,500)	$0	($74,500)
House version - Northwest Human Service Center	45.75	$4,884,332	$3,790,236	$8,674,568

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mentally ill		($1,444,661)	$0	($1,444,661)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(70,740)	0	(70,740)
Reduce funding for operating expenses (departmentwide reduction)		(16,257)	0	(16,257)

Total House changes - North Central Human Service Center	0.00	($1,531,658)	$0	($1,531,658)
House version - North Central Human Service Center	117.78	$11,878,369	$9,023,857	$20,902,226

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - House changes:				
Reduce funding for temporary salaries		($37,930)	($52,047)	($89,977)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(75,320)	0	(75,320)
Reduce funding for operating expenses (departmentwide reduction)		(8,628)	0	(8,628)
Total House changes - Lake Region Human Service Center	0.00	($121,878)	($52,047)	($173,925)
House version - Lake Region Human Service Center	60.00	$6,760,312	$4,483,994	$11,244,306

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($72,720)	$0	($72,720)
Reduce funding for operating expenses (departmentwide reduction)		(20,439)	0	(20,439)
Total House changes - Northeast Human Service Center	0.00	($93,159)	$0	($93,159)
House version - Northeast Human Service Center	138.30	$13,116,564	$14,972,886	$28,089,450

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - House changes:				
Remove funding added in the department's base budget for additional staff at the Cooper House		($350,400)	$0	($350,400)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(92,100)	0	(92,100)
Reduce funding for operating expenses (departmentwide reduction)		(14,086)	0	(14,086)
Total House changes - Southeast Human Service Center	0.00	($456,586)	$0	($456,586)
House version - Southeast Human Service Center	182.15	$21,729,147	$16,278,987	$38,008,134

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($84,020)	$0	($84,020)
Reduce funding for operating expenses (departmentwide reduction)		(10,668)	0	(10,668)
Total House changes - South Central Human Service Center	0.00	($94,688)	$0	($94,688)
House version - South Central Human Service Center	85.50	$9,248,859	$7,610,152	$16,859,011

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - House changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds		($309,128)	$0	($309,128)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		(61,420)	0	(61,420)
Reduce funding for operating expenses (departmentwide reduction)		(17,502)	0	(17,502)
Total House changes - West Central Human Service Center	0.00	($388,050)	$0	($388,050)
House version - West Central Human Service Center	135.30	$13,721,482	$12,630,961	$26,352,443

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	72.70	$6,529,292	$5,260,362	$11,789,654
Badlands Human Service Center - House changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($69,180)	$0	($69,180)
Reduce funding for operating expenses (departmentwide reduction)		(12,420)	0	(12,420)
Total House changes - Badlands Human Service Center	0.00	($81,600)	$0	($81,600)
House version - Badlands Human Service Center	72.70	$6,447,692	$5,260,362	$11,708,054

2011 SENATE APPROPRIATIONS

CONFERENCE COMMITTEE

SB 2012

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-13-2011
Job # 16534

☒ Conference Committee

Committee Clerk Signature Alice Dilzer

Explanation or reason for introduction of bill/resolution:
A CONFERENCE COMMITTEE HEARING ON DEPARTMENT OF HUMAN SERVICES.

Minutes: You may make reference to "attached testimony."

MEMBERS OF THE CONFERENCE COMMITTEE ARE AS FOLLOWS:

SENATE: Senator Kilzer (Chair), Senator Fischer, Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor
OMB: Lori Laschkewitsch, LEGISLATIVE COUNCIL: Roxanne Woeste

Senator Kilzer opened the conference committee hearing at 9:30 am on Wednesday, April 13th. Let the record show that all the conferees are present. This is the largest budget in the history of the state. You will hear my voice more than Senator Fischer; we are all subject to Chairman Holmberg. These changes the House has made since it left the Senate.

Rep. Pollert states, please ask questions as we are going along. You end up with amendment .02011 going back and forth. Page 5, Administration Support. All of these things were not unanimous in our section or through the whole appropriations but that is what had passed. Overall, the first one says, reduce salaries and wages for anticipated savings from vacant positions. The overall, the Dept. of Human Services, there was $750,000, as an amendment for vacant positions. If you add up $31,930 and you are going to see it through the dept. came up with the dollar figures per administration, information technology, medical services, child support and you will see that that all through those pages. I will try not to bring that up again. We did go through, in our section, to make sure that the $750,000 added up. The first one, administration, $31,930, that is part of the $750,000. The next one, Reduced Funding for Operating Expenses, Dept.-wide. What we had done was we had an amendment passed for $375,000 of general funds, department wide, the same as how they did the vacant positions and so the Dept. split them through. You will see that. If you add them up for the departments, that will add up to the $375,000. You will also see when you get to the Human Service Centers, another cumulative of $100,000 of the same way of dept.-wide reductions on operating expense for $100,000 on the Human Service Centers. Reduced Funding for Operating Expenses, $102,300, that is the division specific. I think there was an attorney hired, during the interim and the dept. had asked for $102,300 for related expenses dealing with the attorney. On the House side, we had taken out the $102,300. Originally, there was a move to pull the attorney but that

did not happen. Information Technology, the first part is part of the $750,000, vacant positions, also operating expenses, department-wide, is $134,672 and then the $120,473, I don't remember what the FTE was, I remember it was 1/5th FTE but can't remember what it was for. $120,000 same as the one for the attorney up in Administration support. Adds funding for activities related to the eligibility system replacement project. It was not in the governor's budget but for the computer eligibility system. The $250,000 total does, it starts the IT basic work of getting a system ready. What we were told for eligibility wise, example of CHIPS, if healthcare reform is instituted there are going to need this system. It is not only for CHIPS.

Senator Fischer asks, on the eligibility replacement system project, is it the feeling of the department that this is all the IT money that is going to be required to start this? We have a proposal in another bill that we were discussing with added FTE's that you took out. Is this the anticipated amount that they are going to need to get that going between now and November?

Rep. Pollert states, I think you and I will be staring at each other at 11:30 due to me being asked to be on that section of government approps for the House side. There is a total accumulation of about $42M for the system. I don't think you were funding that whole thing in the ITD dept. What I had asked the dept. was, what would you need to start? That was the $250,000. With the acknowledgement that coming in for special session, on the House side, we have talked about all the healthcare reform is going to have to be addressed during the special session. That was our thoughts of that computer eligibility system; we would start the IT planning. Depending on how the ITD budget goes, this will have to probably be taken out unless whatever happens on the other budget for the two to reconcile.

Senator Fischer asks, if this for an FTE for personnel? Have we got duplication in this the ITD budget?

Rep. Pollert states, I should have brought the piece of paper I have but I put it on the ITD thing for 11:30. So I didn't bring it down. I am sorry for that.

Rep. Pollert states, Section 6, engrossed bill, is removed relating to office space lease limitation. On the House side, we had gone through all the departments and I think this was on the discussion about the Prairie Hills Plaza, we got 90-95% of all the rates charged in the state and the discussions on where could they move if they had to move from Prairie Hills Plaza if the rates weren't there, after our discussions? It was moved and approved to take out the language about the lease office space.

Senator Warner asks, was that because there was no other space at a price or was it just that you thought that things were going good there and they should stay there?

Rep. Pollert states, with the size of Prairie Hills Plaza and all the office space being leased there, we asked the question, there is no other place in Bismarck that could accommodate that size for all the services that are being offered there. We had some discussion, as far as rates statewide and I don't have those numbers in front of me. Was it high? I don't know

how to answer that yet? Yes and no. There was definitely higher in the north part of the state of $25. and some odd cents a sq. ft.

Senator Warner states, if I recall, that one was 190 sq. ft. office space at $25/sq. ft. one, a large closet. I think one of the things we need to, at some point, and I hope this will provoke the discussion, is whether the state should be building or renovating a building in order for its own needs, within 4 years, 2 biennium's, could easily pay for a building at the rate we are paying rent. I think there are properties in town which could be renovated starting from scratch with stick construction. I would hope at some point we would seriously look at this issue and we do incorporate a study resolution within this since we will be meeting again.

Rep. Pollert states, there isn't any study language in this bill. Continuing on, then you will see .0211, page 3, you will see that section 6 is a Dept. of Human Services study on a Human Services delivery system. You will see 7 is a study on Patient Centered Medical Homes. I think we should have some discussion about that. If I am correct, section 7, the Medicaid Advisory Committee is currently in a study but it was brought forward and was passed and put in to the amendments. Then there was a section added, that would be page 3, section 8, added Providing Report to Legislative Management on the Dementia Care Services Program from the last biennium. There was $1.2M added to the Dept. of Human Services. It was approved by the committee and whole appropriations and the floor that we should get a more detailed report on what that $1.2M is doing with services it is providing. That was Rep. Bellew's amendment, if I am correct, and you are hoping to accomplish? That is why section 8, page 3, was added. Program Policy and you will see anything dealing with healthcare reform; the FTE's were pulled out. That is what you will see on page 6 on amendments. You will see there is a -7 under House changes. What that will be is an FTE from economic assistance division, the child support division and 5 from medical services. You will see those numbers as I go down the program and policy. That is why the 7 is out there so that would need to be addressed in the special session. On a similar subject matter as our discussion on the eligibility system. Page 6, Program and Policy, unless you ask me to do something in particular, anything dealing with department wide vacant positions, that is part of the $750,000, and then you will see Operating Expense, off and on through here, depending on where the department wanted those cumulatives of the operating expenses to come from. You will see in Economic Assistants, is one of the FTE's from Healthcare Reform, and was pulled. Child Support, one of the FTE's of the 7, was pulled. Medical Services, same thing, a part of the vacant FTE's, part of the operating expense of $375,000 and then the Senate had added CHIPS. On the Senate side, we are at currently at $160,000 net. The Senate had added it going up to $175,000, the House had pulled that out, that was not unanimous, and it was voted and approved. That is why you see the $567,367; $1.8M was to put us back at the current level at the 60%. There was $650,000 that was approved for outreach that was approved last session and I think it was a grant program. That is still in the DHS budget. Page 7, the Reduced Funding, funding for the State Children's Health Insurance Program to reflect revised premium amounts. That deals with BC/BS and lower dollar amounts. That does not deal with the $175,000 back to the $160,000 level. The other 7 FTE's on healthcare reform that is the other 5 for a total of 7 FTE's. We looked at Caseload Utilization. The last two biennium's, the House side has looked at caseloads on medical services, long term care and DD population. What the House side did this time, we looked at caseload on medical

services and caseload on long term care. The medical services are $2.7M, $6.2 total. We looked at inpatient hospital and when we get further, if we meet again, we can get down to how we come with those dollar figures but that is where that comes from is the House's look at caseload. We did not touch the cost parts of the caseload utilization, just on the caseload. Reduced Funding for Medicaid Payments to Physicians, the 100% I think should be 102.48%, I think, that is $17.4M. General funds, $39.486M total funds. Last biennium, the budget, from then Governor Hoeven, was 25% of physician's services, 25% of the costs of physician's services and at the end of the legislative session, last session, it was put at 75% and on the House side had asked what that meant? As far as the % of Medicare and that particular date of July 2010, that came out to 142% of Medicare. The amendment was brought forward, wanting to have the discussion, and it was definitely not unanimous that we wanted to have a discussion with the Senate as far as 142% of Medicare and what that means vs. 75% of physicians services. And that is why you see the amendment there. We also have a 3&3 inflationary through everything. The idea about the Medicare 142% vs. dropping that to 102.48% and the 3&3 was not meant to some things being a double hit. We want to have the discussion as far as that $17.4M general funds and the $2M of the 3&3. One time funding for healthcare from the Healthcare Trust Fund for $200,000 to a nursing facility. That comes out of the healthcare trust fund for $200,000.

Senator Kilzer asks, which facility is that?

Rep. Pollert states, that would be in District 23, McVille. That stems from the discussion on HB 1152. Originally, HB 1152 was $18M and $500,000 to 36 facilities and then it put down as critical access hospitals. So originally, McVille would have received $500,000 on the $18M and when HB 1152 went through its evolution on the House side, it ended up being dollar amounts on diagnostic lab tests and McVille basically had nothing and I think that is the reason for the amendment.

Senator Kilzer states, that was diagnostic labs and CRNA's.

Rep. Pollert continues testimony. Long term care. Members, we did a dollar increase to the DD providers, a dollar increase to the QSP's and an approximate 85 cent increase to the nursing homes for staffing. Not all nursing homes. Plus there was a 6&6 in the dept. but the hospitals are 0&6. When we looked at what we did last biennium and then we looked at the 3&3, we looked at the 50 cents, we thought the 3&3 was appropriate and so we reduced it 6 cents. Moving down, $12.8M is dealing with turn back. Page 2, of the amendments, the Dept. is calculating they are going to have $12.8M of turn back. They had put it in the agency budget under the long term care division. General fund turn back is not suppose to affect the budget stabilization fund, Section 5 of the bill, page 2. That is where the $12.8M comes from. So it is budget neutral. House bill 1169, is a bill that has passed. The funding was taken out of HB 1169 and that is why you see the $56,423, $126,500 total for the funding was put in that addresses HB 1169. We thought it should be in the Human Services budget. We looked at caseload again. On the long term care and that is why you see the $6.7M, $15.2M total equates to 100 beds. Aging Services, nothing done. Children and Family Services is the same thing. Page 7, is the $5700, deals with the vacant, Mental Health and Substance Abuse, same thing dealing with the vacant positions and operating expenses. No changes to DD council. Page 7, the DD division is the same thing about the vacant positions. Top of page 8, adding funding for expenses associated

with implementing SB 2043. The funding, the appropriations in SB 2043, was pulled out and this $887,500 and $$1.775M is the funding for SB 2043, which is basically moving the DD from a retrospective system to a prospective system dealing with assessments. Increased funding for petitioning costs for indigent people with DD. Amendment was added for $21,970 and that deals with petitioning costs and courts. We questioned if all those costs was robbing from Peter to pay Paul. They said they were. That is why the almost $22,000 was added to the budget. Vocational Rehabilitation. It deals with the vacant positions we had done. Other changes affect in program, our policy, SB 2314, dealt with Students Against Destructive Behavior. We talked to the dept. page 3, section 9. That is the $250,000 coming out of a onetime grant of $4.4M. The dept. agreed to fund that up to $250,000. There is language in section 9, saying a dollar for dollar match from an outside source. We were told in discussions, SB 2314, failed on the House side with the understanding that the funding would be found in the Human Services budget, $250,000. Legislative intent regarding DD grants. Other biennium's, we had looked at caseloads utilization in the DD section and taken money out but we did not do that this time. It was not unanimous but the majority of the committee felt there was going to be money in the DD section. The priority was to move from the developmental center out to the comment. The intent language is on page 3, section 10. We purposely did not take any reduction from the developmental center and you will see that later and also did not do anything as far as the caseload utilization saying any of those dollars should be going to move them out into the community. Last thing, page 3, section 11.

Senator Kilzer states we will quit there and take this up next time.

Senator Kilzer closes the conference committee on SB 2012. (Conference Committee on Dept. of Human Services).

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-14-2011
Job # 16585

☒ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A CONFERENCE COMMITTEE FOR THE DEPARTMENT OF HUMAN SERVICES.

Minutes: You may make reference to "attached testimony."

MEMBERS OF THE CONFERENCE COMMITTEE ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair); Senator Fischer, Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor
OMB: Lori Laschkewitsch
LEGISLATIVE COUNCIL: Roxanne Woeste

Chairman Kilzer opened the conference hearing at 9:00 am on Thursday, April 14, 2011 in the Harvest Room in reference to SB 2012. Let the record show that all 6 conferees are present, working off document # 02011. Chairman Kilzer states that he would like to pick up from there today about the two largest changes that the House made. Please proceed.

Rep. Pollert states, the section added regarding legislative intent regarding the DD grants, dealing with the developmental center and going out to the community and caseload utilization. That was unanimous in our section. Starting down on **Page 8, with the State Hospital.** We removed the funding added by the Senate for **Onetime Capital Projects**. If I am correct, the State Hospital had submitted $1.961M. The executive budget had $1.8M approved and the Senate added the $161,000 and we had taken that out. **Reduced Funding for Operating Expense**. We looked at the State Hospitals. We had a discussion on sex offenders and caseload amounts. That was then amended and we looked at their operating expense and we thought there was a little money there so that is why you see a reduction of $250,000. **Page 9**, there was nothing on the **Developmental Center** that we changed. **Page 9, the Human Service Center**. You will see the continual of the $750,000 vacant FTE vacant FTE for the **Northwest Human Service Center**. You will see the amount throughout all the Human Service Centers. What we also did was a $100,000 of general fund operating expense that you will see through some of these Human Service Centers. **On page 10,** you will see a **North Central** where that shows up, $16,257 is part of the $100,000. Our section did go through and see if it did add up to $100,000 and that was there. What you will see in the **North Central**, on the psychiatric hospital, there was about $6.1M for psychiatric hospital in-patient care. That was left in the Human Service budget. There were 3 items included in that. That was for a $939,000 for **South East** for a

chemical dependency included in that $6M. **North Central** was the $1.44M and you will see **West Central** for about $309;000 to go from 10 beds up to 14. It was not unanimous but was done by the section and approved by the whole appropriations, was removing the funding for the SMI beds in **North Central** for $1.44M, that you see on page 10. You will see the vacant positions in there and the department wide operating reductions. **Lake Region**, I think there was 7/10th of a part time FTE. That 7/10th for the $37,930 came out of temporary salaries. The vacant FTE's are there again and the operating expense. **North East** and the only changes were the same thing with the vacant positions and the department wide operating expense. **South East** is where all the psychiatric hospital $6M, besides the miscellaneous and where that was located. I will say that the 4932 days, which is the Big 6+1, through the human service centers, is where that was located at. This is still in the budget. What you will see in the **South East**, it says, remove funding added into the departments base budget for additional staff at **Cooper House**. I would have to go back but it was around $490,000 is what the department was requesting. I would have requested a second FTE, a 24-7 FTE position. There was a move to remove all of $400,000 but what was removed was $350,000, which was the second FTE, 24-7. Last biennium, there was not enough dollars for Cooper House. There was one FTE that was authorized for 24-7. There was not enough dollars to accommodate that 24-7 FTE. That is why the total $400,000 was not taken. $350,000 was for the second FTE for Cooper House. The part of the psychiatric, the chemical dependency unit, at **South East**, that did not change and is in the Southeast Service Center budget. **South Central**, there is not any changes except for the vacant FTE's and department wide operating expense. **West Central**, what you will see for the $309,000 budget is to expand the residential adult crisis from 10 beds to 14 beds. The section had removed that $309,128, those 4 beds which was part of the psychiatric hospital, $6M. You see the vacant FTE's and MD department wide. Then you will see **Badlands**, it has vacant FTE's and department wide expenses. So when you look at the Human Service Centers, the psychiatric hospital treatment, that is $6M for the Big 6+, for the $3M that is still in the Human Service budget, the chemical dependency unit and the **South East Human Service Center**. That was in the budget and that was $939,000 but was taken for that was the **North Central Service Centers** for the SMI bids at $1.44M and the $309,000 in **West Central**. Did I get all the sections covered as far as the studies? Yes, I did. Mr. Chairman and members of the conference committee, I think I went through the amendments in .02011. I may have missed some but that is the overview.

Chairman Kilzer asks, any additional comments regarding those items? Any ideas on your generalized philosophy on how you started and how you finished on the House changes? These are tremendous changes. Very large changes. Very unit directional. I think on the Senate side, we feel some can be upheld, others are way far out.

Rep. Pollert states, general overview, the case load utilization, those are some numbers and we have always looked at those numbers. Medical services, long term care and the DD. We did reduce the caseload, we did not look at costs, and we looked at the case loads. So 2 out of the 3, we did do the reductions in the case loads there. We did not look at the DD portion. We thought if there was any anticipated case load not being used; it should be used for the transfer from the developmental center out to the community. The House has always looked at the vacant FTE positions. Maybe I am wrong about this until the Senate has a say but House side, as far as the House Republicans, aren't as overall as friendly on the CHIPS program. From the 175 to 160, the outreach is still in there. The

other major thing is the physician's services and 3&3. We will need to have some discussion.

Senator Fischer asks, on the DD that you left in and that they can use any leftover money on the developmental center, we got to the point where it is very difficult to move some of these people because of their medical situations. Would that money be available to look for alternatives for housing those folks somewhere other than Grafton or it could be a Grafton by a different method. The reason I bring that up is there has been some discussions between Anne Carlson and Alex for these people that have serious medical situations. Would that be construed, as a good use for that money, if everyone is moved out of that, than can be, in this biennium?

Rep. Pollert states, I think I said in a previous biennium and this biennium in our section and in our deliberations as well, that there is a population at the developmental center, move severe cases that are going to have to be in some sort of center. I question, whether they are able to be serviced in a community setting, as a lot of the others, the other way so they can keep them. (Conversation inaudible). Will they all be transferred out of there? They are going to have to be looked at. Will they be at the developmental center? I know there could be some modifications at the developmental center and so some modifications to some cottage-type apartment type, that could work, if this is what the town and developmental center want to do. They better be looking at it but that is my opinion. We do not have that as far as a study and that message has been relayed to one of the House members, at least on the House side, from that district. There is going to be a continual move from the developmental center out to the community of some sort. They are going to have to be taken care of somewhere.

Rep. Kaldor states, I don't know if this testimony came before Senate or after crossover but we did have testimony on the Olmsted case and the issue of transitioning. One of the points of disagreement that we had on our side was how this is done. Utilizing unexpended funds to help transition was described as probably a difficult thing to do. You can't really transition and save at the same time. You have to invest in the transition first, and then move them out. You question about where would they go and how would we do the transitioning? That did come up in our committee. The difference of opinion was some of the minority felt; we should probably make some kind of investment in that up front as opposed to the methodology that is used here. That was the difference in our discussion.

Rep. Bellew states, it was some of our thought that they are going into transition now without extra money. We think there is money in the DD line item that they can continue to do that. That is why we did not look at caseload utilization numbers in the DD line. Some of us on our committee feel there are monies there for the department and the developmental center that they can continue to transition into communities.

Senator Kilzer states, the testimony from Mr. Schweitzer was that the transition is going much slower than in other ways than if there was more money being used for the transition.

Rep. Pollert states, we had talked about, Rep. Bellew and myself, sat down and were going through the caseload utilization on our own. We looked at the caseload utilization in the past and we thought it was more appropriate instead of taking the $2.6M out, on the caseload utilization, like the long term care with the 100 nursing home beds. We thought

the legislature intent was a smoother way of bringing it forward instead of arguing about caseload utilization on DD like we normally do.

Senator Kilzer asks for your response on the way you handled vacant positions? You have eliminated them and removed the funding. Do you have concerns when you remove vacant positions that you realize these are the hard to find positions and maybe the most necessary and difficult to eliminate?

Rep. Bellew states, the positions are still there. The department has the ability to fund those positions within their current budget, the one that passes. They have the ability to move from line item to line item within their budgets. The positions were not removed. We underfunded what we thought was an adequate number of FTE's. They will be hard to fill. The money could be used better elsewhere or not at all. We thought maybe not all in this case.

Rep. Pollert states, Rep. Bellew has normally brought forth that amendment. It is a snapshot in time. At around the end of December, there was around 78 FTE's that we asked for and sometime around the end of February or around crossover, there was a snapshot at 48. We took that number difference; we took that number at 75%, to come with the $750,000. That was not the unanimous in the section. So that is how we came to that methodology. Is that correct Rep. Bellew? The response is, correct.

Senator Kilzer states, I am not familiar with large accounting practices, if that is a practice used in budgeting. However, 78 positions unfilled out of department of 2200, is less than 5%. I am not sure the accounting procedure. I do have concern about the more difficult and more essential position that has to be filled.

Rep. Pollert states, we look at that in kind of the same fashion as we looked at operating expense. When we go through the detailing and the SPARE reports and the operating expense, through the line item and we thought travel expense was high. We make notations of that. Then we ask for them for the year 1 expenditures, take that times 2, how much have you done, and that is the methodology that we have gone through. I was shown that by the previous chairman as well.

Senator Fischer asks, did I hear you say that you underfunded hard to fill positions?

Rep. Bellew states, it was based off the FTE list that we were given.

Senator Fischer asks, let's say you are taking so many positions and taking dollars out for each one, through this methodology.

Rep. Bellew states, it was based off the FTE list that we were given.

Senator Fischer asks, let's say you are taking so many positions and taking dollars out for each one, through this methodology.

Rep. Bellew states, basically yes. There are positions that differ hugely in the budget and how do you account for that? That is why we have managers in the Dept. of Human Service.

Senator Fischer asks, if you underfund them, how can they fill them if the last shift they can make in dollars isn't enough to cover the position, such as a psychiatrist at the hospital?

Rep. Bellew states, they have the ability to move in the line items.

Senator Fischer states, you are okay with not fully staffing certain areas?

Rep. Bellew states, that is not what I said. I said, they can shift funding from one line item to the other.

Senator Fischer states, only so much.

Senator Bellew states, to their ability to manage the department. Yes, they can.

Senator Fischer states, because of the underfunding, at some point they are understaffed in certain areas, do you have a problem with that?

Rep. Bellew states, I don't think it will come to pass like that senator.

Senator Fischer asks, and if it does?

Rep. Bellew states, they are wonderful manager, they will figure it out. Their dept. will run very smoothly.

Senator Fischer asks, you are sure of that?

Rep. Bellew states, yes I am.

Senator Fischer asks, Senator Warner, will you make your presence known by saying something?

Senator Fischer states, we will conclude this meeting. The next meeting, we will talk about the two largest changes. #1) is the reimbursement for physicians #2) in long care, the case load.

Rep. Pollert states, when I let them know we needed to meet again, they talked about us possibly going two times in one day. I told them I would let the committee know they may try to sneak in more than one a day.

Senator Kilzer states, think about proposals to bring forward because we have a lot of changes to be dealt with. Thank you.

Senator Kilzer closed the hearing on SB2012 (Conference Committee for Dept. of Human Service).

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-14-2011
Job # 16623

☒ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A CONFERENCE COMMITTEE HEARING ON DEPARTMENT OF HUMAN SERVICES

Minutes: Discussion

MEMBERS OF THE CONFERENCE COMMITTEE ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair); Senator Fischer, Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew; Rep. Kaldor
Lori Laschkewitsch, OMB; Roxanne Woeste, Legislative Council

Chairman Kilzer: Opened the conference committee hearing at 4:30 pm in the Harvest Room on SB 2012. Let the record show that all 6 conferees are present. This is our third meeting, the second one today. We will focus today a little on the specifics, .20211, page 6 and 7 the medical services program, particularly want to focus on the very large items in the physicians program, the change of thirty nine million four hundred and eighty six thousand and also the item above it, the 6.2 million and if we have time we will go to long term care and ask for detailed explanation from the house members regarding the executive budget allowing the department to continue unspent general fund appropriations and utilize unexpended funding in the present biennium and removing section 5, will ask for the details of that. We will focus on the item reducing funding for Medicaid payments to physicians to one hundred percent of the Medicare rate. Representative Bellew, take us through the thinking and the reasons on that line item now.

Rep. Bellew: Whenever we do the detailing of the human services budget we ask for a list of the OAR, and they list their priorities.

Chairman Kilzer: OAR's are optional adjustment requests.

Rep. Bellew: The number one priority was a savings plan, which is a reduction of 61 million dollars. They said they were asked to present a 97% budget and this would have taken care of that, in that 3% savings plan and in that 3% savings plan they got a list hospital rebasing, physician rebasing, dental, ambulance and chiropractic rebasing. That is what they would have reduced, if the ninety percent budget would have been requested by the governor. We noticed how big the physicians was, the physicians last session were rebased at a 142% of Medicare,

this was not based on Medicare rebasing reimbursement rates it was based on the physicians cost through a report that the department received. This was the report based on last session; Governor Hoeven presented 25% cost of rebasing, during conference committee that was increased to 75%. We didn't know that the 75% of cost went to 142% of Medicare. I proposed the amendment and this is where it is now.

Chairman Kilzer: Is this really what you would like to see happen.

Rep Bellow: They were collecting 142% of Medicare rate while the other services weren't.

Chairman Kilzer: You were on the committee last session you had the benefits at looking at the rebasing reports for hospitals, nursing homes, physicians, chiropractors and ambulance drivers and dentist, at the end of the session we accepted 100% rebasing of nursing homes and hospitals, and we accepted 75% for the other four categories.

Rep Bellew: Were not the hospitals rebased at Medicare and not at cost?

Chairman Kilzer: Not the critical access. Medicare was figured in the factor, let's focus on physicians, the pre rebasing returned to physicians is 51% of their costs. They cost shift 49% over to other payers, these are individual payers, commercial insurance, workers comp, all of the various third party payers that there are, after the rebasing at 75% the actual return since the rebasing went into effect to physicians is 89% of their costs. Even in the present situation they still had to cost shift 11% over to other 3rd party payers. The reduction by the house returns basically back to the Medicare rate, why would you choose Medicare as your base?

Rep Bellew: I chose that because it is what the feds reimburse at.

Chairman Kilzer: What do you think physicians will respond to this type of reduction? I think they will say sorry. When you can't keep your doors open, you are forced to not see people. This is a state program.

Rep Pollert: The hospitals were rebased at allowable costs. First I think in that public consulting group, the study was down in 2008, and it was done in the surrounding states, they were all around 103%. The last biennium Governor Hoeven's executive budget was 100% for hospitals, 25% for physicians, we had tried to keep it at 25% then the senate put it at 75%. That would have meant 142% of Medicare rates and when you look at the reimbursement from the other states, it is a little high.

Chairman Kilzer: I find great fault with your dependence on Medicare because Medicare is being shrunk all the time. As you know in the health care reform there are reductions of up to four hundred and seventy billion dollars in Medicare. To tie our Medicaid reimbursement rate to Medicare is unacceptable. You would think 142% is high, but it's not compared to other third party payers, the blues pay more than that. You are going to run physicians out of business, it really isn't appropriate for us to be adding physicians by expanding the medical school graduating class when we don't even retain half of our physicians in ND, and then put this burden on them is not very good, I would ask you to reconsider this. Yesterday, someone made the point that physicians should be paid less if their employed by a hospital. I would contend it is reflected in the charges of services of certain lab or x-rays and done in a hospital

the overhead is a higher of a physician based hospital then it is of someone who works in a clinic or out- patient facility.

Senator Fischer: In a discussion about using Medicare as the comparison or to base these rates on, is that Medicare is directly going to be affected by the federal healthcare that we are facing now. This morning you were adamant about the entire house position but that they didn't want to do anything that was attached to the federal government. This state has severed the income tax from the federal government but you decide to use the federal government to carve out one service.

Rep Bellow: That was a different bill.

Discussion continued

Chairman Kilzer: Asked him to go one line up and comment about the decreased funding for medical services to reduce projected case load utilization rates. Is that referring to a specific population?

Rep Bellow: That was the utilization in the medical services included inpatient hospital, outpatient hospital, physicians, drugs, etc. He explained the changes.

Chairman Kilzer: The healthy steps, isn't that bid out, that's the CHIPS, but how could you even talk about utilization, when that's bid out.

Rep Bellow: We thought it was high. He continues going over the changes.

Chairman Kilzer: A little over half of it is inpatient hospitalization.

Rep Pollert: Those numbers are detailed of the selected services and what the department brings forward inpatient hospital is because of the timing of the budget. He explains how they came up with the numbers.

Chairman Kilzer: I want to spend a moment on the 3 and 3 for physicians.

Rep Pollert: He explained his vote. He said it was discussed that they needed to vote on the 3 and 3 or else it could not come up in the conference committee. That was the main reason he requested the vote of the committee, for the 3 and 3 to be pulled.

Chairman Kilzer: Are there any specific subjects for tomorrow morning sometime. I invite you to ask the council or the clerk to bring your ideas into amendment form. We will close the hearing.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-16-2011
Job # 16697

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A CONFERENCE COMMITTEE HEARING ON DHS

Minutes: You may make reference to "attached testimony."

MEMBERS PRESENT ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair); Senator Fischer, Senator Taylor
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor

OMB – Lori Laschkewitsch; LEGISLATIVE COUNCIL – Roxanne Woeste

Chairman Kilzer opened the conference committee hearing at 1:30 on Saturday, April 16, 2011 in reference to SB 2012, The Department of Human Services. Let the record show that all conferees are present. (Senator Taylor is sitting in for Senator Warner).

Chairman Kilzer states, I assume Senator Taylor will have a lot of questions. I relinquish this back to Senator Warner. Welcome everyone; we probably have about 3 more meetings to go into next week. I invite amendments, and we will be working off of .0211 that is our starting document at this point. Welcome any questions or comments from committee people here.

Senator Fischer asks, one thing in reading through this the health care trust fund, if council or OMB, where's the status of it as of today? I don't know if we will get to it today. If you could get that for us, we would appreciate it.

Chairman Kilzer asks, for Roxanne to also include, what are the future commitments of that fund? As I recall in HB 1041, rated it, around $800,000, and I don't know what the commitments are. We'd appreciate having that.

Rep. Pollert asks, I thought there was a bill dealing with registry, HB 1041?

Chairman Kilzer states, that concerned the registration of unlicensed nursing home people, particularly certified nurse aides. Are there any other questions?

Rep. Pollert asks, are there areas where we are really far apart? Did you have a question on the case load utilization or on long care beds?

Chairman Kilzer states, I could use a little refreshing in that area. Particularly how solid the 100 beds are and any other implications that go with that. Things like the future, if 100 beds is too low or too high, what do we do or forced to do down the line?

Rep. Bellew states, I yield to my chairman.

Rep. Pollert states, what we figured on the nursing homes were 100 beds. We used the cost of $187 and that came out to $14M. We didn't do anything on basic care. We looked at home and community based services and that was around $700,000. My notes show using 25. Then we looked at xbed. We figured 5 beds but that was $34,000. That in a nutshell, we would gathered them off of the caseload worksheets that we asked the dept. to pull for us. There was some consideration of adding another 25 beds. We didn't do that. We felt very comfortable with 100 beds as the centerpiece of the $15.2M. That is how we came up with the figures. We did not play with the costs.

Chairman Kilzer asks, any other comments?

Rep. Kaldor states, regarding the caseload utilization, one of the questions on the House side, what would the consequence might be, if our estimate is off or too optimistic, in reference to caseload utilization? What impact will this have if we are on the short side? I don't know if the Senate entertained that when it was in front of you or not.

Chairman Kilzer states, I don't think we changed that part of it at all. This is a House action, of course. He asks Rep. Bellew if he has any additional comments. The response is no.

Rep. Pollert states, in previous biennium's, we have always looked at the medical services and the long term care and the DD. Two biennium's ago, we actually were close on our caseload numbers. Last biennium, we were pretty close on long term care. I will be the first to admit, we were off on the DD and that is why we were very careful this time about looking at the DD portion. Also, when we looked at the DD, we always put in the statement of the Bank of ND. Since we did not touch DD, and have intent language, that is why there is no mention of the Bank of ND. We seem to run into trouble, when we look at the caseload utilization on the DD population and that is why we didn't go there. The numbers coming from Rep. Kreidt are usually pretty good.

Chairman Kilzer states, that is why there can be two safety nets, one would be a line of credit at the Bank of ND and one is going to the emergency commission.

Rep. Pollert states, we have nothing in our amendments that have the Bank of ND as a backup. We avoided that this time. **Legislative Intent on the DD**. This is more for the record than anything else. The **legislative intent on Section 10, page 3,** on the OAR listing, I think that was from the developmental center down, is about $2.7M general funds and $6M total. Our language in there is our attempt to try and to accomplish the step to get down to 67. It is not to get down to 60 or 50 or 40. The intent language is to work in the direction of 67. It is not to pull all that out of there. The whole system is not ready for that yet. As I mentioned, there are some opportunities out there for people in the town of Grafton or it could be anywhere in

the state. There are maybe 40 individuals out there that are going to take a little more than just a congregate type of setting. I have to ask for the other members opinions about that.

Rep. Bellew states, that it is correct. We thought that there was probably some saving in DD on the caseload utilization. However, we know to try to get the developmental center down to their goal of 67, they would need some leeway to put these people out in the public. That is our goal. This amendment is to encourage excess funds in that line item to get those people out of that developmental center.

Chairman Kilzer asks, does the estimate of the reduction of 40 FTE's at the developmental center still hold?

Rep. Bellew states, yes.

Rep. Pollert states, I think there is an opportunity at the developmental center to have some sort of cottage congregate type of living for the DD population. I know it would take some remodeling and I know that is not in the budget right now. I think that is part of future considerations, that needs to come forward, of how to possibly take care of 40-50 clients. There are some other facilities that I think could work as well.

Rep. Kaldor states, to give the alternative side of the discussion. We did have testimony on this particular subject and the transition to community task force that is chaired by Alex Schweitzer. The testimony was that, OAR was necessary because during the transition we experienced the circumstance where we actually are required to do dual funding. The per diem per resident, for those who remain actually goes up because the fixed costs of the institution are spread over fewer residents, and at the same time, the community based services will also have to be made available, which will also result in increased costs. That was one of the reasons for OAR. It's a difficult situation because if the goal is to reduce the residents at the center but in doing that you have that awkward timing where you are covering costs on both sides. That was the other part of the discussion held in the House.

Chairman Kilzer states, you mention the dual payment. I seem to recall the testimony, that when they move people out of Grafton, they can't close the unit until 6 people have, who have occupied that unit, has been removed. Only then, can they close down that ward or section. I have to admit I have not been to Grafton but I do intend on making rounds at some time.

Chairman Kilzer asks, if there are any other questions or comments? I think that is an acceptable amendment that is on it. Are there any requests or anything relating to the sections 5-11 or 12? Those were additions made by the House that we did not see in the Senate.

Rep. Pollert states, we on the House side put in section 7 on page 3. I have been told that patient centered medical home segment is being studied by the Medicaid advisory committee and I don't know the exact name of it. We were told by the committee.

Chairman Kilzer asks, any comments or we will adjourn soon. I do want committee members to be thinking about changes that they want made in .02011.

Rep. Pollert asks, do you want hour meeting or half hour meetings?

Chairman Kilzer states, for the present we will do half hour meetings on regular work days. We may have to have an hour meeting when we have lots of amendments before us to consider.

Chairman Kilzer states, we are adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-18-2011
Job # 16720

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

CONFERENCE COMMITTEE HEARING ON DEPARTMENT OF HUMAN SERVICES

Minutes: You may make reference to "attached testimony."

MEMBERS PRESENT ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair) Senator Fischer Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor
OMB – Lori Laschkewitsch; LEGISLATIVE COUNCIL: Roxanne Woeste.

Chairman Kilzer opened the conference committee hearing at 11:30, Monday, April 18, in reference to SB 2012, Department of Human Services. Let the record show that Senator Warner is back with us and everyone else is here too. All conferees are present. I've asked committee members to bring in amendments and changes that they would like to see. I have taken a set of amendments to Legislative Council, they're not ready yet, so this meeting is entirely for questions or discussion that any members may have.

Senator Warner: I won't offer them now but at the appropriate time, but I do have two amendments, one that would recognize the role of the Dunseith Nursing Home and generating ITT funds and would compensate the same level as the hospital. Those institutions were responsible for generating the funds that aided so many different communities and the second one is I will propose a 25% increase in salaries to DD staff

Senator Kilzer: Would those add an appropriation coming from the general fund and I assume it's $200,000 for the Dunseith institution?

Senator Warner: The Dunseith limit is $200,000 but it doesn't come from general fund, comes from the health care trust fund. Earlier I think that was 2 ½ M from the general fund for the 25 cent raise for the DD people. We had talked earlier about the million dollars a dime, so 2 ½ dimes would be about two and a half million dollars. he other one, the salary increase is general fund.

Chairman Kilzer: Any other comments or questions? We will adjourn until we do have more amendments to talk about. The Hearing on SB 2012 was adjourned.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-19-2011
Job # 16776

☒ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

A CONFERENCE COMMITTEE HEARING ON DEPARTMENT OF HUMAN SERVICES

Minutes: See attached testimony A & B

MEMBERS PRESENT ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair), Senator Fischer, Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor

OMB: Lori Laschkewitsch; LEGISLATIVE COUNCIL: Roxanne Woeste

Chairman Kilzer: Opened the conference committee at 2: 30 pm on Tuesday, April 19, 2011 in reference to the Department of Human Services. Let the record show that all 6 conferees are present. First of all I would like to thank Brenda for the work that she did in putting together **Testimony attached # A,The Comparison of Payment Methodology of Selected Services,** which included the six provider groups and the types of reimbursements. The columns that have been put together are present appropriation in the biennium and the executive budget, the 100% rebasing report, 75% rebasing report, 68% Rebasing Report, at the end trying to get some kind of comparison with Medicare. He handed out the .02014 amendment.

Roxanne Woeste: Working off the amendment # .02014 on page 5, on the Statement and Purpose of the Amendment. She went over the amendment.

Rep. Bellew: The first one that says, retain section six of the engrossed bill, I thought we put it back to the original way, the Senate put an amendment saying that the lease rates could not go any higher than $12.50 a square foot and we removed that portion.

Roxanne Woeste: that's correct. It was added in the Senate, it was removed in the House, this version, because of we need to work off the engrossed version of the bill this amendment keeps that language in. Just to continue on, this amendment does not include a section relating to a study of the Human Services Delivery System which was added in the House. Next, this section does not include a section relating to the Legislative Management Study of Patient Centered Medical Homes, this section was also added in the House. The last item there is the section does retain, this amendment does retain a section that was added by the

House relating to the Dementia Care Services Program Report. So that is the changes in the Management Subdivision. Turning to page 6 of the amendment, the changes you see on page 6 for Economic Assistance Policy Program, Child Support, Medical Services and beginning with Medical Services, all those listed were also changes made by the House with one exception, about the bottom third of the page there is a change relating to remove funding for outreach for children, the State Children's Health Insurance Program. Total funds are $650,000 of that $168,285 is general fund. Also noted on page 6

Rep. Pollert: Do you want us to bring up questions or do you want to wait and go through all the amendments and then ask questions?

Chairman Kilzer: Let's go through the amendments and then come back. Because there may be some items that Roxanne did not make any changes that we still have questions on.

Roxanne Woeste: continuing on page 6, you will also note under Medical Services there is no longer , there is no reduction to the physician services, the House had made a reduction, reduce funding for Medicaid payments to physicians to 100% of the Medicare rate, that was a reduction of approximately $39.5M and the House version of the amendment, that change is not included in this set of amendments. Continuing on page 7, for Long Term Care, the first 4 changes under Long Term Care were also made in the House version of the amendment to this bill. You will note that there was one change added; this does add one time funding from the Health Care Trust Fund for a grant for the government nursing facility which participated in the intergovernmental transfer payment program. So under this amendment, there would be 2 payments made out of the Health Care Trust Fund, each for $200,000, one to the Macville Hospital and one to the Dunseith Nursing Home. Continuing on under Aging Services, you'll see 2 adjustments, these were made by the House. Also one under children and Family services, you can see the same thing for Mental Health and Substance Abuse, and the same for Developmental Disabilities, those changes were also made by the House. Turning on page 8, the same holds true for Vocational Rehabilitation. In regards to other changes relating to program and policy areas, you can see they are in the top third of page 8. This amendment does include the section relating to mental health and substance abuse use of some federal dollars for SAAD, it also includes a section of legislative intent regarding Development Disabilities Grants and that also includes the same section that was added in the House for a Legislative Management Study of the state's qualified service providers system. Moving on to the State Hospital, this amendment also incorporates both adjustments that were made in the House relating to the State Hospital. Turning to page 9, once again there are no changes to the Developmental Center, and for the Human Service Centers, this amendment incorporates all changes made by the House for Human Service Centers. (Meter 10.59)

Chairman Kilzer: Thank-you very much and now is the opportunity for committee members to ask questions of the items that are new or changed, or any other items in the document .02014.

Rep. Pollert: On page 6 of the amendments remove funding for the outreach of CHIPS, just wondering what the committee thoughts are on that and the one time funding from the health care trust fund, is there a possibility that Dunseith is at the upper payments limits to the nursing homes and if they are, if we leave this language in, I would like to see some language added

regarding if the money isn't used, it needs to go back to the health care trust fund. As far as the outreach program, should this be in these amendments?

Chairman Kilzer: First of all on the Dunseith situation as we discussed it in the committee, we would like to add that as an amendment to these after they have been adopted. We would raise that as an additional amendment.

Senator Warner: It's already in the amendment it shows up on two different lines.

Rep. Pollert: On the amendment for Dunseith, page three section eleven shows the supplemental payment going there but in case they are at their upper payment limit, I would like to see language adopted to this to say if they hit the upper payment level and if they are not going to use the money that the money is retained or would it automatically stay in the health care trust fund? It would, so the language isn't needed then.

Chairman Kilzer: Should we take up the question on CHIPS and the outreach?

Senator Fischer: The outreach because of the amount of money the state is putting in; I think it would be worthwhile to put that back in the bill.

Rep. Kaldor: I am wondering about the process, is your intention to approve .02014 and then further amend?

Chairman Kilzer: Moved the amendment # .02014. and if we adopt these amendments that we would further amend. Seconded by Senator Fischer.

Rep. Kaldor: Since we have the amendments on the table, section six of the engrossed bill relating to the office space lease limitation, that is an area that we had quite a bit of discussion on in our committee on, I am assuming that that language would be restored in the bill, I am wondering if there is any discussion that should be had on that. I think we learned that the rent was not unreasonable, if that's an important issue for the Senate.

Senator Warner: My understanding from the conference committee was that the Senate had acceded to the House position on that issue. However, if it's going to go the other way, I am all enthused.

Rep. Pollert: What I was understanding of, is the language dealing with the lease, the side that the House took, that would still be in these amendments.

Rep. Kaldor: Based on the way we have this framed, we will have to make a motion to further amend to adopt what the House did.

Chairman Kilzer: Roxanne, is that not part of these amendments or is there still something hanging out there yet?

Roxanne Woeste: If the committee adopts .02014, the language regarding the office space lease limitation remains in the bill. The committee could move to further amend to remove that language in a separate motion.

Rep. Pollert: I would make a motion that that language is omitted from 02014. Seconded by Rep. Kaldor.

Chairman Kilzer: We have a motion before the group now but we can further amend after. The clerk will pease call the roll on .02014. (1st roll call vote)

A roll call vote was taken on amendment .02014.Yea: 6; Nay: 0; Absent: 0. Motion carried.

Chairman Kilzer: Now we are open for considering additional amendments. We are on .02014.

Rep. Pollert: I would like to remove that language about the office space lease limitation that was on the House side that the language should be removed that was added from the Senate.

Rep. Kaldor: Seconded the motion.

Chairman Kilzer: Please call the roll on removal of that language regarding the rental space. (2nd roll call vote)

A roll call vote was taken to remove the language regarding the rental space. Yea: 6; Nay:0; Absent:0. Motion carried.

Chairman Kilzer: The measure passes to change that item on the next amendments. The next item is the outreach on the CHIPS.

Senator Fisher: **I move that the funding for the outreach for the children's health insurance be restored. Seconded by Senator Warner.**

Chairman Kilzer: We have a motion on the outreach of CHIPS be restored. Any discussion? Better take a recorded vote. Madam Secretary, please call the roll. (3rd roll call vote)

A roll call vote was taken for the outreach of CHIPS be restored. Yea: 6; Nay:0; Absent: 0. Motion carried.

Chairman Kilzer: Additional proposed amendments?

Senator Warner: I have an amendment I would like to propose, 11.8152.02013. This amendment provides twenty five cents per hour increase for developmental disabilities provider's employees. This was in the Senate version at fifty cents, the House removed it and this will be a compromise position.

Chairman Kilzer: Is there a second.

Senator Warner moved the amendment #.02013. Seconded by Rep. Kaldor.

Rep. Pollert: I am going to resist the motion. It wasn't unanimous on the House side when we made the motion of the reduction of the fifty cents. My feeling is the main priority for Long Term Care, DD, or whoever you want to say is to keep the three and three intact. We felt if we were going to do a raise than it should be for everyone but if you are going to do that then we are probably going to ask for a reduction in the 3 and 3 inflator. So you will see how my vote will be.

Rep. Kaldor: I would hope we would support the amendment, DD provider's are still at a disadvantage behind some of the other providers. This will bring them up closer but not in excess of some of the other providers. This is an important move considering the case work that they have to do and also the issues of turnover and trying to attract people to do the work that they do.

Senator Warner: I have a handout that shows that DD employees at entry level positions are at about twenty five cents below nursing homes and the average employee is thirty eight cents below long term care. This would be a modest proposal. **Handout Attached #B, NDLTCA data.**

Chairman Kilzer: Any further discussion? If not, the clerk will please call the roll. (4th roll call vote)

A roll call vote was taken on amendment # .02013. Yea: 2; Nay: 4; Absent: 0. Motion failed. (the recorder stopped during the vote – see attached roll call vote sheet)

Chairman Kilzer: Any further amendments that anybody wants to bring before the committee?

Senator Fischer: Could I ask Carol Olson a question about an amendment that was put together but never introduced, it has to do with the developmental center and alternative uses. Is that study ongoing, this is not how I would propose it but the senator that had these drawn was wondering if we shouldn't be looking at alternatives for the Developmental Center, what can you tell me about that?

Carol Olson, Executive Director of the Department of Human Services: There are always ongoing discussions of the future of the developmental center that goes on within the department and also with the community of Grafton and there are interested parties that are looking for answers on what is going to happen with the buildings and grounds in Grafton and the state hospital in Jamestown. As far as the department goes we haven't put anything down as to the direction we are going to go yet.

Chairman Kilzer: We will adjourn.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

SB 2012
04-20-11
Job # 16789

Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A CONFERENCE COMMITTEE ON DEPARTMENT OF HUMAN SERVICES (DO PASS AS AMENDED)

Minutes: You may make reference to "attached testimony."

MEMBERS PRESENT ARE AS FOLLOWS:

SENATE: Senator Kilzer, (Chair), Senator Fischer, Senator Warner
HOUSE: Rep. Pollert, Rep. Bellew, Rep. Kaldor
OMB: Lori Laschkewitsch; LEGISLATIVE COUNCIL: Roxanne Woeste

Chairman Kilzer opened the Conference Committee hearing at 9:30 a.m. on Wed., April 20th in reference to SB 2012, the Department of Human Services. Let the record show that all 6 regular conferees are present. I'd like to start off letting everyone know that Rep Pollert is a year older today. Roxanne, could you tell us about .02016 which has the two new changes from yesterday? Thank you for getting them up so quickly.

Roxanne Woeste: Amendment # .02016 is .02014 from yesterday and including the two changes that were further adopted from yesterday. They're kind of difficult to see that they are not there. Beginning on page 5, under other changes, we reflect that we removed section 6 of the engrossed bill that related to the office space lease limitation. This section was added by the Senate and was also removed by the House, so that was one change. The other change is under Program and Policy on page 6, under Medical Services. Yesterday you would have seen a reduction for removing SCHIP state children's health insurance program) Outreach funding. That funding has been restored. So there is no reduction for SCHIP outreach. That is the only two changes that you were working off of yesterday.

Rep. Kaldor: Yesterday I had a member ask me about the study on the Human Services Delivery System which the House added and I was wondering; we didn't' have any discussion on that yesterday whether or not that what the reasoning was for eliminating that study. I think one of the other ones is included in a different bill, but that one, I don't believe is.

Senator Fischer: That study was in a bill that came over to us and was killed on the floor of the Senate, the reason for that and for this being taken out is because we are in the middle of

a lot of transmission in the country as well as the state with programs such as MIIS and health care reform, and just thought that the timing was bad to look at the delivery system and a do a study of the Department and maybe wait 'til next session and take a look at it then. That was the reasoning behind it. The other reason is there is some provider study that is ongoing and that's still in, maybe in the health budget.

Chairman Kilzer: I would move the adoption of amendment # .02016. Seconded by Senator Fischer. .

Chairman Kilzer: Any discussion? Do we have any comments from the Department about the Dunseith situation reaching a cap or anything new in that area.

Maggie Anderson, DHS: The Dunseith nursing facility is at the upper payment limit for the Medicaid payments but the way that it's worded in here it is $200,000 of general funds, so it would not be a Medicaid payment and we would just issue it. Health Care Trust Fund with no federal money attached. So it would have to be made as a direct payment but not through the Medicaid program.

Chairman Kilzer: Any other comments before we call the roll?

Rep. Kaldor: I will support this amendment but will offer another amendment afterwards.

Chairman Kilzer: Would you call the roll on the adoption on #.02016.

A roll call vote was taken on the Amendment #.02016. YEA: 6; NAY:0; Motion carried.

Rep. Kaldor: Thank-you, Mr. chairman for your indulgence. You have before you amendment .02017 which is an amendment I had asked Roxanne to prepare. After our discussion yesterday about what we had done in restoration of the eligibility outreach program I began to consider that the Senate had increased the CHIP eligibility to 175%, and while we were wanting to go above that, we had several attempts and were unable to do that, but as I considered the cost of the eligibility outreach and the reduction in the premium that we are going to accrue the benefit from that I suggested that we instead, put those dollars into increasing eligibility, all this amendment does, it's a pretty small amendment but it increases the eligibility from 160 to 165, a $239,000 general fund, $533,000 from other funds (federal funds) and it would be slightly more, about $20,000 more than the difference between the premium savings and the outreach costs of $168,000 and $42,000 in general fund dollars. So I thought rather than, I know outreach is important, and I agree with that, but I think the Senate's move to increase eligibility to 175% is also a demonstration that we want to afford these children the opportunity to participate in the program to the extent possible and I tried to find a way that was as cost neutral as possible and I would move the amendment.

Rep. Kaldor moved the amendment # .0217. Seconded by Senator Warner.

Chairman Kilzer: Would you call the roll on amendment #.02017?

A Roll Call Vote was taken on Amendment # .02017. YEA: 2; NAY: 4; ABSENT: 0. MOTION FAILED.

Chairman Kilzer: I think we are completed and I thank all of those who had an interest in this bill and those who have spoken to us and testified.

Senator Fischer: Do we need a vote on this bill?

Chairman Kilzer: Is that a motion?

Senator Fischer moved a DO PASS AS AMENDED. Seconded by Representative Pollert.

Chairman Kilzer: Further discussion? Motion was made by Senator Fischer, seconded by Representative Pollert. Please call the roll.

A ROLL CALL VOTE WAS TAKEN ON A DO PASS AS AMENDED ON SB 2012. YEA: 6; NAY: 0; ASENT: 0. Motion carried. Chairman Kilzer is the carrier on theSenate side; Representative Pollert – House side. Senator Kilzer will carry the bill on the floor.

Chairman Kilzer: Once again, thank-you and we are dismissed.

Prepared by the Legislative Council staff for
Senator Kilzer
April 18, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

That the House recede from its amendments as printed on pages 1204-1214 of the Senate Journal and pages 1371-1381 of the House Journal and that Engrossed Senate Bill No. 2012 be amended as follows:

Page 1, line 2, remove "to amend and"

Page 1, remove line 3

Page 1, line 4, replace "children's health insurance program" with "to provide for a legislative management study"

Page 1, replace lines 16 through 21 with:

"Salaries and wages	$14,231,353	$2,226,715	$16,458,068
Operating expenses	46,548,787	15,735,631	62,284,418
Capital assets	0	138,400	138,400
Total all funds	$60,780,140	$18,100,746	$78,880,886
Less estimated income	34,477,817	13,285,595	47,763,412
Total general fund	$26,302,323	$4,815,151	$31,117,474"

Page 2, replace lines 3 through 10 with:

"Salaries and wages	$41,389,716	$8,330,668	$49,720,384
Operating expenses	75,461,417	16,961,863	92,423,280
Capital assets	8,580	(8,580)	0
Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	299,532,682	1,600,175,005
Total all funds	$1,870,492,778	$358,831,928	$2,229,324,706
Less estimated income	1,381,801,240	114,576,410	1,496,377,650
Total general fund	$488,691,538	$244,255,518	$732,947,056"

Page 2, replace lines 15 through 27 with:

"Northwest human service center	$8,452,001	$222,567	$8,674,568
North central human service center	19,208,018	1,694,208	20,902,226
Lake region human service center	10,886,645	357,661	11,244,306

Northeast human service center	25,768,431	2,321,019	28,089,450
Southeast human service center	30,139,636	7,868,498	38,008,134
South central human service center	15,567,495	1,291,516	16,859,011
West central human service center	24,683,076	1,669,367	26,352,443
Badlands human service center	10,857,338	850,716	11,708,054
State hospital	65,641,609	7,581,591	73,223,200
Developmental center	52,939,281	(1,130,034)	51,809,247
Total all funds	$264,143,530	$22,727,109	$286,870,639
Less estimated income	132,787,875	(7,198,220)	125,589,655
Total general fund	$131,355,655	$29,925,329	$161,280,984"

Page 3, replace lines 3 through 6 with:

"Grand total general fund	$646,349,516	$278,995,998	$925,345,514
Grand total special funds	1,549,066,932	120,663,785	1,669,730,717
Grand total all funds	$2,195,416,448	$399,659,783	$2,595,076,231
Full-time equivalent positions	2,216.88	(27.53)	2,189.35"

Page 3, after line 15, insert:

"Supplemental payment	0	400,000"

Page 3, replace lines 17 through 20 with:

"State hospital capital projects	0	1,800,000
Total all funds	$92,329,503	$2,719,175
Less estimated income	88,033,205	919,175
Total general fund	$4,296,298	$1,800,000"

Page 4, remove lines 9 through 13

Page 4, remove lines 18 through 30

Page 5, replace lines 1 through 23 with:

"**SECTION 6. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS.** Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the

American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and ending June 30, 2013, including $25,516,808 for inflationary increases for human services providers.

SECTION 7. REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services shall periodically report to the legislative management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes.

SECTION 8. RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENTS. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall require an entity receiving a grant under this section to provide $1 of matching funds for each $1 of state funds provided.

SECTION 9. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

SECTION 10. LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 11. SUPPLEMENTAL PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $400,000 from the health care trust fund which the department shall provide as a one-time grant, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall provide a grant of $200,000 to the government nursing facility that participated in the intergovernmental transfer payment program in a city with a population of more than six hundred according to the 2000 census and a grant of $200,000 to the hospital in a city with a population of less than five hundred according to the 2000 census which also has a government nursing facility that participated in the intergovernmental transfer payment program."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Conference Committee Action

Executive Budget	Senate Version	Conference Committee	Conference Committee	House Version	Comparison to House

			Changes	Version		
DHS - Management						
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
DHS - Program/Policy						
Total all funds	$2,241,950,229	$2,255,138,635	($25,813,929)	$2,229,324,706	$2,190,288,567	$39,036,139
Less estimated income	1,510,481,136	1,518,090,686	(21,713,036)	1,496,377,650	1,474,622,151	21,755,499
General fund	$731,469,093	$737,047,949	($4,100,893)	$732,947,056	$715,666,416	$17,280,640
DHS - State Hospital						
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
DHS - Developmental Center						
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247	$51,809,247	$0
Less estimated income	31,391,817	31,391,817	0	31,391,817	31,391,817	0
General fund	$20,417,430	$20,417,430	$0	$20,417,430	$20,417,430	$0
DHS - Northwest HSC						
Total all funds	$8,749,068	$8,749,068	($74,500)	$8,674,568	$8,674,568	$0
Less estimated income	3,790,236	3,790,236	0	3,790,236	3,790,236	0
General fund	$4,958,832	$4,958,832	($74,500)	$4,884,332	$4,884,332	$0
DHS - North Central HSC						
Total all funds	$22,433,884	$22,433,884	($1,531,658)	$20,902,226	$20,902,226	$0
Less estimated income	9,023,857	9,023,857	0	9,023,857	9,023,857	0
General fund	$13,410,027	$13,410,027	($1,531,658)	$11,878,369	$11,878,369	$0
DHS - Lake Region HSC						
Total all funds	$11,418,231	$11,418,231	($173,925)	$11,244,306	$11,244,306	$0
Less estimated income	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	0
General fund	$6,882,190	$6,882,190	($121,878)	$6,760,312	$6,760,312	$0
DHS - Northeast HSC						
Total all funds	$28,182,609	$28,182,609	($93,159)	$28,089,450	$28,089,450	$0
Less estimated income	14,972,886	14,972,886	0	14,972,886	14,972,886	0
General fund	$13,209,723	$13,209,723	($93,159)	$13,116,564	$13,116,564	$0
DHS - Southeast HSC						
Total all funds	$38,464,720	$38,464,720	($456,586)	$38,008,134	$38,008,134	$0
Less estimated income	16,278,987	16,278,987	0	16,278,987	16,278,987	0
General fund	$22,185,733	$22,185,733	($456,586)	$21,729,147	$21,729,147	$0
DHS - South Central HSC						
Total all funds	$16,953,699	$16,953,699	($94,688)	$16,859,011	$16,859,011	$0
Less estimated income	7,610,152	7,610,152	0	7,610,152	7,610,152	0
General fund	$9,343,547	$9,343,547	($94,688)	$9,248,859	$9,248,859	$0
DHS - West Central HSC						
Total all funds	$26,740,493	$26,740,493	($388,050)	$26,352,443	$26,352,443	$0
Less estimated income	12,630,961	12,630,961	0	12,630,961	12,630,961	0
General fund	$14,109,532	$14,109,532	($388,050)	$13,721,482	$13,721,482	$0
DHS - Badlands HSC						
Total all funds	$11,789,654	$11,789,654	($81,600)	$11,708,054	$11,708,054	$0
Less estimated income	5,260,362	5,260,362	0	5,260,362	5,260,362	0
General fund	$6,529,292	$6,529,292	($81,600)	$6,447,692	$6,447,692	$0
Bill total						
Total all funds	$2,611,024,908	$2,624,375,154	($29,298,923)	$2,595,076,231	$2,556,040,092	$39,036,139
Less estimated income	1,683,661,250	1,691,270,800	(21,540,083)	1,669,730,717	1,647,975,218	21,755,499
General fund	$927,363,658	$933,104,354	($7,758,840)	$925,345,514	$908,064,874	$17,280,640

Senate Bill No. 2012 - DHS - Management - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House

Salaries and wages	$16,513,336	$16,513,336	($55,268)	$16,458,068	$16,458,068	
Operating expenses	62,408,138	62,408,138	(123,720)	62,284,418	62,284,418	
Capital assets	138,400	138,400		138,400	138,400	
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
FTE	116.10	116.10	0.00	116.10	116.10	0.00

1

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - Conference committee changes:				
Administration - Support				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($31,930)	$0	($31,930)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,275)	0	(16,275)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(102,300)	0	(102,300)
Information Technology Services				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(23,338)	0	(23,338)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(134,672)	0	(134,672)
Reduce funding for operating expenses (division-specific reduction) (This) adjustment was also made by the House.)		(120,473)	0	(120,473)
Add funding for activities relating to the eligibility system replacement project (This adjustment was also made by the House.)		25,000	225,000	250,000
Total conference committee changes - Management	0.00	($403,988)	$225,000	($178,988)
Conference committee version - Management subdivision	116.10	$31,117,474	$47,763,412	$78,880,886

Other changes affecting Management programs or multiple programs of the department:

Retains Section 6 of the engrossed bill relating to office space lease limitation. This section was added by the Senate but removed by the House.

Does not include a section relating to a study of the human services delivery system which was added by the House.

Does not include a section relating to a Legislative Management study of patient-centered medical homes.

Adds a section providing for a report to the Legislative Management on the dementia care services program. This section was also added by the House.

Senate Bill No. 2012 - DHS - Program/Policy - Conference Committee Action

Executive Budget	Senate Version	Conference Committee	Conference Committee	House Version	Comparison to House

			Changes[1]	Version		
Salaries and wages	$50,346,211	$50,346,211	($625,827)	$49,720,384	$49,720,384	
Operating expenses	90,850,363	90,850,363	1,572,917	92,423,280	92,423,280	
Grants	487,016,037	487,006,037		487,006,037	487,006,037	
Grants - Medical assistance	1,613,737,618	1,626,936,024	(26,761,019)	1,600,175,005	1,561,138,866	39,036,139
Total all funds	$2,241,950,229	$2,255,138,635	($25,813,929)	$2,229,324,706	$2,190,288,567	$39,036,139
Less estimated income	1,510,481,136	1,518,090,686	(21,713,036)	1,496,377,650	1,474,622,151	21,755,499
General fund	$731,469,093	$737,047,949	($4,100,893)	$732,947,056	$715,666,416	$17,280,640
FTE	374.50	374.50	(7.00)	367.50	367.50	0.00

[1]

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
Program and Policy - Conference committee changes:				
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($12,054)	$0	($12,054)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(17,805)	0	(17,805)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(36,574)	0	(36,574)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(62,714)	(121,742)	(184,456)
Medical Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions care reform (This adjustment was also made by the House.)		(24,105)	0	(24,105)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(180,116)	0	(180,116)
Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level (This adjustment was also made by the House.)		(567,367)	(1,266,990)	(1,834,357)
Reduce funding for the state children's health insurance program to reflect a revised premium amount (This adjustment was also made by the House.)		(42,989)	(95,928)	(138,917)
Remove funding for outreach for the state children's health insurance program		(168,285)	(481,715)	(650,000)
Remove positions and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(5.00)	(144,988)	(183,846)	(328,834)
Decrease funding for medical services to reduce projected caseload/utilization rates (This adjustment was also made by the House.)		(2,739,780)	(3,460,220)	(6,200,000)
Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians (This adjustment was also made by the House.)		(2,065,704)	(2,634,500)	(4,700,204)

Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program (This adjustment was also made by the House.)	0	200,000	200,000
Long-Term Care Program			
Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011 (This adjustment was also made by the House.)	(5,021,489)	(6,342,560)	(11,364,049)
Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority, requires the department to turn back any unexpended general fund authority from the 2009-11 biennium, and appropriates funds from the general fund for the 2011-13 biennium. (This adjustment was also made by the House.)	12,800,000	0	12,800,000
Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates (This adjustment was also made by the House.)	56,423	70,085	126,508
Decrease funding for long-term care to reduce projected caseload/utilization rates (This adjustment was also made by the House.)	(6,716,880)	(8,483,120)	(15,200,000)
Add one-time funding from the health care trust fund for a grant to a government nursing facility which participated in the intergovernmental transfer payment program	0	200,000	200,000
Aging Services Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(5,263)	0	(5,263)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)	(17,231)	0	(17,231)
Children and Family Services Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(5,697)	0	(5,697)
Mental Health and Substance Abuse Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(6,240)	0	(6,240)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)	(26,706)	0	(26,706)
Developmental Disabilities Council			
No changes	0	0	0
Developmental Disabilities Division			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(2,804)	0	(2,804)
Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043	887,500	887,500	1,775,000

(This adjustment was also made by the House.)

Increase funding for petitioning costs for indigent people with developmental disabilities (This adjustment was also made by the House.)		21,970	0	21,970
Vocational Rehabilitation				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(1,995)	0	(1,995)
Total conference committee changes - Program and Policy	(7.00)	($4,100,893)	($21,713,036)	($25,813,929)
Conference committee version - Program and Policy subdivision	367.50	$732,947,056	$1,496,377,650	$2,229,324,706

Other changes affecting Program and Policy programs:

Add a section to provide that the department utilize $250,000 of federal funds appropriated to the Mental Health and Substance Abuse Division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts (This section was also added by the House.)

Add a section to provide legislative intent regarding developmental disabilities grants (This section was also added by the House.)

Add a section to provide for a Legislative Management study of the state's qualified service provider system (This section was also added by the House.)

Senate Bill No. 2012 - DHS - State Hospital - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
State Hospital	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
FTE	467.51	467.51	0.00	467.51	467.51	0.00

[1]

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - Conference committee changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects. (This adjustment was also made by the House.)		($161,840)	$0	($161,840)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(250,000)	0	(250,000)
Total conference committee changes - State Hospital	0.00	($411,840)	$0	($411,840)
Conference committee version - State Hospital	467.51	$53,076,797	$20,146,403	$73,223,200

Senate Bill No. 2012 - DHS - Developmental Center - Conference Committee Action

The conference committee did not make any changes to the Senate version.

Senate Bill No. 2012 - Human Service Centers - General Fund Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	4,958,832	4,958,832	(74,500)	4,884,332	4,884,332	
DHS - North Central HSC	13,410,027	13,410,027	(1,531,658)	11,878,369	11,878,369	
DHS - Lake Region HSC	6,882,190	6,882,190	(121,878)	6,760,312	6,760,312	
DHS - Northeast HSC	13,209,723	13,209,723	(93,159)	13,116,564	13,116,564	
DHS - Southeast HSC	22,185,733	22,185,733	(456,586)	21,729,147	21,729,147	
DHS - South Central HSC	9,343,547	9,343,547	(94,688)	9,248,859	9,248,859	
DHS - West Central HSC	14,109,532	14,109,532	(388,050)	13,721,482	13,721,482	
DHS - Badlands HSC	6,529,292	6,529,292	(81,600)	6,447,692	6,447,692	
Total general fund	$90,628,876	$90,628,876	($2,842,119)	$87,786,757	$87,786,757	

Senate Bill No. 2012 - Human Service Centers - Other Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	3,790,236	3,790,236		3,790,236	3,790,236	
DHS - North Central HSC	9,023,857	9,023,857		9,023,857	9,023,857	
DHS - Lake Region HSC	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	
DHS - Northeast HSC	14,972,886	14,972,886		14,972,886	14,972,886	
DHS - Southeast HSC	16,278,987	16,278,987		16,278,987	16,278,987	
DHS - South Central HSC	7,610,152	7,610,152		7,610,152	7,610,152	
DHS - West Central HSC	12,630,961	12,630,961		12,630,961	12,630,961	
DHS - Badlands HSC	5,260,362	5,260,362		5,260,362	5,260,362	
Total other funds	$74,103,482	$74,103,482	($52,047)	$74,051,435	$74,051,435	

Senate Bill No. 2012 - Human Service Centers - All Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	8,749,068	8,749,068	(74,500)	8,674,568	8,674,568	
DHS - North Central HSC	22,433,884	22,433,884	(1,531,658)	20,902,226	20,902,226	
DHS - Lake Region HSC	11,418,231	11,418,231	(173,925)	11,244,306	11,244,306	
DHS - Northeast HSC	28,182,609	28,182,609	(93,159)	28,089,450	28,089,450	
DHS - Southeast HSC	38,464,720	38,464,720	(456,586)	38,008,134	38,008,134	
DHS - South Central HSC	16,953,699	16,953,699	(94,688)	16,859,011	16,859,011	
DHS - West Central HSC	26,740,493	26,740,493	(388,050)	26,352,443	26,352,443	
DHS - Badlands HSC	11,789,654	11,789,654	(81,600)	11,708,054	11,708,054	
Total all funds	$164,732,358	$164,732,358	($2,894,166)	$161,838,192	$161,838,192	
FTE	837.48	837.48	0.00	837.48	837.48	0.00

[1]

NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($74,500)	$0	($74,500)
Total conference committee changes - Northwest Human Service Center	0.00	($74,500)	$0	($74,500)

Conference committee version - Northwest Human Service Center	45.75	$4,884,332	$3,790,236	$8,674,568

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mentally ill (This adjustment was also made by the House.)		($1,444,661)	$0	($1,444,661)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(70,740)	0	(70,740)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,257)	0	(16,257)
Total conference committee changes - North Central Human Service Center	0.00	($1,531,658)	$0	($1,531,658)

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - Conference committee changes:				
Reduce funding for temporary salaries (This adjustment was also made by the House.)		($37,930)	($52,047)	($89,977)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(75,320)	0	(75,320)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(8,628)	0	(8,628)
Total conference committee changes - Lake Region Human Service Center	0.00	($121,878)	($52,047)	($173,925)
Conference committee version - Lake Region Human Service Center	60.00	$6,760,312	$4,483,994	$11,244,306

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($72,720)	$0	($72,720)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(20,439)	0	(20,439)
Total conference committee - Northeast Human Service Center	0.00	($93,159)	$0	($93,159)
House version - Northeast Human Service Center	138.30	$13,116,564	$14,972,886	$28,089,450

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total

Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - Conference committee changes:				
Remove funding added in the department's base budget for additional staff at the Cooper House (This adjustment was also made by the House.)		($350,400)	$0	($350,400)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(92,100)	0	(92,100)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(14,086)	0	(14,086)
Total conference commitee changes - Southeast Human Service Center	0.00	($456,586)	$0	($456,586)
Conference committee version - Southeast Human Service Center	182.15	$21,729,147	$16,278,987	$38,008,134

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($84,020)	$0	($84,020)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(10,668)	0	(10,668)
Total conference committee changes - South Central Human Service Center	0.00	($94,688)	$0	($94,688)
Conference committee version - South Central Human Service Center	85.50	$9,248,859	$7,610,152	$16,859,011

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds (This adjustment was also made by the House.)		($309,128)	$0	($309,128)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(61,420)	0	(61,420)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(17,502)	0	(17,502)
Total conference committee changes - West Central Human Service Center	0.00	($388,050)	$0	($388,050)
Conference committee version - West Central Human Service Center	135.30	$13,721,482	$12,630,961	$26,352,443

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	72.70	$6,529,292	$5,260,362	$11,789,654
Badlands Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions		($69,180)	$0	($69,180)

and employee turnover (This adjustment was also made by the House.)				
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(12,420)	0	(12,420)
Total conference committee changes - Badlands Human Service Center	0.00	($81,600)	$0	($81,600)
Conference committee version - Badlands Human Service Center	72.70	$6,447,692	$5,260,362	$11,708,054

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-19-11

Roll Call Vote #: 1 # 11.8152.02014

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) --

☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Sen Kilzer Seconded by: Senator Fischer

Senators	4/16	4/18	4/19	Yes	No		Representatives	4/16	4/18	4/19	Yes	No
Senator Kilzer	✓	✓	✓	✓			Rep. Pollert	✓	✓	✓	✓	
Senator Fischer	✓	✓	✓	✓			Rep. Bellew	✓	✓	✓	✓	
~~Senator Warner~~ Warner		✓	✓	✓			Rep. Kaldor	✓	✓	✓	✓	
Senator Taylor	✓											

Vote Count: Yes 6 No 0 Absent _____

Senate Carrier _____ House Carrier _____

LC Number 11.8152.02014 . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Committee: Senate Appropriations

Bill/Resolution No. 2012 as (re) engrossed

Date: 4-19-11

Roll Call Vote #: 2. on part of .02014 amendment

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) _____

☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Pollert Seconded by: Kaldor

Senators	Yes	No	Representatives	Yes	No
Warner	✓		Pollert	✓	
Kilzer	✓		P. Kaldor	✓	
Fischer	✓		Beller	✓	

Vote Count: Yes _____ No _____ Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

remove that language on the upcoming amendments (Lease issue)

Committee: Senate Appropriations

Bill/Resolution No. 2012 as (re) engrossed

Date: 4-19-11

Roll Call Vote #: 3

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) on part of .0204 amendment

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Fischer Seconded by: Warner

Senators				Yes	No		Representatives				Yes	No
Warner				✓			Dalrymple				✓	
Fischer				✓			Holdorf				✓	
Kilzer				✓			Bellew				✓	

Vote Count: Yes _____ No _____ Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Outreach of Chips to be restored

11.8152.02013
Title.
Fiscal No. 2

Prepared by the Legislative Council staff for
Senator Warner
April 18, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

That the House recede from its amendments as printed on pages 1204-1214 of the Senate Journal and pages 1371-1381 of the House Journal and that Engrossed Senate Bill No. 2012 be amended as follows:

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	320,611,684	1,621,254,007
Total all funds	$1,870,492,778	$378,963,840	$2,249,456,618
Less estimated income	1,381,801,240	133,118,170	1,514,919,410
Total general fund	$488,691,538	$245,845,670	$734,537,208"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$284,244,097	$930,593,613
Grand total special funds	1,549,066,932	139,032,592	1,688,099,524
Grand total all funds	$2,195,416,448	$423,276,689	$2,618,693,137"

Page 4, line 20, replace "$11,364,049" with "$5,682,032"

Page 4, line 20, replace "$5,021,489" with "$2,510,748"

Page 4, line 21, replace "$6,342,560" with "$3,171,284"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
DHS - Management						
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874	$78,880,886	$178,988
Less estimated income	47,538,412	47,538,412	0	47,538,412	47,763,412	(225,000)
General fund	$31,521,462	$31,521,462	$0	$31,521,462	$31,117,474	$403,988
DHS - Program/Policy						
Total all funds	$2,241,950,229	$2,255,138,635	($5,682,017)	$2,249,456,618	$2,190,288,567	$59,168,051
Less estimated income	1,510,481,136	1,518,090,686	(3,171,276)	1,514,919,410	1,474,622,151	40,297,259
General fund	$731,469,093	$737,047,949	($2,510,741)	$734,537,208	$715,666,416	$18,870,792
DHS - State Hospital						
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040	$73,223,200	$411,840
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	$0	$53,488,637	$53,076,797	$411,840
DHS - Developmental Center						
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247	$51,809,247	$0
Less estimated income	31,391,817	31,391,817	0	31,391,817	31,391,817	0
General fund	$20,417,430	$20,417,430	$0	$20,417,430	$20,417,430	$0

DHS - Northwest HSC						
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068	$8,674,568	$74,500
Less estimated income	3,790,236	3,790,236	0	3,790,236	3,790,236	0
General fund	$4,958,832	$4,958,832	$0	$4,958,832	$4,884,332	$74,500
DHS - North Central HSC						
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884	$20,902,226	$1,531,658
Less estimated income	9,023,857	9,023,857	0	9,023,857	9,023,857	0
General fund	$13,410,027	$13,410,027	$0	$13,410,027	$11,878,369	$1,531,658
DHS - Lake Region HSC						
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231	$11,244,306	$173,925
Less estimated income	4,536,041	4,536,041	0	4,536,041	4,483,994	52,047
General fund	$6,882,190	$6,882,190	$0	$6,882,190	$6,760,312	$121,878
DHS - Northeast HSC						
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609	$28,089,450	$93,159
Less estimated income	14,972,886	14,972,886	0	14,972,886	14,972,886	0
General fund	$13,209,723	$13,209,723	$0	$13,209,723	$13,116,564	$93,159
DHS - Southeast HSC						
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720	$38,008,134	$456,586
Less estimated income	16,278,987	16,278,987	0	16,278,987	16,278,987	0
General fund	$22,185,733	$22,185,733	$0	$22,185,733	$21,729,147	$456,586
DHS - South Central HSC						
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699	$16,859,011	$94,688
Less estimated income	7,610,152	7,610,152	0	7,610,152	7,610,152	0
General fund	$9,343,547	$9,343,547	$0	$9,343,547	$9,248,859	$94,688
DHS - West Central HSC						
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493	$26,352,443	$388,050
Less estimated income	12,630,961	12,630,961	0	12,630,961	12,630,961	0
General fund	$14,109,532	$14,109,532	$0	$14,109,532	$13,721,482	$388,050
DHS - Badlands HSC						
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654	$11,708,054	$81,600
Less estimated income	5,260,362	5,260,362	0	5,260,362	5,260,362	0
General fund	$6,529,292	$6,529,292	$0	$6,529,292	$6,447,692	$81,600
Bill total						
Total all funds	$2,611,024,908	$2,624,375,154	($5,682,017)	$2,618,693,137	$2,556,040,092	$62,653,045
Less estimated income	1,683,661,250	1,691,270,800	(3,171,276)	1,688,099,524	1,647,975,218	40,124,306
General fund	$927,363,658	$933,104,354	($2,510,741)	$930,593,613	$908,064,874	$22,528,739

Senate Bill No. 2012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
Salaries and wages	$50,346,211	$50,346,211		$50,346,211	$49,720,384	$625,827
Operating expenses	90,850,363	90,850,363		90,850,363	92,423,280	(1,572,917)
Grants	487,016,037	487,006,037		487,006,037	487,006,037	
Grants - Medical assistance	1,613,737,618	1,626,936,024	(5,682,017)	1,621,254,007	1,561,138,866	60,115,141
	$2,241,950,229	$2,255,138,635	($5,682,017)	$2,249,456,618	$2,190,288,567	$59,168,051
Total all funds						
Less estimated income	1,510,481,136	1,518,090,686	(3,171,276)	1,514,919,410	1,474,622,151	40,297,259
	$731,469,093	$737,047,949	($2,510,741)	$734,537,208	$715,666,416	$18,870,792
General fund						
FTE	374.50	374.50	0.00	374.50	367.50	7.00

Department No. 328 - DHS - Program/Policy - Detail of Conference Committee Changes

	Decrease Funding for Salary and	Total Conference Committee

	Benefit Increase[1]	Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	(5,682,017)	(5,682,017)
Total all funds	($5,682,017)	($5,682,017)
Less estimated income	(3,171,276)	(3,171,276)
General fund	($2,510,741)	($2,510,741)
FTE	0.00	0.00

[1] Funding added by the Senate to provide for a supplemental payment to allow for a salary and benefit increase for developmental disabilities providers employees is reduced from funding to allow for a 50-cent per hour increase to a 25-cent per hour increase.

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-19-11

Roll Call Vote #: 4

adopt 1st page 11.8152.02013

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

failed

Senate/House Amendments on SJ/HJ page(s) --

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Warner Seconded by: Kaldor

Senators	Yes	No	Representatives	Yes	No
Senator Kilzer		✓	Rep. Pollert		✓
Senator Fischer	–	✓	Rep. Bellew		✓
Senator Warner	✓		Rep. Kaldor	✓	

Vote Count: Yes 2 No 4 Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-13-11

Roll Call Vote #: _____

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) _____

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: _____ Seconded by: _____

Senators	4/13	AM 4/14	4/14	Yes	No		Representatives	4/13	AM 4/14	4/14	Yes	No
Senator Kilzer	✓	✓	✓				Rep. Pollert	✓	✓	✓		
Senator Fischer	✓	✓	✓				Rep. Bellew	✓	✓	✓		
Senator Warner	✓	✓	✓				Rep. Kaldor	✓	✓	✓		

Vote Count: Yes _____ No _____ Absent _____

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

11.8152.02016
Title.04000
Fiscal No. 5

Prepared by the Legislative Council staff for
Conference Committee
April 19, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

That the House recede from its amendments as printed on pages 1204-1214 of the Senate Journal and pages 1371-1381 of the House Journal and that Engrossed Senate Bill No. 2012 be amended as follows:

Page 1, line 2, remove "to amend and"

Page 1, remove line 3

Page 1, line 4, replace "children's health insurance program" with "to provide for a legislative management study"

Page 1, replace lines 16 through 21 with:

"Salaries and wages	$14,231,353	$2,226,715	$16,458,068
Operating expenses	46,548,787	15,735,631	62,284,418
Capital assets	0	138,400	138,400
Total all funds	$60,780,140	$18,100,746	$78,880,886
Less estimated income	34,477,817	13,285,595	47,763,412
Total general fund	$26,302,323	$4,815,151	$31,117,474"

Page 2, replace lines 3 through 10 with:

"Salaries and wages	$41,389,716	$8,330,668	$49,720,384
Operating expenses	75,461,417	16,961,863	92,423,280
Capital assets	8,580	(8,580)	0
Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	300,182,682	1,600,825,005
Total all funds	$1,870,492,778	$359,481,928	$2,229,974,706
Less estimated income	1,381,801,240	115,058,125	1,496,859,365
Total general fund	$488,691,538	$244,423,803	$733,115,341"

Page 2, replace lines 15 through 27 with:

"Northwest human service center	$8,452,001	$222,567	$8,674,568
North central human service center	19,208,018	1,694,208	20,902,226
Lake region human service center	10,886,645	357,661	11,244,306

Northeast human service center	25,768,431	2,321,019	28,089,450
Southeast human service center	30,139,636	7,868,498	38,008,134
South central human service center	15,567,495	1,291,516	16,859,011
West central human service center	24,683,076	1,669,367	26,352,443
Badlands human service center	10,857,338	850,716	11,708,054
State hospital	65,641,609	7,581,591	73,223,200
Developmental center	52,939,281	(1,130,034)	51,809,247
Total all funds	$264,143,530	$22,727,109	$286,870,639
Less estimated income	132,787,875	(7,198,220)	125,589,655
Total general fund	$131,355,655	$29,925,329	$161,280,984"

Page 3, replace lines 3 through 6 with:

"Grand total general fund	$646,349,516	$279,164,283	$925,513,799
Grand total special funds	1,549,066,932	121,145,500	1,670,212,432
Grand total all funds	$2,195,416,448	$400,309,783	$2,595,726,231
Full-time equivalent positions	2,216.88	(27.53)	2,189.35"

Page 3, after line 15, insert:

"Supplemental payment	0	400,000"

Page 3, replace lines 17 through 20 with:

"State hospital capital projects	0	1,800,000
Total all funds	$92,329,503	$2,719,175
Less estimated income	88,033,205	919,175
Total general fund	$4,296,298	$1,800,000"

Page 4, remove lines 9 through 30

Page 5, replace lines 1 through 23 with:

"**SECTION 5. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS.** Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts

resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and ending June 30, 2013, including $23,451,104 for inflationary increases for human services providers.

SECTION 6. REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services shall periodically report to the legislative management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes.

SECTION 7. RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENTS. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall require an entity receiving a grant under this section to provide $1 of matching funds for each $1 of state funds provided.

SECTION 8. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

SECTION 9. LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 10. SUPPLEMENTAL PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $400,000 from the health care trust fund which the department shall provide as a one-time grant, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall provide a grant of $200,000 to the government nursing facility that participated in the intergovernmental transfer payment program in a city with a population of more than six hundred according to the 2000 census and a grant of $200,000 to the hospital in a city with a population of less than five hundred according to the 2000 census which also has a government nursing facility that participated in the intergovernmental transfer payment program."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
DHS - Management						

Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
DHS - Program/Policy						
Total all funds	$2,241,950,229	$2,255,138,635	($25,163,929)	$2,229,974,706	$2,190,288,567	$39,686,139
Less estimated income	1,510,481,136	1,518,090,686	(21,231,321)	1,496,859,365	1,474,622,151	22,237,214
General fund	$731,469,093	$737,047,949	($3,932,608)	$733,115,341	$715,666,416	$17,448,925
DHS - State Hospital						
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
DHS - Developmental Center						
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247	$51,809,247	$0
Less estimated income	31,391,817	31,391,817	0	31,391,817	31,391,817	0
General fund	$20,417,430	$20,417,430	$0	$20,417,430	$20,417,430	$0
DHS - Northwest HSC						
Total all funds	$8,749,068	$8,749,068	($74,500)	$8,674,568	$8,674,568	$0
Less estimated income	3,790,236	3,790,236	0	3,790,236	3,790,236	0
General fund	$4,958,832	$4,958,832	($74,500)	$4,884,332	$4,884,332	$0
DHS - North Central HSC						
Total all funds	$22,433,884	$22,433,884	($1,531,658)	$20,902,226	$20,902,226	$0
Less estimated income	9,023,857	9,023,857	0	9,023,857	9,023,857	0
General fund	$13,410,027	$13,410,027	($1,531,658)	$11,878,369	$11,878,369	$0
DHS - Lake Region HSC						
Total all funds	$11,418,231	$11,418,231	($173,925)	$11,244,306	$11,244,306	$0
Less estimated income	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	0
General fund	$6,882,190	$6,882,190	($121,878)	$6,760,312	$6,760,312	$0
DHS - Northeast HSC						
Total all funds	$28,182,609	$28,182,609	($93,159)	$28,089,450	$28,089,450	$0
Less estimated income	14,972,886	14,972,886	0	14,972,886	14,972,886	0
General fund	$13,209,723	$13,209,723	($93,159)	$13,116,564	$13,116,564	$0
DHS - Southeast HSC						
Total all funds	$38,464,720	$38,464,720	($456,586)	$38,008,134	$38,008,134	$0
Less estimated income	16,278,987	16,278,987	0	16,278,987	16,278,987	0
General fund	$22,185,733	$22,185,733	($456,586)	$21,729,147	$21,729,147	$0
DHS - South Central HSC						
Total all funds	$16,953,699	$16,953,699	($94,688)	$16,859,011	$16,859,011	$0
Less estimated income	7,610,152	7,610,152	0	7,610,152	7,610,152	0
General fund	$9,343,547	$9,343,547	($94,688)	$9,248,859	$9,248,859	$0
DHS - West Central HSC						
Total all funds	$26,740,493	$26,740,493	($388,050)	$26,352,443	$26,352,443	$0
Less estimated income	12,630,961	12,630,961	0	12,630,961	12,630,961	0
General fund	$14,109,532	$14,109,532	($388,050)	$13,721,482	$13,721,482	$0
DHS - Badlands HSC						
Total all funds	$11,789,654	$11,789,654	($81,600)	$11,708,054	$11,708,054	$0
Less estimated income	5,260,362	5,260,362	0	5,260,362	5,260,362	0
General fund	$6,529,292	$6,529,292	($81,600)	$6,447,692	$6,447,692	$0
Bill total						
Total all funds	$2,611,024,908	$2,624,375,154	($28,648,923)	$2,595,726,231	$2,556,040,092	$39,686,139
Less estimated income	1,683,661,250	1,691,270,800	(21,058,368)	1,670,212,432	1,647,975,218	22,237,214
General fund	$927,363,658	$933,104,354	($7,590,555)	$925,513,799	$908,064,874	$17,448,925

Senate Bill No. 2012 - DHS - Management - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee	Conference Committee	House Version	Comparison to House

			Changes[1]	Version		
Salaries and wages	$16,513,336	$16,513,336	($55,268)	$16,458,068	$16,458,068	
Operating expenses	62,408,138	62,408,138	(123,720)	62,284,418	62,284,418	
Capital assets	138,400	138,400		138,400	138,400	
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
FTE	116.10	116.10	0.00	116.10	116.10	0.00

1

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - Conference committee changes:				
Administration - Support				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($31,930)	$0	($31,930)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,275)	0	(16,275)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(102,300)	0	(102,300)
Information Technology Services				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(23,338)	0	(23,338)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(134,672)	0	(134,672)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(120,473)	0	(120,473)
Add funding for activities relating to the eligibility system replacement project (This adjustment was also made by the House.)		25,000	225,000	250,000
Total conference committee changes - Management	0.00	($403,988)	$225,000	($178,988)
Conference committee version - Management subdivision	116.10	$31,117,474	$47,763,412	$78,880,886

Other changes affecting Management programs or multiple programs of the department:

Removes Section 6 of the engrossed bill relating to office space lease limitation. This section was added by the Senate and also removed by the House.

Does not include a section relating to a study of the human services delivery system which was added by the House.

Does not include a section relating to a Legislative Management study of patient-centered medical homes.

Adds a section providing for a report to the Legislative Management on the dementia care services program. This section was also added by the House.

Senate Bill No. 2012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
Salaries and wages	$50,346,211	$50,346,211	($625,827)	$49,720,384	$49,720,384	
Operating expenses	90,850,363	90,850,363	1,572,917	92,423,280	92,423,280	
Grants	487,016,037	487,006,037		487,006,037	487,006,037	
Grants - Medical assistance	1,613,737,618	1,626,936,024	(26,111,019)	1,600,825,005	1,561,138,866	39,686,139
Total all funds	$2,241,950,229	$2,255,138,635	($25,163,929)	$2,229,974,706	$2,190,288,567	$39,686,139
Less estimated income	1,510,481,136	1,518,090,686	(21,231,321)	1,496,859,365	1,474,622,151	22,237,214
General fund	$731,469,093	$737,047,949	($3,932,608)	$733,115,341	$715,666,416	$17,448,925
FTE	374.50	374.50	(7.00)	367.50	367.50	0.00

[1]

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
Program and Policy - Conference committee changes:				
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($12,054)	$0	($12,054)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(17,805)	0	(17,805)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(36,574)	0	(36,574)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(62,714)	(121,742)	(184,456)
Medical Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions care reform (This adjustment was also made by the House.)		(24,105)	0	(24,105)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(180,116)	0	(180,116)
Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level (This adjustment was also made by the House.)		(567,367)	(1,266,990)	(1,834,357)
Reduce funding for the state children's health insurance program to reflect a revised premium amount (This adjustment was also made by the House.)		(42,989)	(95,928)	(138,917)
Remove positions and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(5.00)	(144,988)	(183,846)	(328,834)
Decrease funding for medical services to reduce projected caseload/utilization rates (This adjustment was also made by the House.)		(2,739,780)	(3,460,220)	(6,200,000)

Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians (This adjustment was also made by the House.)	(2,065,704)	(2,634,500)	(4,700,204)
Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program (This adjustment was also made by the House.)	0	200,000	200,000
Long-Term Care Program			
Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011 (This adjustment was also made by the House.)	(5,021,489)	(6,342,560)	(11,364,049)
Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority, requires the department to turn back any unexpended general fund authority from the 2009-11 biennium, and appropriates funds from the general fund for the 2011-13 biennium. (This adjustment was also made by the House.)	12,800,000	0	12,800,000
Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates (This adjustment was also made by the House.)	56,423	70,085	126,508
Decrease funding for long-term care to reduce projected caseload/utilization rates (This adjustment was also made by the House.)	(6,716,880)	(8,483,120)	(15,200,000)
Add one-time funding from the health care trust fund for a grant to a government nursing facility which participated in the intergovernmental transfer payment program	0	200,000	200,000
Aging Services Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(5,263)	0	(5,263)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)	(17,231)	0	(17,231)
Children and Family Services Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(5,697)	0	(5,697)
Mental Health and Substance Abuse Program			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(6,240)	0	(6,240)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)	(26,706)	0	(26,706)
Developmental Disabilities Council			
No changes	0	0	0
Developmental Disabilities Division			
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)	(2,804)	0	(2,804)

Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043 (This adjustment was also made by the House.)		887,500	887,500	1,775,000
Increase funding for petitioning costs for indigent people with developmental disabilities (This adjustment was also made by the House.)		21,970	0	21,970
Vocational Rehabilitation				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(1,995)	0	(1,995)
Total conference committee changes - Program and Policy	(7.00)	($3,932,608)	($21,231,321)	($25,163,929)
Conference committee version - Program and Policy subdivision	367.50	$733,115,341	$1,496,859,365	$2,229,974,706

Other changes affecting Program and Policy programs:

Add a section to provide that the department utilize $250,000 of federal funds appropriated to the Mental Health and Substance Abuse Division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts (This section was also added by the House.)

Add a section to provide legislative intent regarding developmental disabilities grants (This section was also added by the House.)

Add a section to provide for a Legislative Management study of the state's qualified service provider system (This section was also added by the House.)

Senate Bill No. 2012 - DHS - State Hospital - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
State Hospital	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
FTE	467.51	467.51	0.00	467.51	467.51	0.00

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STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - Conference committee changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects. (This adjustment was also made by the House.)		($161,840)	$0	($161,840)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(250,000)	0	(250,000)
Total conference committee changes - State Hospital	0.00	($411,840)	$0	($411,840)
Conference committee version - State Hospital	467.51	$53,076,797	$20,146,403	$73,223,200

Senate Bill No. 2012 - DHS - Developmental Center - Conference Committee Action

The conference committee did not make any changes to the Senate version.

Senate Bill No. 2012 - Human Service Centers - General Fund Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	4,958,832	4,958,832	(74,500)	4,884,332	4,884,332	
DHS - North Central HSC	13,410,027	13,410,027	(1,531,658)	11,878,369	11,878,369	
DHS - Lake Region HSC	6,882,190	6,882,190	(121,878)	6,760,312	6,760,312	
DHS - Northeast HSC	13,209,723	13,209,723	(93,159)	13,116,564	13,116,564	
DHS - Southeast HSC	22,185,733	22,185,733	(456,586)	21,729,147	21,729,147	
DHS - South Central HSC	9,343,547	9,343,547	(94,688)	9,248,859	9,248,859	
DHS - West Central HSC	14,109,532	14,109,532	(388,050)	13,721,482	13,721,482	
DHS - Badlands HSC	6,529,292	6,529,292	(81,600)	6,447,692	6,447,692	
Total general fund	$90,628,876	$90,628,876	($2,842,119)	$87,786,757	$87,786,757	

Senate Bill No. 2012 - Human Service Centers - Other Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	3,790,236	3,790,236		3,790,236	3,790,236	
DHS - North Central HSC	9,023,857	9,023,857		9,023,857	9,023,857	
DHS - Lake Region HSC	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	
DHS - Northeast HSC	14,972,886	14,972,886		14,972,886	14,972,886	
DHS - Southeast HSC	16,278,987	16,278,987		16,278,987	16,278,987	
DHS - South Central HSC	7,610,152	7,610,152		7,610,152	7,610,152	
DHS - West Central HSC	12,630,961	12,630,961		12,630,961	12,630,961	
DHS - Badlands HSC	5,260,362	5,260,362		5,260,362	5,260,362	
Total other funds	$74,103,482	$74,103,482	($52,047)	$74,051,435	$74,051,435	

Senate Bill No. 2012 - Human Service Centers - All Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	8,749,068	8,749,068	(74,500)	8,674,568	8,674,568	
DHS - North Central HSC	22,433,884	22,433,884	(1,531,658)	20,902,226	20,902,226	
DHS - Lake Region HSC	11,418,231	11,418,231	(173,925)	11,244,306	11,244,306	
DHS - Northeast HSC	28,182,609	28,182,609	(93,159)	28,089,450	28,089,450	
DHS - Southeast HSC	38,464,720	38,464,720	(456,586)	38,008,134	38,008,134	
DHS - South Central HSC	16,953,699	16,953,699	(94,688)	16,859,011	16,859,011	
DHS - West Central HSC	26,740,493	26,740,493	(388,050)	26,352,443	26,352,443	
DHS - Badlands HSC	11,789,654	11,789,654	(81,600)	11,708,054	11,708,054	
Total all funds	$164,732,358	$164,732,358	($2,894,166)	$161,838,192	$161,838,192	
FTE	837.48	837.48	0.00	837.48	837.48	0.00

1

NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - Conference committee changes:				

Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($74,500)	$0	($74,500)
Total conference committee changes - Northwest Human Service Center	0.00	($74,500)	$0	($74,500)
Conference committee version - Northwest Human Service Center	45.75	$4,884,332	$3,790,236	$8,674,568

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mentally ill (This adjustment was also made by the House.)		($1,444,661)	$0	($1,444,661)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(70,740)	0	(70,740)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,257)	0	(16,257)
Total conference committee changes - North Central Human Service Center	0.00	($1,531,658)	$0	($1,531,658)

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - Conference committee changes:				
Reduce funding for temporary salaries (This adjustment was also made by the House.)		($37,930)	($52,047)	($89,977)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(75,320)	0	(75,320)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(8,628)	0	(8,628)
Total conference committee changes - Lake Region Human Service Center	0.00	($121,878)	($52,047)	($173,925)
Conference committee version - Lake Region Human Service Center	60.00	$6,760,312	$4,483,994	$11,244,306

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($72,720)	$0	($72,720)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(20,439)	0	(20,439)
Total conference committee - Northeast Human Service Center	0.00	($93,159)	$0	($93,159)

House version - Northeast Human Service Center	138.30	$13,116,564	$14,972,886	$28,089,450

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - Conference committee changes:				
Remove funding added in the department's base budget for additional staff at the Cooper House (This adjustment was also made by the House.)		($350,400)	$0	($350,400)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(92,100)	0	(92,100)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(14,086)	0	(14,086)
Total conference committee changes - Southeast Human Service Center	0.00	($456,586)	$0	($456,586)
Conference committee version - Southeast Human Service Center	182.15	$21,729,147	$16,278,987	$38,008,134

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($84,020)	$0	($84,020)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(10,668)	0	(10,668)
Total conference committee changes - South Central Human Service Center	0.00	($94,688)	$0	($94,688)
Conference committee version - South Central Human Service Center	85.50	$9,248,859	$7,610,152	$16,859,011

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds (This adjustment was also made by the House.)		($309,128)	$0	($309,128)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(61,420)	0	(61,420)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(17,502)	0	(17,502)
Total conference committee changes - West Central Human Service Center	0.00	($388,050)	$0	($388,050)
Conference committee version - West Central Human Service Center	135.30	$13,721,482	$12,630,961	$26,352,443

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total

Senate version	72.70	$6,529,292	$5,260,362	$11,789,654
Badlands Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($69,180)	$0	($69,180)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(12,420)	0	(12,420)
Total conference committee changes - Badlands Human Service Center	0.00	($81,600)	$0	($81,600)
Conference committee version - Badlands Human Service Center	72.70	$6,447,692	$5,260,362	$11,708,054

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-20-11

Roll Call Vote #: 1

amendment 11.8152.02016

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) --

☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Kilzer Seconded by: Fischer

Senators	4/20			Yes	No		Representatives	4/20			Yes	No
Senator Kilzer	✓			✓			Rep. Pollert	✓			✓	
Senator Fischer	✓			✓			Rep. Bellew	✓			✓	
Senator Warner	✓			✓			Rep. Kaldor	✓			✓	

Vote Count: Yes 4 No 0 Absent 0

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

11.8152.02017
Title.
Fiscal No. 6

Prepared by the Legislative Council staff for
Representative Kaldor
April 19, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

That the House recede from its amendments as printed on pages 1204-1214 of the Senate Journal and pages 1371-1381 of the House Journal and that Engrossed Senate Bill No. 2012 be amended as follows:

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	324,582,091	1,625,224,414
Total all funds	$1,870,492,778	$382,934,247	$2,253,427,025
Less estimated income	1,381,801,240	135,074,477	1,516,875,717
Total general fund	$488,691,538	$247,859,770	$736,551,308"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$286,258,197	$932,607,713
Grand total special funds	1,549,066,932	140,988,899	1,690,055,831
Grand total all funds	$2,195,416,448	$427,247,096	$2,622,663,544"

Page 5, line 9, replace "seventy-five" with "sixty-five"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
DHS - Management						
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874	$78,880,886	$178,988
Less estimated income	47,538,412	47,538,412	0	47,538,412	47,763,412	(225,000)
General fund	$31,521,462	$31,521,462	$0	$31,521,462	$31,117,474	$403,988
DHS - Program/Policy						
Total all funds	$2,241,950,229	$2,255,138,635	($1,711,610)	$2,253,427,025	$2,190,288,567	$63,138,458
Less estimated income	1,510,481,136	1,518,090,686	(1,214,969)	1,516,875,717	1,474,622,151	42,253,566
General fund	$731,469,093	$737,047,949	($496,641)	$736,551,308	$715,666,416	$20,884,892
DHS - State Hospital						
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040	$73,223,200	$411,840
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	$0	$53,488,637	$53,076,797	$411,840
DHS - Developmental Center						
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247	$51,809,247	$0
Less estimated income	31,391,817	31,391,817	0	31,391,817	31,391,817	0
General fund	$20,417,430	$20,417,430	$0	$20,417,430	$20,417,430	$0
DHS - Northwest HSC						
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068	$8,674,568	$74,500
Less estimated income	3,790,236	3,790,236	0	3,790,236	3,790,236	0

General fund	$4,958,832	$4,958,832	$0	$4,958,832	$4,884,332	$74,500
DHS - North Central HSC						
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884	$20,902,226	$1,531,658
Less estimated income	9,023,857	9,023,857	0	9,023,857	9,023,857	0
General fund	$13,410,027	$13,410,027	$0	$13,410,027	$11,878,369	$1,531,658
DHS - Lake Region HSC						
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231	$11,244,306	$173,925
Less estimated income	4,536,041	4,536,041	0	4,536,041	4,483,994	52,047
General fund	$6,882,190	$6,882,190	$0	$6,882,190	$6,760,312	$121,878
DHS - Northeast HSC						
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609	$28,089,450	$93,159
Less estimated income	14,972,886	14,972,886	0	14,972,886	14,972,886	0
General fund	$13,209,723	$13,209,723	$0	$13,209,723	$13,116,564	$93,159
DHS - Southeast HSC						
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720	$38,008,134	$456,586
Less estimated income	16,278,987	16,278,987	0	16,278,987	16,278,987	0
General fund	$22,185,733	$22,185,733	$0	$22,185,733	$21,729,147	$456,586
DHS - South Central HSC						
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699	$16,859,011	$94,688
Less estimated income	7,610,152	7,610,152	0	7,610,152	7,610,152	0
General fund	$9,343,547	$9,343,547	$0	$9,343,547	$9,248,859	$94,688
DHS - West Central HSC						
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493	$26,352,443	$388,050
Less estimated income	12,630,961	12,630,961	0	12,630,961	12,630,961	0
General fund	$14,109,532	$14,109,532	$0	$14,109,532	$13,721,482	$388,050
DHS - Badlands HSC						
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654	$11,708,054	$81,600
Less estimated income	5,260,362	5,260,362	0	5,260,362	5,260,362	0
General fund	$6,529,292	$6,529,292	$0	$6,529,292	$6,447,692	$81,600
Bill total						
Total all funds	$2,611,024,908	$2,624,375,154	($1,711,610)	$2,622,663,544	$2,556,040,092	$66,623,452
Less estimated income	1,683,661,250	1,691,270,800	(1,214,969)	1,690,055,831	1,647,975,218	42,080,613
General fund	$927,363,658	$933,104,354	($496,641)	$932,607,713	$908,064,874	$24,542,839

Senate Bill No. 2012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
Salaries and wages	$50,346,211	$50,346,211		$50,346,211	$49,720,384	$625,827
Operating expenses	90,850,363	90,850,363		90,850,363	92,423,280	(1,572,917)
Grants	487,016,037	487,006,037		487,006,037	487,006,037	
Grants - Medical assistance	1,613,737,618	1,626,936,024	(1,711,610)	1,625,224,414	1,561,138,866	64,085,548
Total all funds	$2,241,950,229	$2,255,138,635	($1,711,610)	$2,253,427,025	$2,190,288,567	$63,138,458
Less estimated income	1,510,481,136	1,518,090,686	(1,214,969)	1,516,875,717	1,474,622,151	42,253,566
General fund	$731,469,093	$737,047,949	($496,641)	$736,551,308	$715,666,416	$20,884,892
FTE	374.50	374.50	0.00	374.50	367.50	7.00

Department No. 328 - DHS - Program/Policy - Detail of Conference Committee Changes

	Removes Funding for Outreach for	Adjusts Funding for the Children's	Total Conference Committee

	the Children's Health Insurance Program[1]	Health Insurance Program[2]	Changes
Salaries and wages			
Operating expenses			
Grants			
Grants - Medical assistance	(650,000)	(1,061,610)	(1,711,610)
Total all funds	($650,000)	($1,061,610)	($1,711,610)
Less estimated income	(481,715)	(733,254)	(1,214,969)
General fund	($168,285)	($328,356)	($496,641)
FTE	0.00	0.00	0.00

[1] Funding for outreach for the children's health insurance program is removed.

[2] Funding is adjusted for the children's health insurance program as follows:

	Senate Version - Eligibility at 175% of Federal Poverty Level	Conference Committee Version - 165% of Federal Poverty Level	Increase (Decrease)
General fund	$567,367	$239,011	($328,356)
Other funds	1,266,990	533,736	(733,254)
Total	$1,834,357	$772,747	($1,061,610)

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-20-11

Roll Call Vote #: 2

Rep. Kaldor amendment 11.8152.02017

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☐ HOUSE recede from House amendments and amend as follows

failed

Senate/House Amendments on SJ/HJ page(s) --

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Kaldor Seconded by: Warner

Senators	Yes	No	Representatives	Yes	No
Senator Kilzer	/	✓	Rep. Pollert		✓
Senator Fischer		✓	Rep. Bellew		✓
Senator Warner	✓		Rep. Kaldor	✓	

Vote Count: Yes 2 No 4 Absent 0

Senate Carrier _____ House Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

2011 SENATE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: Senate Appropriations

Bill/Resolution No. SB 2012 as (re) engrossed

Date: 4-20-11

Roll Call Vote #: 3

SB 2012

Action Taken

- ☐ SENATE accede to House amendments
- ☐ SENATE accede to House amendments and further amend
- ☐ HOUSE recede from House amendments
- ☒ HOUSE recede from House amendments and amend as follows

Senate/House Amendments on SJ/HJ page(s) 1207 - 1214

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) SB 2012 was placed on the Seventh order of business on the calendar

Motion Made by: Fischer Seconded by: Rep Pollert

Senators	Yes	No	Representatives	Yes	No
Senator Kilzer	✓		Rep. Pollert	✓	
Senator Fischer	✓		Rep. Bellew	✓	
Senator Warner	✓		Rep. Kaldor	✓	

Vote Count: Yes 6 No 0 Absent 0

Senate Carrier Kilzer House Carrier Pollert

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

SB 2012, as engrossed: Your conference committee (Sens. Kilzer, Fischer, Warner and Reps. Pollert, Bellew, Kaldor) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1204-1214, adopt amendments as follows, and place SB 2012 on the Seventh order:

That the House recede from its amendments as printed on pages 1204-1214 of the Senate Journal and pages 1371-1381 of the House Journal and that Engrossed Senate Bill No. 2012 be amended as follows:

Page 1, line 2, remove "to amend and"

Page 1, remove line 3

Page 1, line 4, replace "children's health insurance program" with "to provide for a legislative management study"

Page 1, replace lines 16 through 21 with:

"Salaries and wages	$14,231,353	$2,226,715	$16,458,068
Operating expenses	46,548,787	15,735,631	62,284,418
Capital assets	0	138,400	138,400
Total all funds	$60,780,140	$18,100,746	$78,880,886
Less estimated income	34,477,817	13,285,595	47,763,412
Total general fund	$26,302,323	$4,815,151	$31,117,474"

Page 2, replace lines 3 through 10 with:

"Salaries and wages	$41,389,716	$8,330,668	$49,720,384
Operating expenses	75,461,417	16,961,863	92,423,280
Capital assets	8,580	(8,580)	0
Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	300,182,682	1,600,825,005
Total all funds	$1,870,492,778	$359,481,928	$2,229,974,706
Less estimated income	1,381,801,240	115,058,125	1,496,859,365
Total general fund	$488,691,538	$244,423,803	$733,115,341"

Page 2, replace lines 15 through 27 with:

"Northwest human service center	$8,452,001	$222,567	$8,674,568
North central human service center	19,208,018	1,694,208	20,902,226
Lake region human service center	10,886,645	357,661	11,244,306
Northeast human service center	25,768,431	2,321,019	28,089,450
Southeast human service center	30,139,636	7,868,498	38,008,134

South central human service center	15,567,495	1,291,516	16,859,011
West central human service center	24,683,076	1,669,367	26,352,443
Badlands human service center	10,857,338	850,716	11,708,054
State hospital	65,641,609	7,581,591	73,223,200
Developmental center	52,939,281	(1,130,034)	51,809,247
Total all funds	$264,143,530	$22,727,109	$286,870,639
Less estimated income	132,787,875	(7,198,220)	125,589,655
Total general fund	$131,355,655	$29,925,329	$161,280,984"

Page 3, replace lines 3 through 6 with:

"Grand total general fund	$646,349,516	$279,164,283	$925,513,799
Grand total special funds	1,549,066,932	121,145,500	1,670,212,432
Grand total all funds	$2,195,416,448	$400,309,783	$2,595,726,231
Full-time equivalent positions	2,216.88	(27.53)	2,189.35"

Page 3, after line 15, insert:

"Supplemental payment	0	400,000"

Page 3, replace lines 17 through 20 with:

"State hospital capital projects	0	1,800,000
Total all funds	$92,329,503	$2,719,175
Less estimated income	88,033,205	919,175
Total general fund	$4,296,298	$1,800,000"

Page 4, remove lines 9 through 30

Page 5, replace lines 1 through 23 with:

"**SECTION 5. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS.** Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts resulting from federal medical assistance percentage changes under the American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and ending June 30, 2013, including $23,451,104 for inflationary increases for human services providers.

SECTION 6. REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services shall periodically report to the legislative management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes.

SECTION 7. RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENTS. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall require an entity receiving a grant under this section to provide $1 of matching funds for each $1 of state funds provided.

SECTION 8. LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

SECTION 9. LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

SECTION 10. SUPPLEMENTAL PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $400,000 from the health care trust fund which the department shall provide as a one-time grant, for the biennium beginning July 1, 2011, and ending June 30, 2013. The department shall provide a grant of $200,000 to the government nursing facility that participated in the intergovernmental transfer payment program in a city with a population of more than six hundred according to the 2000 census and a grant of $200,000 to the hospital in a city with a population of less than five hundred according to the 2000 census which also has a government nursing facility that participated in the intergovernmental transfer payment program."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes	Conference Committee Version	House Version	Comparison to House
DHS - Management						
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
DHS - Program/Policy						
Total all funds	$2,241,950,229	$2,255,138,635	($25,163,929)	$2,229,974,706	$2,190,288,567	$39,686,139
Less estimated income	1,510,481,136	1,518,090,686	(21,231,321)	1,496,859,365	1,474,622,151	22,237,214
General fund	$731,469,093	$737,047,949	($3,932,608)	$733,115,341	$715,666,416	$17,448,925
DHS - State Hospital						
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
DHS - Developmental Center						
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247	$51,809,247	$0

Less estimated income	31,391,817	31,391,817	0	31,391,817	31,391,817	0
General fund	$20,417,430	$20,417,430	$0	$20,417,430	$20,417,430	$0
DHS - Northwest HSC						
Total all funds	$8,749,068	$8,749,068	($74,500)	$8,674,568	$8,674,568	$0
Less estimated income	3,790,236	3,790,236	0	3,790,236	3,790,236	0
General fund	$4,958,832	$4,958,832	($74,500)	$4,884,332	$4,884,332	$0
DHS - North Central HSC						
Total all funds	$22,433,884	$22,433,884	($1,531,658)	$20,902,226	$20,902,226	$0
Less estimated income	9,023,857	9,023,857	0	9,023,857	9,023,857	0
General fund	$13,410,027	$13,410,027	($1,531,658)	$11,878,369	$11,878,369	$0
DHS - Lake Region HSC						
Total all funds	$11,418,231	$11,418,231	($173,925)	$11,244,306	$11,244,306	$0
Less estimated income	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	0
General fund	$6,882,190	$6,882,190	($121,878)	$6,760,312	$6,760,312	$0
DHS - Northeast HSC						
Total all funds	$28,182,609	$28,182,609	($93,159)	$28,089,450	$28,089,450	$0
Less estimated income	14,972,886	14,972,886	0	14,972,886	14,972,886	0
General fund	$13,209,723	$13,209,723	($93,159)	$13,116,564	$13,116,564	$0
DHS - Southeast HSC						
Total all funds	$38,464,720	$38,464,720	($456,586)	$38,008,134	$38,008,134	$0
Less estimated income	16,278,987	16,278,987	0	16,278,987	16,278,987	0
General fund	$22,185,733	$22,185,733	($456,586)	$21,729,147	$21,729,147	$0
DHS - South Central HSC						
Total all funds	$16,953,699	$16,953,699	($94,688)	$16,859,011	$16,859,011	$0
Less estimated income	7,610,152	7,610,152	0	7,610,152	7,610,152	0
General fund	$9,343,547	$9,343,547	($94,688)	$9,248,859	$9,248,859	$0
DHS - West Central HSC						
Total all funds	$26,740,493	$26,740,493	($388,050)	$26,352,443	$26,352,443	$0
Less estimated income	12,630,961	12,630,961	0	12,630,961	12,630,961	0
General fund	$14,109,532	$14,109,532	($388,050)	$13,721,482	$13,721,482	$0
DHS - Badlands HSC						
Total all funds	$11,789,654	$11,789,654	($81,600)	$11,708,054	$11,708,054	$0
Less estimated income	5,260,362	5,260,362	0	5,260,362	5,260,362	0
General fund	$6,529,292	$6,529,292	($81,600)	$6,447,692	$6,447,692	$0
Bill total						
Total all funds	$2,611,024,908	$2,624,375,154	($28,648,923)	$2,595,726,231	$2,556,040,092	$39,686,139
Less estimated income	1,683,661,250	1,691,270,800	(21,058,368)	1,670,212,432	1,647,975,218	22,237,214
General fund	$927,363,658	$933,104,354	($7,590,555)	$925,513,799	$908,064,874	$17,448,925

Senate Bill No. 2012 - DHS - Management - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
Salaries and wages	$16,513,336	$16,513,336	($55,268)	$16,458,068	$16,458,068	
Operating expenses	62,408,138	62,408,138	(123,720)	62,284,418	62,284,418	
Capital assets	138,400	138,400		138,400	138,400	
Total all funds	$79,059,874	$79,059,874	($178,988)	$78,880,886	$78,880,886	$0
Less estimated income	47,538,412	47,538,412	225,000	47,763,412	47,763,412	0
General fund	$31,521,462	$31,521,462	($403,988)	$31,117,474	$31,117,474	$0
FTE	116.10	116.10	0.00	116.10	116.10	0.00

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MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - Conference committee changes:				
Administration - Support				

Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($31,930)	$0	($31,930)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,275)	0	(16,275)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(102,300)	0	(102,300)
Information Technology Services				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(23,338)	0	(23,338)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(134,672)	0	(134,672)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(120,473)	0	(120,473)
Add funding for activities relating to the eligibility system replacement project (This adjustment was also made by the House.)		25,000	225,000	250,000
Total conference committee changes - Management	0.00	($403,988)	$225,000	($178,988)
Conference committee version - Management subdivision	116.10	$31,117,474	$47,763,412	$78,880,886

Other changes affecting Management programs or multiple programs of the department:

Removes Section 6 of the engrossed bill relating to office space lease limitation. This section was added by the Senate and also removed by the House.

Does not include a section relating to a study of the human services delivery system which was added by the House.

Does not include a section relating to a Legislative Management study of patient-centered medical homes.

Adds a section providing for a report to the Legislative Management on the dementia care services program. This section was also added by the House.

Senate Bill No. 2012 - DHS - Program/Policy - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
Salaries and wages	$50,346,211	$50,346,211	($625,827)	$49,720,384	$49,720,384	
Operating expenses	90,850,363	90,850,363	1,572,917	92,423,280	92,423,280	
Grants	487,006,037	487,006,037		487,006,037	487,006,037	
Grants - Medical assistance	1,613,737,618	1,626,936,024	(26,111,019)	1,600,825,005	1,561,138,866	39,686,139
Total all funds	$2,241,950,229	$2,255,138,635	($25,163,929)	$2,229,974,706	$2,190,288,567	$39,686,139
Less estimated income	1,510,481,136	1,518,090,686	(21,231,321)	1,496,859,365	1,474,622,151	22,237,214
General fund	$731,469,093	$737,047,949	($3,932,608)	$733,115,341	$715,666,416	$17,448,925
FTE	374.50	374.50	(7.00)	367.50	367.50	0.00

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PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635

Program and Policy - Conference committee changes:				
Economic Assistance Policy Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($12,054)	$0	($12,054)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(17,805)	0	(17,805)
Child Support Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(36,574)	0	(36,574)
Remove position and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(1.00)	(62,714)	(121,742)	(184,456)
Medical Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions care reform (This adjustment was also made by the House.)		(24,105)	0	(24,105)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(180,116)	0	(180,116)
Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level (This adjustment was also made by the House.)		(567,367)	(1,266,990)	(1,834,357)
Reduce funding for the state children's health insurance program to reflect a revised premium amount (This adjustment was also made by the House.)		(42,989)	(95,928)	(138,917)
Remove positions and funding added in the executive budget relating to health care reform (This adjustment was also made by the House.)	(5.00)	(144,988)	(183,846)	(328,834)
Decrease funding for medical services to reduce projected caseload/utilization rates (This adjustment was also made by the House.)		(2,739,780)	(3,460,220)	(6,200,000)
Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians (This adjustment was also made by the House.)		(2,065,704)	(2,634,500)	(4,700,204)
Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program (This adjustment was also made by the House.)		0	200,000	200,000
Long-Term Care Program				
Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011 (This adjustment was also made by the House.)		(5,021,489)	(6,342,560)	(11,364,049)
Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority, requires the department to turn back any unexpended		12,800,000	0	12,800,000

general fund authority from the 2009-11 biennium, and appropriates funds from the general fund for the 2011-13 biennium. (This adjustment was also made by the House.)				
Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates (This adjustment was also made by the House.)		56,423	70,085	126,508
Decrease funding for long-term care to reduce projected caseload/utilization rates (This adjustment was also made by the House.)		(6,716,880)	(8,483,120)	(15,200,000)
Add one-time funding from the health care trust fund for a grant to a government nursing facility which participated in the intergovernmental transfer payment program		0	200,000	200,000
Aging Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(5,263)	0	(5,263)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(17,231)	0	(17,231)
Children and Family Services Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(5,697)	0	(5,697)
Mental Health and Substance Abuse Program				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(6,240)	0	(6,240)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(26,706)	0	(26,706)
Developmental Disabilities Council				
No changes		0	0	0
Developmental Disabilities Division				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(2,804)	0	(2,804)
Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043 (This adjustment was also made by the House.)		887,500	887,500	1,775,000
Increase funding for petitioning costs for indigent people with developmental disabilities (This adjustment was also made by the House.)		21,970	0	21,970
Vocational Rehabilitation				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(1,995)	0	(1,995)
Total conference committee changes - Program and Policy	(7.00)	($3,932,608)	($21,231,321)	($25,163,929)
Conference committee version - Program and Policy subdivision	367.50	$733,115,341	$1,496,859,365	$2,229,974,706

Other changes affecting Program and Policy programs:

Add a section to provide that the department utilize $250,000 of federal funds appropriated to the Mental Health and Substance Abuse Division for

grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts (This section was also added by the House.)

Add a section to provide legislative intent regarding developmental disabilities grants (This section was also added by the House.)

Add a section to provide for a Legislative Management study of the state's qualified service provider system (This section was also added by the House.)

Senate Bill No. 2012 - DHS - State Hospital - Conference Committee Action

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
State Hospital	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	
Total all funds	$73,473,200	$73,635,040	($411,840)	$73,223,200	$73,223,200	$0
Less estimated income	20,146,403	20,146,403	0	20,146,403	20,146,403	0
General fund	$53,326,797	$53,488,637	($411,840)	$53,076,797	$53,076,797	$0
FTE	467.51	467.51	0.00	467.51	467.51	0.00

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STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - Conference committee changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects. (This adjustment was also made by the House.)		($161,840)	$0	($161,840)
Reduce funding for operating expenses (division-specific reduction) (This adjustment was also made by the House.)		(250,000)	0	(250,000)
Total conference committee changes - State Hospital	0.00	($411,840)	$0	($411,840)
Conference committee version - State Hospital	467.51	$53,076,797	$20,146,403	$73,223,200

Senate Bill No. 2012 - DHS - Developmental Center - Conference Committee Action

The conference committee did not make any changes to the Senate version.

Senate Bill No. 2012 - Human Service Centers - General Fund Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	4,958,832	4,958,832	(74,500)	4,884,332	4,884,332	
DHS - North Central HSC	13,410,027	13,410,027	(1,531,658)	11,878,369	11,878,369	
DHS - Lake Region HSC	6,882,190	6,882,190	(121,878)	6,760,312	6,760,312	
DHS - Northeast HSC	13,209,723	13,209,723	(93,159)	13,116,564	13,116,564	
DHS - Southeast HSC	22,185,733	22,185,733	(456,586)	21,729,147	21,729,147	
DHS - South Central HSC	9,343,547	9,343,547	(94,688)	9,248,859	9,248,859	
DHS - West Central HSC	14,109,532	14,109,532	(388,050)	13,721,482	13,721,482	
DHS - Badlands HSC	6,529,292	6,529,292	(81,600)	6,447,692	6,447,692	
Total general fund	$90,628,876	$90,628,876	($2,842,119)	$87,786,757	$87,786,757	

Senate Bill No. 2012 - Human Service Centers - Other Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	3,790,236	3,790,236		3,790,236	3,790,236	
DHS - North Central HSC	9,023,857	9,023,857		9,023,857	9,023,857	
DHS - Lake Region HSC	4,536,041	4,536,041	(52,047)	4,483,994	4,483,994	
DHS - Northeast HSC	14,972,886	14,972,886		14,972,886	14,972,886	
DHS - Southeast HSC	16,278,987	16,278,987		16,278,987	16,278,987	
DHS - South Central HSC	7,610,152	7,610,152		7,610,152	7,610,152	
DHS - West Central HSC	12,630,961	12,630,961		12,630,961	12,630,961	
DHS - Badlands HSC	5,260,362	5,260,362		5,260,362	5,260,362	
Total other funds	$74,103,482	$74,103,482	($52,047)	$74,051,435	$74,051,435	

Senate Bill No. 2012 - Human Service Centers - All Funds Summary

	Executive Budget	Senate Version	Conference Committee Changes[1]	Conference Committee Version	House Version	Comparison to House
DHS - Northwest HSC	8,749,068	8,749,068	(74,500)	8,674,568	8,674,568	
DHS - North Central HSC	22,433,884	22,433,884	(1,531,658)	20,902,226	20,902,226	
DHS - Lake Region HSC	11,418,231	11,418,231	(173,925)	11,244,306	11,244,306	
DHS - Northeast HSC	28,182,609	28,182,609	(93,159)	28,089,450	28,089,450	
DHS - Southeast HSC	38,464,720	38,464,720	(456,586)	38,008,134	38,008,134	
DHS - South Central HSC	16,953,699	16,953,699	(94,688)	16,859,011	16,859,011	
DHS - West Central HSC	26,740,493	26,740,493	(388,050)	26,352,443	26,352,443	
DHS - Badlands HSC	11,789,654	11,789,654	(81,600)	11,708,054	11,708,054	
Total all funds	$164,732,358	$164,732,358	($2,894,166)	$161,838,192	$161,838,192	
FTE	837.48	837.48	0.00	837.48	837.48	0.00

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NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($74,500)	$0	($74,500)
Total conference committee changes - Northwest Human Service Center	0.00	($74,500)	$0	($74,500)
Conference committee version - Northwest Human Service Center	45.75	$4,884,332	$3,790,236	$8,674,568

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mentally ill (This adjustment was also made by the House.)		($1,444,661)	$0	($1,444,661)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(70,740)	0	(70,740)

Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(16,257)	0	(16,257)
Total conference committee changes - North Central Human Service Center	0.00	($1,531,658)	$0	($1,531,658)

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - Conference committee changes:				
Reduce funding for temporary salaries (This adjustment was also made by the House.)		($37,930)	($52,047)	($89,977)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(75,320)	0	(75,320)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(8,628)	0	(8,628)
Total conference committee changes - Lake Region Human Service Center	0.00	($121,878)	($52,047)	($173,925)
Conference committee version - Lake Region Human Service Center	60.00	$6,760,312	$4,483,994	$11,244,306

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($72,720)	$0	($72,720)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(20,439)	0	(20,439)
Total conference committee - Northeast Human Service Center	0.00	($93,159)	$0	($93,159)
House version - Northeast Human Service Center	138.30	$13,116,564	$14,972,886	$28,089,450

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - Conference committee changes:				
Remove funding added in the department's base budget for additional staff at the Cooper House (This adjustment was also made by the House.)		($350,400)	$0	($350,400)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(92,100)	0	(92,100)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(14,086)	0	(14,086)
Total conference committee changes - Southeast Human Service Center	0.00	($456,586)	$0	($456,586)

Conference committee version - Southeast Human Service Center	182.15	$21,729,147	$16,278,987	$38,008,134

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($84,020)	$0	($84,020)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(10,668)	0	(10,668)
Total conference committee changes - South Central Human Service Center	0.00	($94,688)	$0	($94,688)
Conference committee version - South Central Human Service Center	85.50	$9,248,859	$7,610,152	$16,859,011

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - Conference committee changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds (This adjustment was also made by the House.)		($309,128)	$0	($309,128)
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		(61,420)	0	(61,420)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(17,502)	0	(17,502)
Total conference committee changes - West Central Human Service Center	0.00	($388,050)	$0	($388,050)
Conference committee version - West Central Human Service Center	135.30	$13,721,482	$12,630,961	$26,352,443

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	72.70	$6,529,292	$5,260,362	$11,789,654
Badlands Human Service Center - Conference committee changes:				
Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover (This adjustment was also made by the House.)		($69,180)	$0	($69,180)
Reduce funding for operating expenses (departmentwide reduction) (This adjustment was also made by the House.)		(12,420)	0	(12,420)
Total conference committee changes - Badlands Human Service Center	0.00	($81,600)	$0	($81,600)
Conference committee version - Badlands Human Service Center	72.70	$6,447,692	$5,260,362	$11,708,054

Engrossed SB 2012 was placed on the Seventh order of business on the calendar.

2011 TESTIMONY

SB 2012

Developments That Have Shaped the Delivery of Human Services in N.D. Since the 1960s

Prepared Jan. 2011 at the request of Sen. Tony Grindberg

1950s – 1960s

American society tended to place people with disabilities into institutions.

- **1953** – ND **State Hospital's (NDSH) patient census** peaked at **2,136** patients
- **1960s** – A total of **1,324** people resided at the **Developmental Center** and **San Haven** institutions (peak)

The Kennedy administration made **federal funds** available to states to **establish community Mental Health and Retardation Centers**

1960s – Implementation of federal ***Great Society*** **and** ***War on Poverty*** initiatives

- Food Stamps, Welfare, Medicaid, Medicare
- **1965** – **Head Start** established to address the needs of underprivileged children in a comprehensive way

1970s

ND worked to comply with **amendments to the Social Security Act** passed in the 1960s requiring states to **establish social service systems by 1975** to ensure:

- Full array of statewide services
- Outreach to people in-need of services (to prevent child abuse and neglect)
- Trained social workers

- **1974** – **Federal Child Abuse Protection and Treatment Act** led to state laws:
  - Created child protective services program and mandatory reporting

ND Lawmakers studied **consolidation of Area Social Services Centers and regional Mental Health and Retardation Service Units**

- **1973** – First **Regional Human Service Centers (HSC)** established in Dickinson and Williston adding mental health and developmental disabilities services to the social service centers' duties

1980s

- **1981** – **ND Department of Human Services was created** by the Legislature consolidating programs formerly operated under multiple agencies
  - Mental Health and Retardation Division (including the State Hospital) and the Division of Alcoholism and Drug Abuse from the Department of Health,
  - Social Service Board of North Dakota, and
  - State Council on Developmental Disabilities.

- **1982** – U.S. District Court ruling in the case of the ***Association of Retarded Citizens of North Dakota, et al., vs. State of ND***, resulted in substantial, court-ordered changes to ND's service system for people with developmental disabilities
  - Provided momentum for deinstitutionalization
    - **1987** – The state's **San Haven** facility closed
  - DHS worked with public and private providers to **continue the development of a system of community-based residential services**

- In response to growing divorce rates, federal requirements related to state **child support enforcement** services grew

1990s

- 1989 -1991 – **Patient movement in public mental health system**
  - Average daily census decreased to 270 at NDSH (down from 440 in 1980s)
  - NDSH merged 17 wards to 10 wards

- Regional Human Service Centers started **pre-screening** all **State Hospital** and **Developmental Center admissions** for appropriateness

- **1996** – Congress passed **welfare reform** (*Personal Responsibility and Work Opportunity Reconciliation Act or PRWORA*) creating the Temporary Assistance for Needy Families **(TANF)** program
  - Added **job readiness, and work participation requirements** to the cash assistance program for low-income families
  - New philosophy: promote self sufficiency while maintaining safety-net for low-income children
  - 60-month life-time limit on benefits
  - At its **peak (April 1993)**, the AFDC Program served **6,625** ND families *(Source: AFDC FR007 Report by R & S, 5/6/93)*
  - July **1997** – ND launched welfare reform; an average of **3,859** families per month received TANF *(Source: 1995-1997 Biennial Report)*
  - December 2010 – **1,988** families received TANF
  - **Also** required **states to create a centralized State Disbursement Unit (SDU)** to process child support payments (**1999 – ND completed SDU** conversion)
- **1997 – Children's Health Insurance Program** created by Congress to meet the needs of low-income children who did not qualify for Medicaid
  - **1999 – Children's Health Insurance Program** established in ND [**140%** Net Federal Poverty Level (FPL)]

- **1997** – federal **Adoption and Safe Families Act** shifted the emphasis in child welfare services toward child permanency, well-being, and safety and away from a policy of reuniting children with parents without regard to prior abusiveness
  - Created **federal performance goals** and **Child and Family Services Reviews (CFSR)** - on-site case file reviews and stakeholder interviews
    - 2001 – ND's **first CFSR;** no states passed. ND met 9 of 14 outcomes - more than any other state
    - 2007 – Subsequent review; no states passed

- **1990s – Newer antipsychotic medications** allow more seriously mentally ill people to be treated outside of institutions

- **1998** – Three State Hospital buildings were renovated to house inmates of the **James River Correctional Center**, which was **co-located on** the **grounds**

- **1997-1999 – Sex offender evaluation and treatment services developed** at the State Hospital; Secure Unit for sex offenders opened

- **1998-2000 – 3 offenders civilly committed** to the State Hospital

2000s

On June 22, 1999, the United States Supreme Court issued a decision in ***Olmstead vs. L.C.*** that continues to shape Human Services

- Fueled continued **growth in home and community-based services for people with disabilities – including the elderly**
  - **Development of community capacity**
  - **Contacts with local hospitals for inpatient care**
  - Implemented **core wrap-around services for children's mental health statewide** (1999-2001 biennium)

ND State Hospital:

- Provided specialized inpatient psychiatric and substance addition treatment
- Became **safety net inpatient facility** for the Devils Lake, Dickinson, Jamestown, and the Williston regions
- Worked with HSCs to achieve **shorter average lengths of stay**
- Established a **Geropsych program** contract *(1999-2001)*
- Adopted **shared management**
  - Combined **State Hospital** and **Developmental Center** administrative support areas under one superintendent
  - Combined director positions at the **regional human service centers** *(4 regional directors, instead of 8)*

ND Developmental Center

- **Vacant buildings** used by other entities
- **2005 Transition Task Force** established
  - **Jan. 2011 – Has discharged or has discharge plans for 54 people**
- **2009 – Expanded** the Center's **CARES team** to consult **statewide** with community providers to keep people in communities/prevent readmissions

- **Interest in addressing needs of an aging population emerged**
  - 2003 – Established **Family Caregiver Support program**
  - 2004 – **Alzheimer's Disease demonstration grant**
  - 2007 – **Money Follows the Person demonstration grant**
  - 2009 – Aging and Disability Resource Center (**ADRC**) pilot project grant

- **Nov. 2003 – Abduction and murder of UND student Dru Sjodin**
  - 2003 Secure Unit Census = 15 offenders
  - 2005 Secure Unit Census = 30 2006 – DHS signed a contract with **RULE-CPC** for community-based treatment of sex offenders under the supervision of DOCR
  - 2007 Secure Unit Census = 54 offenders
  - 2011 (January) = 59 offenders
  - 16 sex offenders have been **discharged** by court order since program began

- **Technology Advancements**
  - Implemented **online child support enforcement services**

- Changed from paper checks to **debit cards** to distribute TANF and child support (2003-2005 biennium)
  - Implemented direct deposit and payroll withholding for child support
  - ND's Supplemental Nutrition Assistance Program implemented Electronic Benefit Transfer (EBT) cards earlier - in 1997

- **Program/Service alignment** – In **July 2007,** funding and the administration of the **8 Regional Child Support Enforcement Units transferred** from the counties **to DHS**

- **Implementation of State legislation addressing health coverage needs**
  - 2004 – ND **Medicaid Workers with Disabilities Program** established
    - Buy-in program to support work by addressing coverage gap
  - 2008 – **Children with Disabilities coverage** (buy-in program to address gaps/limits in private coverage, income up to 200% FPL)
  - 2008 – Feds approved ND's **Medicaid waiver** to provide services at home for up to 15 **medically fragile children** who meet institutional level of care
  - 2008 – started 12-month **continuous eligibility** for children on Medicaid
  - 2008 – **CHIP eligibility level increased to 150%** FPL (net)
  - 2009 – **CHIP eligibility** level increased **to 160%** FPL (net) income

2010s

Efforts to address child health coverage gaps continued

- July 2010 – **Children's hospice waiver** approved by CMS
- Nov. 2010 – Feds approve ND's **Children's Autism Waiver**

ND State Hospital

- **Jan. 2011 – 132 individuals** were **receiving traditional** mental health and substance abuse inpatient treatment **services** at the NDSH
  - **90** at the **Tompkins** program; **59 sex offenders** in the **Secure Unit**

Developmental Center

- **Jan. 2011** – Provided services to **105** individuals
- **July 2011** – Resident population **goal = 95 residents**
- Opportunities for residents to be active in the Grafton area abound and include involvement in local churches; City Council meetings; and community events and activities

FUTURE

- **National economy and debt** – shaping federal policy and fiscal realities
- Ongoing tension related to **federal mandates, states' rights and flexibility in program implementation** and administration (i.e. TANF flexibility)
- Federal **Health Care Reform**
  - Impact on number of Medicaid clients (estimated up to 50% increase)
  - Health insurance exchange relationship to Medicaid/ CHIP eligibility system
- 2011 – **TANF & Beyond** initiative to promote self-sufficiency and end dependence
- **Demographic changes**
  - Aging Baby Boomers and service utilization & cultural diversity
- **Scientific advances**/evidence-based practices in services for people with disabilities
- **New technology** to improve client access to services (telemedicine, on-line applications, screening tools, monitoring, and training and technical assistance)

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Appropriations Committee, I am Carol Olson, Executive Director of the North Dakota Department of Human Services. Thank you for the opportunity to introduce the Department's budget request for the 2011-2013 biennium.

The Department's budget request is $2.6 billion total, which is a $277.7 million increase in total funds (11.9% increase)

- $927.3 million general funds
  - $272.8 million general fund increase (41.67% increase)
- $1.57 billion federal funds
- $114 million other funds

- *2009-2011 Biennium Budget History*
  - *$2.3 billion budget total*
    - *$654.6 million general funds*
    - *$1.56 billion federal funds*
    - *$118 million other funds*

This budget also includes a reduction in 20.5 Full Time Equivalents (FTE).

The significant general fund increase ($272.8 million) is due to these reasons:

- The **decrease in the Federal Medical Assistance Percentage**

(federal match rate for Medicaid that is referred to as FMAP) = $171.4 million,

- **Cost and caseload increases in major grant areas** (especially Medicaid) = $46 million,
- Annual **inflationary increases of 3% for Medicaid providers and other providers** during the biennium = $25.5 million, and
- The **cost to continue the employee second-year salary increase** from the 2009-2011 biennium = $3.8 million.

While the FMAP has fallen, the Medicaid caseload and health care costs and utilization in general have gone up, which compounds the Medicaid funding situation. Together, these areas represent about 80% of the general fund increase in the Department's budget.

I would like to expand on the cost and caseload growth in the major grants area, which again is responsible for a $46 million increase in general funds. Most of this grant area increase is in Medicaid – the federal and state funded health coverage program for qualifying individuals – and much of it is in the Traditional Medicaid Grants area of the budget.

These funds go to thousands of health care providers and other providers of covered services. Without Medicaid, many of these services could be uncompensated.

These services include inpatient hospital care, outpatient surgery, clinic visits, prescription medications, and other health-related services. Traditional Medicaid grants also pay for preventive health screenings of children.

Caseload and utilization increases are also driving up costs in the long-term care area of Department's budget. This area includes support services that help the elderly and people with developmental and other disabilities to remain living in their homes and community settings, as well as 24-hour skilled nursing home care. Medicaid pays for the care of about half of the nursing facility residents in North Dakota.

Medicaid supports the quality of life of thousands of individuals who rely on Medicaid-funded services. It also compensates thousands of doctors, dentists, chiropractors, therapists, and ambulance service providers.

In this budget, there is only one significant policy change. This budget includes a $6.1 million increase for behavioral health services to address psychiatric inpatient hospitalization needs in the regions and other capacity concerns. Most of this increase ($3.43 million) is for about 4,900 contracted inpatient psychiatric hospital days to be paid at the Medicaid equivalent rate for regional human service center clients who do not qualify for Medicaid.

The other behavioral health capacity increases are as follows:

- An added 10-bed crisis residential unit in Minot for people with serious mental illness who need emergency shelter and care, but not hospitalization ($1.4 million),
- Expands the adult crisis bed capacity in Bismarck by four additional beds ($309,000),
- A 15-bed long-term residential facility in the Fargo region for people affected by chronic and serious addiction ($940,000).

I want to close by stressing that aside from the highlighted areas, this budget holds other existing Department programs and services pretty even. Again, most of this budget is passed directly out-the-door to pay for health-related and other services in communities across the state and to provide benefits to qualifying vulnerable North Dakotans.

We take our mission very seriously and strive "to provide quality, efficient, and effective human services, which improve the lives of people." I am very proud of the fact that the Department can perform its responsibilities and also hold the line on administrative costs. For the past three biennia, the Department has held its administrative costs at six percent.

Thank you for this opportunity. Allow me to introduce the Department's Chief Financial Officer, Brenda Weisz who will provide a detailed overview of the Department's 2011-2013 budget.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations Committee
Senator Holmberg, Chairman
January 17, 2010

Chairman Holmberg, members of the Senate Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide an overview of the Department's 2011 – 2013 Executive Budget request included in SB 2012 along with fiscal related information.

2009 – 2011 Appropriation and Estimated Spending

When comparing the current biennium expenditures in the major program areas to the amount of general fund appropriated, the Department is expecting the following:

- Long Term Care area of the Department's budget (including developmental disability grants) – we are estimating the overall spending to be under budget by $26.9 million in total with $13.2 million of that amount from the general fund. Nursing Facilities and the SPED program are experiencing lower utilization than budgeted while Basic Care services are being utilized in excess of the amounts budgeted.
- Medicaid traditional grants and Healthy Steps – we are estimating the overall shortfall to be $19.6 million in total with a $5.8 million shortfall in general fund. The general fund shortfall in this area is offset by a general fund savings in the Medicare Part D clawback payment of $2.8 million – all from the general fund. The net general fund shortfall amounts to $3.0 million.

2

- Human Services Centers - we are estimating the overall general fund spending to be under budget by $1.6 million.
- Institutions - we are estimating the overall general fund spending to be under budget by $800,000 at the State Hospital and on budget at the Developmental Center.
- Central Office - we are estimating the overall general fund spending to be under budget by $200,000.

When considering all areas of the budget, the Department is expecting to have an unexpended general fund appropriation of approximately $12.8 million at June 30, 2011. It is this estimated $12.8 million for which an exemption is being made in Section 5 of SB 2012 for the purpose of funding the medical assistance grants portion of our 2011 - 2013 Executive Budget.

Status of 2009 - 2011 One-Time Funding

Developmental disabilities rate study *Study completed and bill introduced - SB 2043*	$ 100,000
Supplemental payment *Approved by federal government- final payment to be made Spring 2010*	400,000
Extraordinary repairs *Projects are complete or will be completed by the end of the biennium*	3,443,692
Federal stimulus funds - *see **Attachment A***	88,033,205
Equipment over $5,000 *Purchases are complete or will be completed by the end of the biennium*	352,606

One-Time Funding Requests in SB 2012 (2011 - 2013 Budget)

The Executive Budget includes one-time funding for the following:

Federal stimulus funds *Amounts to be expended by 9/30/11*	$ 519,175
State Hospital capital projects *Details to be covered by Alex Schweitzer*	$1,800,000

Major Policy Changes in Developing the 2011 – 2013 Budget

In developing the budget for **Inpatient Hospitalization at the Human Service Centers,** the Department continued contracts for inpatient hospital services for those who are not eligible for Medicaid but are clients of the Department in the following regions: North Central, Northeast, Southeast, West Central and Badlands in the amount of $829,243. The Executive Budget includes an additional $3.43 million for a total budget of $4.26 million. This will allow the Department to provide approximately 4,900 inpatient hospital days across the state to be paid at the Medicaid equivalent rate. The Department also plans to move forward with a centralized contract allowing for consistent contract terms statewide and allowing flexibility for amounts to be moved from region to region based upon need.

Current Budget / Budget Request

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	59,416,844	66,859,547	7,442,703
Operating	124,195,067	153,258,501	29,063,434
Capital Assets	1,206,747	138,400	(1,068,347)
Capital Construction Carryover	30,234,275	0	(30,234,275)
Grants	483,066,261	487,016,037	3,949,776
HSCs and Institutions	270,150,215	290,014,805	19,864,590
Grants-Medical Assistance	1,365,095,313	1,613,737,618	248,642,305
Total	2,333,364,722	2,611,024,908	277,660,186
General Funds	654,611,574	927,363,658	272,752,084
Federal Funds	1,560,552,211	1,569,357,603	8,805,392
Other Funds	118,200,937	114,303,647	(3,897,290)
Total	2,333,364,722	2,611,024,908	277,660,186

FTE	2,216.88	2,196.35	(20.53)

Explanation of Major Budget Changes – General Fund Only - Increase of $272.8 million

$171.4 million – increase in state funds as a result of the decrease in the Federal Medical Assistance Percentage (FMAP). First, we need to replace the discontinuation of the enhanced FMAP as a result of the federal stimulus funding. The enhanced FMAP during this time period was 69.95%. This enhanced FMAP was to have expired December 31, 2010, however, as a result of federal legislation it was extended through June 30, 2011 at "stepped down" intervals. For North Dakota those rates are 66.95% for the period of January 2011 – March 2011 and 64.95% for April 2011 – June 2011. Also impacting the FMAP is the per capita income of North Dakota in relation to other states and the strength of North Dakota's economy compared to that of the Nation. The FMAP rates for the upcoming biennium are as follows:

- FFY 2011 (July 2011 – Sept 2011) 60.35% Final
- FFY 2012 55.40% Final
- FFY 2013 55.40% Estimated

$25.5 million – 3% inflationary increase extended to providers each year of the biennium.

$24.4 million – net cost changes in the grant programs of the Department including traditional Medicaid grants, nursing facilities, developmental disability grants, extended services, home and community based services, child welfare grants, Indian County allocation payments to counties. Changes are the result of several factors such as rate setting rules, federal mandates, continuation of the year two 6% inflationary increase granted during the current biennium, along with costs that

cannot be controlled by the Department (drugs, premiums – Medicare and Healthy Steps.)

$21.6 million – net increase in caseload / utilization. The largest impact of change in this area is an increase of $12.2 million in traditional Medicaid grants followed by a $5.6 million increase in the nursing home area.

$16.2 million – to replace with general fund, the other funding sources no longer available as follows: the ability to use child support incentive funds for match as allowed by stimulus legislation ($2.8 million); Bank of North Dakota loan ($8.5 million); Health Care Trust Fund ($4.1); and the use of the Community Health Trust Fund, which was used as match for the allowable treatment and other medical costs for clients qualifying through the Women's Way Program ($800,000).

$14.3 million – increase ($10.3 million) attributed to the Governor's salary and benefit package, the cost to continue this biennium's year two salary increase ($3.8 million) for just under 2,200 employees; and ($200,000) for the addition of seven new Full Time Equivalents (FTE).

$6.9 million – increase in the Medicare Part D clawback payment as a result of increased required payments and increased dual eligibles – those eligible for both Medicare and Medicaid.

$6.1 million – increase to address behavioral health needs at the Human Service Centers to 1) allow for consistent payment of psychiatric inpatient hospitalization statewide at the Medicaid equivalent rate for Human Service Center clients who are not eligible for Medicaid ($3.43 million);

and 2) address the capacity issues in the Regions by: adding a ten bed crisis residential facility in Minot for those with serious mental illness ($1.44 million); adding four beds to the current ten bed adult crisis residential facility in Bismarck ($300,000); and adding a 15 bed long term residential facility for those with an addiction in Fargo ($940,000).

$3.1 million – to fund extraordinary repairs ($1.3 million) and capital improvements at the State Hospital ($1.8 million).

$2.6 million – increased information technology costs in both the rates charged by the Information Technology Department and ongoing operational costs of the new systems developed under the Medicaid Systems Project.

($7.2) million – decrease in one-time funding for extraordinary repairs, equipment over $5,000 and bond payments ($6.2 million) and funding for the Medicaid Systems Project ($1.0 million).

($12.8) million – reduction to the overall budget submitted by the Department and anticipated amount of general fund turnback at June 30, 2011 as explained earlier in my testimony.

The remaining **$.7 million** or 0.3% of the general fund increase is tied to miscellaneous net increases throughout the Department, which will be addressed by each division as they present their overview testimony.

FTE Changes

The Executive Budget includes a **net decrease of 20.53 FTE.** As the Department developed its budget we arrived at that reduction

incrementally. First, we began with an overall decrease of 40.53 at the Developmental Center resulting from the decreased need of staff as we have transitioned clients to the community. Our current budget was built on a population of 115 clients with a goal of 95 clients by June 30, 2011. As we developed the budget for the 2011 – 2013 biennium, we analyzed the FTE needs Department-wide and this decrease was offset as follows:

- Information Technology Services – we added 1 FTE for Health Information Technology and 3 FTE for individuals who have worked in the Department full time as temporary staff for over four years without benefits on data entry of primarily Medicaid claims.
- Medical Services – we added 1 FTE for the conversion of a claims analyst who has been a temporary employee working for the Department full time over four years without benefits.
- Mental Health / Substance Abuse Division – we added 6 FTE for work that was previously accomplished under contract. The federal funding was moved from the operating line item to the salaries line item for this change.
- NCHSC – we added a staff psychiatrist, who will serve both Northwest Human Service Center and North Central Human Service Center.
- State Hospital – we added a pharmacist to provide telepharmacy services to the eight Human Service Centers, which provide medication monitoring on a routine basis. This will be more efficient than adding a pharmacist at each location.

After our internal work, the Department's budget request submitted to OMB included a net decrease of 27.53 FTE.

The Executive Budget then added seven FTE to address the policy changes that will be needed to implement Health Care Reform. Health Care Reform is scheduled to go into effect January 2014, should there be no changes with this legislation at the federal level. The seven include one FTE each in the area of Economic Assistance Policy and Child Support and the remaining five in Medical Services. The FTE have a staggered employment date ranging from as early as July 1, 2011 to as late as April 1, 2013. This brings the net reduction in FTE to **20.53.**

Key Points in Developing the Budget

Traditional Medicaid Grants – The traditional Medicaid grants budget is built on utilization and cost data by service. However, the utilization is often driven by the number of individuals on the program. The number of eligibles in May 2010, when we began preparing the 2011 – 2013 budget was 62,257. This compares to 51,308 eligibles in April 2008 when we began preparing our current budget.

Healthy Steps Program – The Executive Budget maintains coverage at 160% of poverty (net). The budget is built on providing coverage to an estimated 4,256 children per month at a monthly premium of $274.03 per child. The premium increase this biennium is 19.82%.

Institutions – The Executive Budget for the State Hospital is based on a total capacity of 298 beds. The breakdown by program includes 132 beds for inpatient psychiatric services, 90 beds for the Tomkins Program, and 76 beds for the civilly committed sex offender program. The Executive Budget for the Developmental Center is based on a population of 95 individuals at the Center.

Home and Community Based Services – Please refer to **Attachment B** for a breakdown among Long Term Care services in the Executive Budget.

As in past presentations, I have included in **Attachment C**, a breakdown of "Where the Money Goes" in the Executive Budget. 84% of the Department's budget goes directly "out the door" to providers or grant recipients. This compares to 83% of the budget for the 2009 – 2011 Legislatively Approved Budget. Another 10% is expended on direct client services at our Human Service Centers and the Institutions, which is down from 11% in the 2009 – 2011 budget. The administrative costs have been held to 6%.

Finally, **Attachment D** provides a one page presentation of our $2.6 billion budget.

This concludes my overview testimony and I would be happy to address your questions.

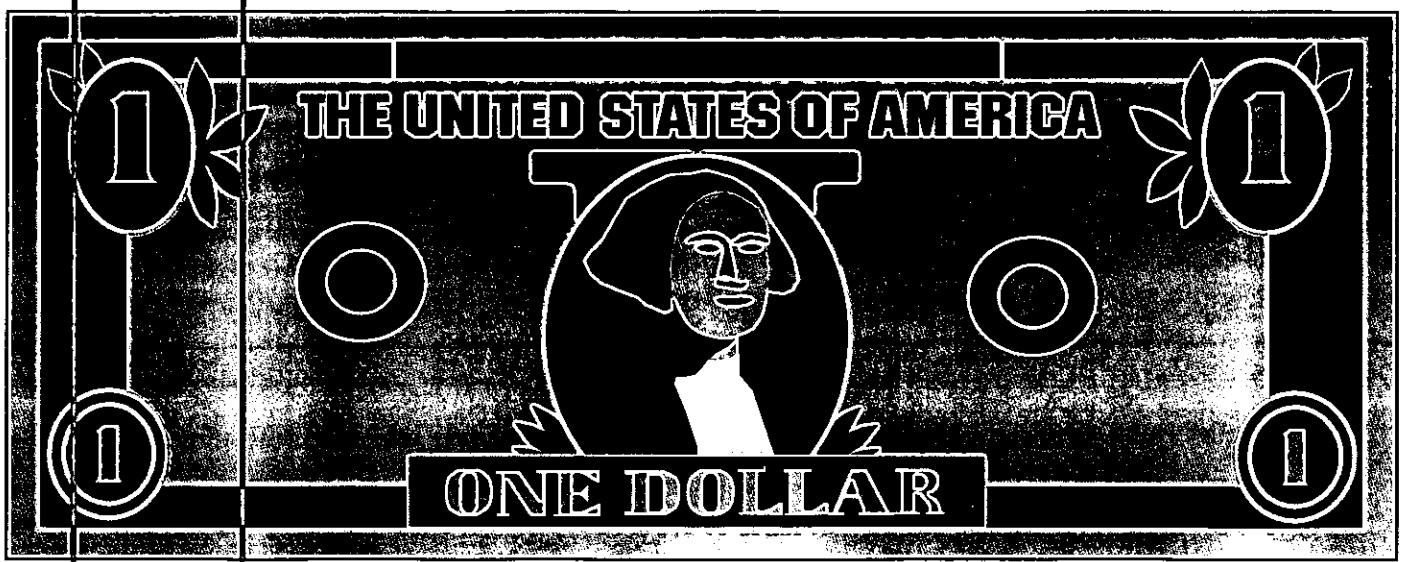
Thank you.

Department of Human Services
2011 - 2013 Executive Budget
One-Time Funding - Federal Stimulus Funds - 2009 - 2011 Budget

Description	Amount	Status
Federal Medical Assistance Percentage (FMAP)	66,500,000	Amount has been fully expended and will be replaced with general fund as outlined in Section 2 of HB 1012 of the 2009 Legislative Session.
Elderly Nutrition Services	485,000	Fully expended and augmented current services. Will not be replaced with general fund.
Child Support Incentive Matching Funds	3,200,000	Amount has been fully expended and will be replaced with general fund in the amount of $2.8 million as outlined in Section 2 of HB 1012 of the 2009 Legislative Session.
Rehabilitation Services and Disability Assistance and Independent Living	2,043,000	All but $69,175 will be spent by June 30, 2011. Funds were used for one time projects or to augment current services. Will not be replaced with general fund.
Individuals with Disabilities Education Act - Part C	2,140,000	We anticipate expending $1,690,000 by the end of the biennium. The expenditures are planned for one-time projects with anticipation of $450,000 needed into the 2011 - 2013 biennium. Program is funded 100% with federal funds and will not be replaced with general fund.
Supplemental Nutrition Assistance Program (SNAP)	9,874,747	Amount has been fully expended. Recipients received an increase in their monthly benefits. SNAP is funded 100% with federal funds and will not be replaced with general fund.
Child Care	3,644,000	Funding was designated for the Growing Childcare Initiative and contracted. Funding will be expended by June 30, 2011 and will not be replaced with general fund.
Senior Employment Program	143,288	All but $6,381 was expended to augment current services. Program is funded 100% with federal funds and will not be replaced with general fund.
Older Blind	3,170	All funds were expended to augment current services. Program is funded 100% with federal funds and will not be replaced with general fund.
	$ 88,033,205	

Attachment A

Department of Human Services
2011 - 2013 Budget to Senate
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $552,798,506



.05
Basic Care

.12
Home & Community Based Services

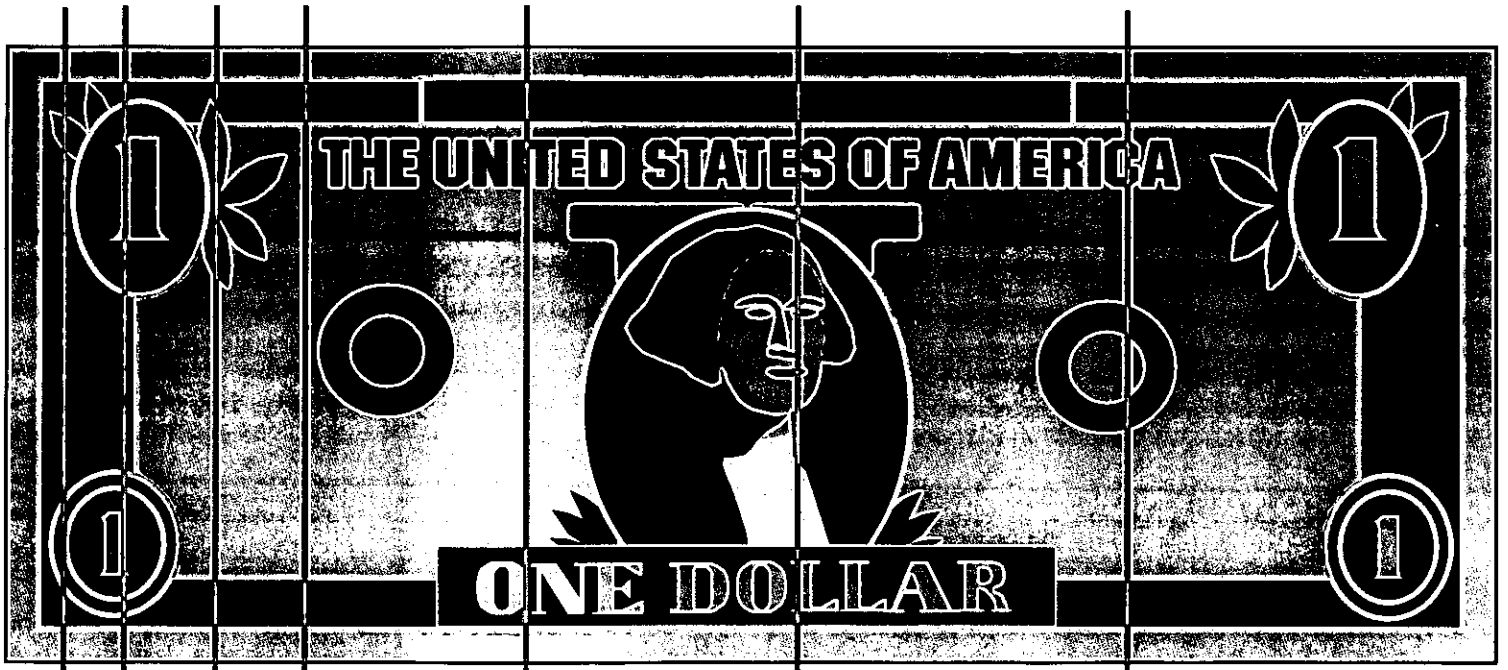
.83
Nursing Homes

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

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Attachment B

Department of Human Services
2011 - 2013 Budget to Senate
Where Does the Money Go?
Department-Wide
Total Funds $2,611,024,908



.04 HCBS & Basic Care	.04 Insti-tu-tions	.06 Admin-istration	.06 Human Service Centers	.15 Developmental Disabilities Grants	.18 Nursing Homes	.22 Direct Client Services *	.25 Traditional Medical Grants & Healthy Steps

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

* Includes TANF, JOBS, Child Care, SNAP, Heating Assistance, IV-D Tribal, IV-D Judicial, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, and Non-Medicaid Developmental Disability grants and services.

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Attachment C

Department of Human Services 2011-13 Executive Budget Recommendation

Subdivision	FTEs (Full Time Equivalents)	Salaries and Wages	Operating Expenses	Capital Assets	Grants	HSCs and Institutions	Grants-Medical Assistance	Total	General	Federal	Other
ADMINISTRATION - SUPPORT	74.60	$10,351,992	$5,683,423					$16,035,415	$7,775,396	$7,090,067	$1,169,952
INFORMATION TECHNOLOGY SRVCS	41.50	$6,161,344	$56,724,715	$138,400				$63,024,459	$23,746,066	$37,243,950	$2,034,443
MANAGEMENT Total	**116.10**	**$16,513,336**	**$62,408,138**	**$138,400**				**$79,059,874**	**$31,521,462**	**$44,334,017**	**$3,204,395**
ECONOMIC ASSISTANCE POLICY - GRANTS	39.80	$5,516,945	$11,703,561		$331,251,570			$348,472,076	$11,439,272	$318,286,921	$18,745,883
CHILD SUPPORT ENFORCEMENT	165.20	$20,858,604	$4,182,317					$25,040,921	$6,874,824	$15,175,197	$2,990,900
MEDICAL SERVICES	73.50	$10,139,971	$34,236,842				$663,715,079	$708,091,892	$239,977,645	$433,243,028	$34,871,219
LONG TERM CARE							$950,022,539	$950,022,539	$422,308,643	$524,438,836	$3,275,060
DD COUNCIL	1.00	$162,095	$132,652		$621,142			$915,889		$915,889	
AGING SERVICES	10.00	$1,461,314	$13,762,611		$2,906,942			$18,130,867	$4,676,276	$13,174,591	$280,000
CHILDREN AND FAMILY SERVICES	17.00	$2,555,408	$5,744,630		$126,793,961			$135,093,999	$31,053,237	$82,978,058	$21,062,704
MENTAL HEALTH AND SUBSTANCE ABUSE	24.00	$3,592,202	$11,687,985		$4,445,584			$19,725,771	$7,128,641	$12,026,270	$570,860
VOC REHAB	35.00	$4,672,532	$2,049,230		$20,558,631			$27,280,393	$4,859,126	$22,326,268	$94,999
DEVELOPMENTAL DISABILITIES DIVISION	9.00	$1,387,140	$7,350,535		$438,207			$9,175,882	$3,151,429	$5,874,450	$150,003
PROGRAM AND POLICY Total	**374.50**	**$50,346,211**	**$90,850,363**		**$487,016,037**		**$1,613,737,618**	**$2,241,950,229**	**$731,469,093**	**$1,428,439,508**	**$82,041,628**
NORTHWEST HSC	45.75					$8,749,068		$8,749,068	$4,958,832	$3,321,230	$469,006
NORTH CENTRAL HSC	117.78					$22,433,884		$22,433,884	$13,410,027	$8,104,420	$919,437
LAKE REGION HSC	60.00					$11,418,231		$11,418,231	$6,882,190	$4,063,599	$472,442
NORTHEAST HSC	138.30					$28,182,609		$28,182,609	$13,209,723	$12,967,908	$2,004,978
SOUTHEAST HSC	182.15					$38,464,720		$38,464,720	$22,185,733	$15,145,044	$1,133,943
SOUTH CENTRAL HSC	85.50					$16,953,699		$16,953,699	$9,343,547	$6,691,551	$918,601
WEST CENTRAL HSC	135.30					$26,740,493		$26,740,493	$14,109,532	$11,430,961	$1,200,000
BADLANDS HSC	72.70					$11,789,654		$11,789,654	$6,529,292	$4,426,122	$834,240
HUMAN SERVICE CENTERS Total	**837.48**					**$164,732,358**		**$164,732,358**	**$90,628,876**	**$66,150,835**	**$7,952,647**
STATE HOSPITAL	381.45					$62,208,285		$62,208,285	$42,061,882	$2,609,783	$17,536,620
SH SECURED SERVICES	86.06					$11,264,915		$11,264,915	$11,264,915		
DEVELOPMENTAL CENTER	400.76					$51,809,247		$51,809,247	$20,417,430	$27,823,460	$3,568,357
INSTITUTIONS Total	**868.27**					**$125,282,447**		**$125,282,447**	**$73,744,227**	**$30,433,243**	**$21,104,977**
GRAND TOTAL	**2,196.35**	**$66,859,547**	**$153,258,501**	**$138,400**	**$487,016,037**	**$290,014,805**	**$1,613,737,618**	**$2,611,024,908**	**$927,363,658**	**$1,569,357,603**	**$114,303,647**

Attachment D

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer of the Department of Human Services. I am here today to provide you an overview of the Administration / Support area.

Programs

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. Each of these areas provides the needed support for the divisions within the Department to carry out their programs. This budget area includes centralized costs for department-wide expenditures such as program appeals, audit fees charged by the State Auditor's Office, and the legal work provided by the Attorney General's Office. Also included are the centralized costs for the Central Office divisions such as motor pool expenses, postage for routine mailings such as federally required client TANF notices, along with the telephone services provided by the Information Technology Department. Finally, this area of the budget reflects the Insurance and Risk Management Fees for the Central Office and Human Service Centers.

Major Program Changes

There have not been any program changes in this area.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	9,346,006	10,351,992	1,005,986
Operating	4,913,798	5,683,423	769,625
Total	14,259,804	16,035,415	1,775,611
General Fund	6,727,982	7,775,396	1,047,414
Federal Funds	6,468,144	7,090,067	621,923
Other Funds	1,063,678	1,169,952	106,274
Total	14,259,804	16,035,415	1,775,611

FTE	74.6	74.6	-

The Salary and Wages line item increased by $1,005,986 and can be attributed to the following:

- $553,938 in total funds of which $356,700 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $91,753 to cover an underfunding of salaries from the 2009-2011 budget.
- $206,867 in total funds of which $166,092 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- During the biennium the Department recognized an increased need in assistance from the Legal Advisory Unit and moved an FTE internally to accommodate this priority. Increased appeals, administrative rules and federal requirements especially from the Centers of Medicare and Medicaid have required additional legal expertise within the Department. The additional attorney hired resulted in additional need of $121,237 for salary and fringes.

- The remaining $32,191 is a combination of increases and decreases needed to sustain the salary of the 74.60 FTE in this area of the budget.

The Operating line item increased by $769,625 (15.7%) and is a combination of the increases and decreases expected next biennium. Outlined below are the significant areas of change:

- $602,146 increase in Professional Fees. $298,481 is a result of increased utilization of the services provided by the Attorney General's office coupled with their rate increase of 4.63% - $73.81 per hour to $77.23 per hour. $267,258 is attributed to services provided by the Office of Administrative Hearings. Our utilization in this area has increased along with a rate increase of 33.99% - $93.29 per hour to $125.00 per hour. The remainder of the increase is attributed to the expected increase in audit fees of $36,407.
- $53,737 is attributable to the increase in the Travel category of the budget. $49,025 is related to an increase in state fleet usage partially offset by a rate decrease established by DOT - $0.40 per mile to $0.37 per mile. The remainder of the increase is related to additional travel required by staff for training and to audit cost reports of the additional basic care facilities across the state.
- $52,867 increase in Insurance the majority being a result of a rate increase by OMB for the Department's Central Office and Human Service Center risk management premium, offset by decreases in property and foster care liability insurance.
- $35,120 increase in Building Leases. $26,298 is attributable to rate increases established by OMB – office space from $8.97 to $10.21 (13.8%) per square foot and storage space $1.36 to $1.42 (4.4%)

per square foot. The payment to OMB is federal/other funds and contains no general funds. $3,189 is due to a $1 per square foot rate increase ($13.50 to $14.50) established by Workforce Safety and Insurance for staff located in the Century Center. The remainder of the increase is essentially due to an oversight, as our current budget did not include two years of rent for staff located at the North Central Human Service Center.

- $21,780 increase in Printing costs as a result of a rate increase by OMB of 3% each year of the biennium, and an anticipated 7% increase each year of the biennium for envelopes based upon information provided by current vendor.
- $10,313 increase in the Postage budget due to a 4% postal rate increase anticipated in October 2011 and October 2012.
- A decrease of $16,235 in IT Communications is primarily due to the reduced long distance rates from $0.09 to $0.07 a minute and reduced utilization of blackberry services and rates.

The general fund request increased by $1,047,414 with 58% of the increase ($608,683) associated with the salary changes as indicated above. The remaining increase of $438,731 is associated with the increase in the operating changes described above.

The net change of the federal and other funds is a result of the increases above and the approved cost allocation plan which is the basis for the majority of the funding in this area of the budget.

This concludes my testimony on the 2011 – 2013 budget request for Administration / Support area of the Department. I would be happy to answer any questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Jenny Witham, Director of Information Technology Services, of the Department of Human Services. I am here today to provide you an overview of Information Technology Services Division, for the Department of Human Services.

Programs

The Department's Information Technology Services Division staff is responsible for information technology strategic planning and budgeting, business analysis, project management, procurement, software development and maintenance, technology standards and policy enforcement, and data entry services.

Customer Base

The Department's Information Technology Services Division (ITS) provides technology services to support the business needs of the central office divisions, the eight Human Service Centers, the State Hospital, the Developmental Center, and the county social service boards across North Dakota.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	5,219,112	6,161,344	942,232
Operating	41,773,438	56,724,715	14,951,277
IT Equipment over $5,000	7,022	138,400	131,378
Capital Construction Carryover	30,234,275	-	(30,234,275)
Total	77,233,847	63,024,459	(14,209,388)
General Fund	20,703,546	23,746,066	3,042,520
Federal Funds	52,180,431	37,243,950	(14,936,481)
Other Funds	4,349,870	2,034,443	(2,315,427)
Total	77,233,847	63,024,459	(14,209,388)
FTE	37.5	41.5	4.0

The Salaries line item increased by $942,232 and can be attributed to the following changes:

- $319,219 in total funds of which $211,811 is general fund needed to fund the Governor's salary package for state employees.
- $140,063 in total funds of which $122,442 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- The Budget includes an increase of 4 FTE in the 2011- 2013 biennium as follows: (All four FTE are derived from the FTE no longer needed at the Developmental Center and were reduced in their budget request.)

- A Health Information Technology Coordinator position to work closely with the Information Technology Department as requirements must be met as the State continues moving forward in sharing health information electronically. Total budget need $214,819, with $21,482 being general fund.
- The conversion of three data entry staff who process primarily Medicaid claims who have been temporary employees working for the Department full time for over four years without benefits. Total budget need for adding benefits - $82,965, with $25,528 being general fund.

- During the biennium the Department recognized an increased need in provider outreach and information system training and moved an FTE internally to accommodate this priority. This represents an increase of $181,601 in total funds of which $118,222 is general fund.
- There was an increase of $3,565 which is a combination of increases and decreases needed to sustain the salary of the 41.5 FTE in this area of the budget.

The Operating line item increased by $14,951,277 major changes including:

- $11,092,427 of which $3,338,800 is general fund to support Information Technology Department services due to increased rates and utilization.
- $1,065,881 of which $317,262 is general fund to support vendor contracts for the ongoing operations of the new Medicaid Management Information Systems, the Pharmacy Point of Sale system and Medicaid Decision Support system.

- $2,500,000 of all federal funds for the replacement of the Vocational Rehabilitation case management system, which is a commercial off the shelf software.
- $112,118 of which $65,221 is general fund for increases in central printing costs and other desktop hardware and software license fees and maintenance.

IT Equipment over $5,000 had a federal funds increase of $131,378 to purchase telemedicine equipment at each of the Human Service Centers to implement Telepharmacy at the State Hospital. The entire project cost is $140,259 of which $138,400 is in IT Equipment over $5,000. The remaining $1,859 is reflected in various accounts contained in the operating line.

Capital Construction Carryover had a decrease of $30,234,275 in total funds of which $996,035 is general fund for the Medicaid System Project. However, section 4 of SB 2012 will be requesting any unexpended funds be made available for the completion of the Medicaid System Project during the 2011-2013 biennium.

This concludes my testimony on the 2011 – 2013 budget request for Information Technology Services Division of the Department. I would be happy to answer any questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Tove Mandigo, Economic Assistance Policy Division Director in the Department of Human Services. I am here today to provide you an overview of the Economic Assistance Division, for the Department of Human Services.

Programs

Economic Assistance Policy (EAP) is responsible for eligibility policy for Basic Care Assistance, Child Care Assistance, Low Income Heating and Energy Assistance Program (LIHEAP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). This includes:

- Distribution of benefits to recipients and payments to providers;
- Direction, supervision, and training of county social service board administration of EAP programs;
- Implementation of applicable state and federal law;
- Operation of electronic eligibility determination and reporting systems; and
- Preparation of required state and federal reports.

Economic Assistance Policy also performs Quality Control reviews of SNAP, Healthy Steps, Medicaid and TANF.

Caseload / Customer Base

EAP will direct and supervise county social services' determination of eligibility for the following:

Basic Care Assistance: An average of 489 residents of licensed Basic Care facilities.

Child Care Assistance: An average of 3,915 cases per month, and pays about 3,055 qualified child care providers an average monthly benefit per case of $219.

SNAP: An average of 33,890 cases each month, and pays about 450 grocers in North Dakota an average monthly benefit per case of $297.

LIHEAP: Approximately 16,000 cases each heating season, and pays about 400 energy providers an average monthly benefit per case of $222 for regular cases.

TANF: An average of 2,241 cases each month receiving an average monthly benefit of $301. Job Opportunities and Basic Skills (JOBS) program will work with 1,221 cases to find jobs and promote family self-sufficiency at an average monthly cost of $246.

Kinship Care: An average of 29 cases each month receiving an average monthly benefit of $614. These children would otherwise be in Foster Care. The limit on child care assistance benefits to those providing Kinship Care has been removed and the Department now pays actual costs of child care.

Program Trends / Major Program Changes

Child Care Assistance: The child care caseloads are lower due to less cases qualifying for benefits as a result of increased wages in North Dakota. Some cases are qualifying at lower benefit amounts due to the increased wages in North Dakota.

SNAP: The SNAP program is the cornerstone of USDA nutrition programs and is the safety net that helps people buy food to help them meet their nutrition needs. The caseload during the 2011-2013 biennium continues to increase. Outreach has been formalized ensuring that people are aware of the program and can access it. The Department launched the online

Application for Assistance early last fall as a way to make it easier for people to apply for and remain on the program.

LIHEAP: The LIHEAP caseload has remained fairly stable but the fuel costs have steadily increased. This is a 100% federally funded program. In the past two Federal Fiscal Years (FFY), the federal government funded $5.1 billion per year nationwide, so states could meet the fiscal demands of increasing fuel costs. With this funding, trends would indicate that North Dakota will meet the heating needs of the LIHEAP clients in the 2011-2013 biennium, although FFY 2011 funding is not yet final.

TANF: North Dakota continues to exceed the federally required 50% work participation rate without the addition of the caseload reduction credit. In order to meet the federally required work participation rate, the Department contracts with Job Service, Community Options and Tribal Employment and Training. As a result of case management by employment contractors, pay after performance, and job opportunities in North Dakota, the TANF caseload remains below 3,000 per month.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	5,236,318	5,516,945	280,627
Operating	11,711,891	11,703,561	(8,330)
Grants	334,441,734	331,251,570	(3,190,164)
Total	351,389,943	348,472,076	(2,917,867)
General Fund	10,676,487	11,439,272	762,785
Federal Funds	322,674,475	318,286,921	(4,387,554)
Other Funds	18,038,981	18,745,883	706,902
Total	351,389,943	348,472,076	(2,917,867)

FTE	38.80	39.80	1.00

The Salary and Wages line item increased by $280,627 and can be attributed to the following:

- $288,487 in total funds of which $123,401 is general fund needed to fund the Governor's salary package for state employees.
- $101,942 in total funds of which $64,213 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $17,058 of which all is general fund to fund the cost of the Training FTE added for Health Care Reform. The FTE is projected to be hired April 2013.
- The remaining $126,860 decrease is a combination of increases and decreases needed to sustain the salary of the 39.80 FTE in this area of the budget.

The Operating line item decreased by ($8,330) and is a combination of the increases expected next biennium which are offset by decreases as follows:

- $190,091 decrease in purchased services, $106,261 general fund, related to federally required estate collection activities. The duties will now be handled by the Legal Advisory Unit.
- $478,261 decrease in Supportive Services, all federal funds, due to decreased JOBS clients and JOBS clients needing less of these supportive services.
- $280,455 increase in the Payment Error Rate Measurement contract, $74,321 general fund, due to the cyclical nature of the three-year federal eligibility review requirements.
- $32,545 increase, all federal funds, due to increased costs to serve JOBS clients.
- $37,273 increase in Parental Responsibility Initiative for the Development of Employment (PRIDE), all federal funds, due to the program being expanded to additional locations in the state.

- $173,091 increase in SNAP, all federal funds, for outreach programs.
- $101,947 increase to SNAP EBT (Electronic Benefit Transfer), $6,117 general fund, due to increased SNAP caseload.
- $10,000 increase in Non-Employee Travel, all federal funds, due to the TANF Work Group assisting with additional projects such as TANF Next Steps and the development of an expanded education program for TANF clients.
- $23,000 increase in LIHEAP Printing, all federal funds, due to an increased caseload.

The Grants line item decreased by $3,190,164 and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $9,474,333 decrease to the TANF Subsidized Employment Program, all federal TANF ARRA funds, which expired September 30, 2010.
- $606,593 decrease in the SNAP Food Nutrition contracted with NDSU, all federal funds, as the amount of match provided by NDSU decreased.
- $365,408 decrease in the SNAP Charitable Food Program created by SB 2231 from the 2009 Legislative Session, $350,000 general fund, expires 6/30/2011.
- $13,126,445 decrease in LIHEAP benefits, all federal funds, which were built on weather and fuel price trends that did not reach the levels budgeted in the 2009-2011 biennium.
- $478,261 decrease in Supportive Services, all federal funds, due to decreased JOBS clients and JOBS clients needing less of these supportive services.

- $2,759,339 decrease in SNAP Administration, all federal funds, due to removal of one-time ARRA funds.
- $1,804,982 decrease in Child Care benefits, all federal funds, due to decreased caseloads and costs.
- $2,081,766 decrease in TANF Regular Benefits, all federal funds, due to decreased caseload and costs.
- $5,589,191 decrease in TANF Diversion Benefits, all federal funds, due to changes in Federal Regulations, very few individuals qualify for this benefit now.
- $1,066,213 increase in Indian County Allocation, all general fund, based upon the statutory funding formula in HB 1540 from the 2009 Legislative Session.
- $1,407,975 increase in JOBS Transportation benefits, all federal funds, due to increased clients working and in need of transportation assistance. Higher gas prices caused an increase in the amount of the maximum monthly benefit.
- $30,506,121 increase in SNAP benefits, all federal funds, based on federal outreach on a national level.

This concludes my testimony on the 2011 – 2013 budget request for Economic Assistance and Policy Division area of the Department. I would be happy to answer any questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am James Fleming, Director of the Child Support Enforcement Division of the Department of Human Services. I am here today to provide an overview of the child support enforcement (CSE) program for the Department of Human Services.

Programs

The CSE program is designed to enhance the well-being of children and reduce the demands on public treasuries by securing child support and medical support from legally responsible parents and by encouraging positive relationships between children and their parents.

The budget includes the staff and operating expenses for nine offices, consisting of the central office in Bismarck and the eight regional child support enforcement units (RCSEUs).

Caseload / Customer Base

The CSE caseload consists of cases receiving full services under Title IV-D of the Social Security Act (IV-D cases) and cases in which CSE only issues income withholding orders and maintains payment records (nonIV-D cases).

A child support case can become a IV-D case:

- Upon application from either parent,
- Upon referral from Foster Care, TANF, or Medical Assistance, or
- Upon request from another state or Tribe.

As shown in the chart below, the total IV-D caseload was 40,399 in December 2010. The nonIV-D portion of the caseload was 11,072. These cases include roughly 62,800 children and 75,600 parents.

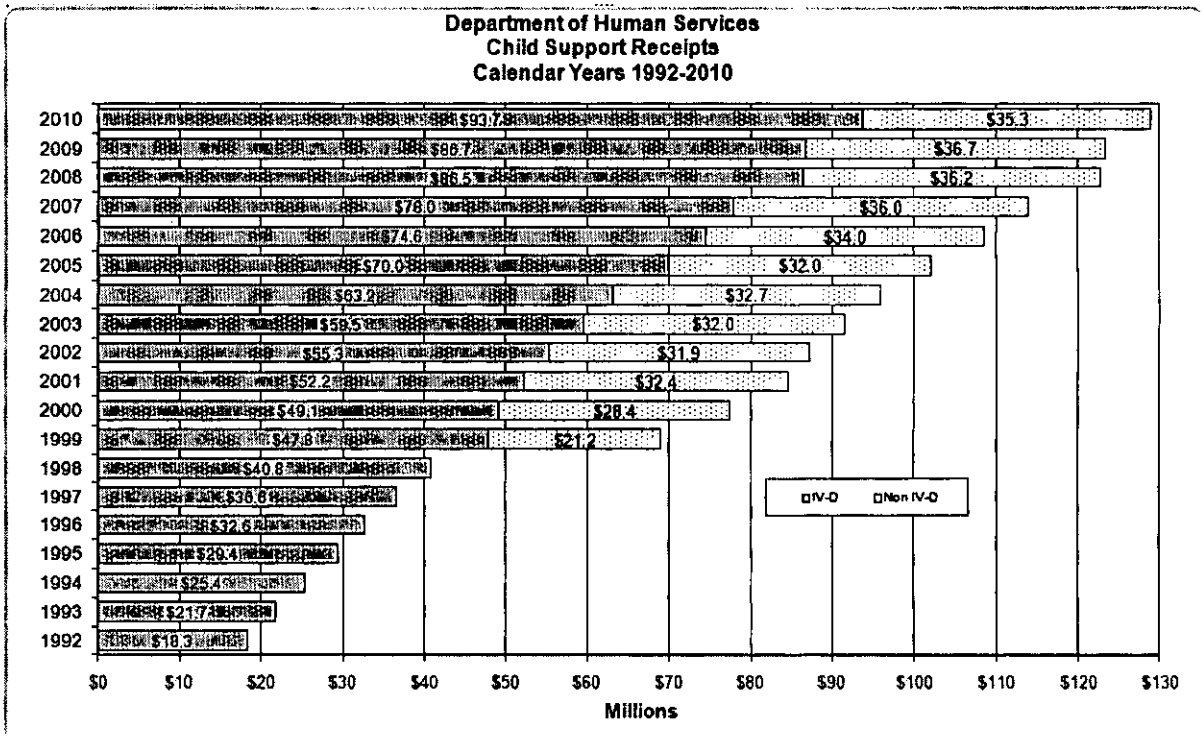
Department of Human Services
Child Support Cases
December 2001 through December 2010

Case Type	12/2001	12/2002	12/2003	12/2004	12/2005	12/2006	12/2007	12/2008	12/2009	12/2010
Non IV-D	13,131	11,872	9,474	9,802	9,771	10,314	10,161	9,971	10,410	11,072
IV-D	39,047	39,236	40,180	41,385	41,886	42,323	42,540	42,108	42,241	40,399
Total	52,178	51,108	49,654	51,187	51,657	52,637	52,701	52,079	52,651	51,471

The decline in the last year is primarily due to changes in the type of Medicaid cases that are referred to CSE.

Program Trends

Collections For calendar year 2010, total collections reached a new record of $129 million. The collections in IV-D cases increased 8.1% to $93.7 million. The collections in nonIV-D cases dropped slightly to $35.3 million. Of the estimated $260 million we expect to collect in the next biennium, about 90% is sent to families, with the balance sent to another jurisdiction for further distribution or retained to reimburse the taxpayers for expenditures from the TANF and Foster Care programs.



Receivables During the last biennium, a key point was reached where our total receivables in IV-D cases stopped growing and started to decrease. At the end of December 2009, our total IV-D receivables, including interest, were $221.1 million, compared to $224.8 million in 2008. This amount rose slightly at the end of 2010 to $223.54 million, which is still less than the total two years ago. With the nonIV-D receivables added, the statewide total at the end of 2010 was $285 million, compared to $282.6 million at the end of 2009 and $279.7 million at the end of 2008.

Performance The CSE program, including the clerks of court and other partners, continues to rank as one of the best programs nationally. Nevertheless, we are committed to achieving our goal of offering a World Class program. Using the most recent federal fiscal year measurements:

- Percent of children in IV-D cases born out of wedlock with paternity established or acknowledged: 108.14% (this formula compares the

children born out of wedlock in this year's IV-D cases with the number of children born out of wedlock in last year's IV-D caseload), improving on 106.33% in FFY 2009 and 103.99% in FFY 2008.

- Percent of cases with court orders for child support: 89.78%, up from 88.68% in FFY 2009 and 87.14% in FFY 2008.
- Percent of current support owed in IV-D cases that is collected: 74.21%, down slightly from 75.05% in FFY 2009 and 75.85% in FFY 2008.
- Amount collected for each $1 spent: $5.61, compared to $5.86 in FFY 2009 and $5.81 in FFY 2008.
- Medical support measurements are still under development at the national level at this time.

Medical Support Establishment and enforcement of medical support has long been a core service of the CSE program. To date, our program focus has been on locating coverage that is available to the custodial parent at no or nominal cost, if any, or else any coverage that is available to the noncustodial parent at reasonable cost. Under federal healthcare reform, we anticipate being expected to conduct a more in-depth analysis of the health insurance or other medical support options available to each parent, considering cost, accessibility, and comprehensiveness of coverage. The largest portion of the increases in time and expense are not expected until January 2014. However, contingent on clarification from the federal government of our program requirements, in the next biennium, we may need to study and re-engineer our program functions and legal practices to provide medical support services that do not unnecessarily disrupt the families we serve or jeopardize children's health coverage. With over 40,000 IV-D cases in

our caseload, this will be a significant undertaking, and one that would need to begin long before the January 2014 implementation date of federal healthcare reform.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	19,170,611	20,858,604	1,687,993
Operating	4,794,376	4,182,317	(612,059)
Total	23,964,987	25,040,921	1,075,934
General Fund	3,585,371	6,874,824	3,289,453
Federal Funds	17,591,107	15,175,197	(2,415,910)
Other Funds	2,788,509	2,990,900	202,391
Total	23,964,987	25,040,921	1,075,934

FTE	164.20	165.20	1.00

The Salary and Wages line item increased by $1,687,993 and can be attributed to the following:

- $1,116,411 in total funds of which $372,793 is general fund needed to fund the Governor's salary package for state employees.
- $258,062 in total funds of which $97,289 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $48,151 of which all is general fund to fund an underfunding of salaries from the 2009-2011 biennium.
- An increase of $174,612 of which $59,368 is general fund to fund the cost of the attorney added for Health Care Reform.
- The remaining $90,757 increase is a combination of increases and decreases needed to sustain the salary of the 165.20 FTEs in this area of the budget.

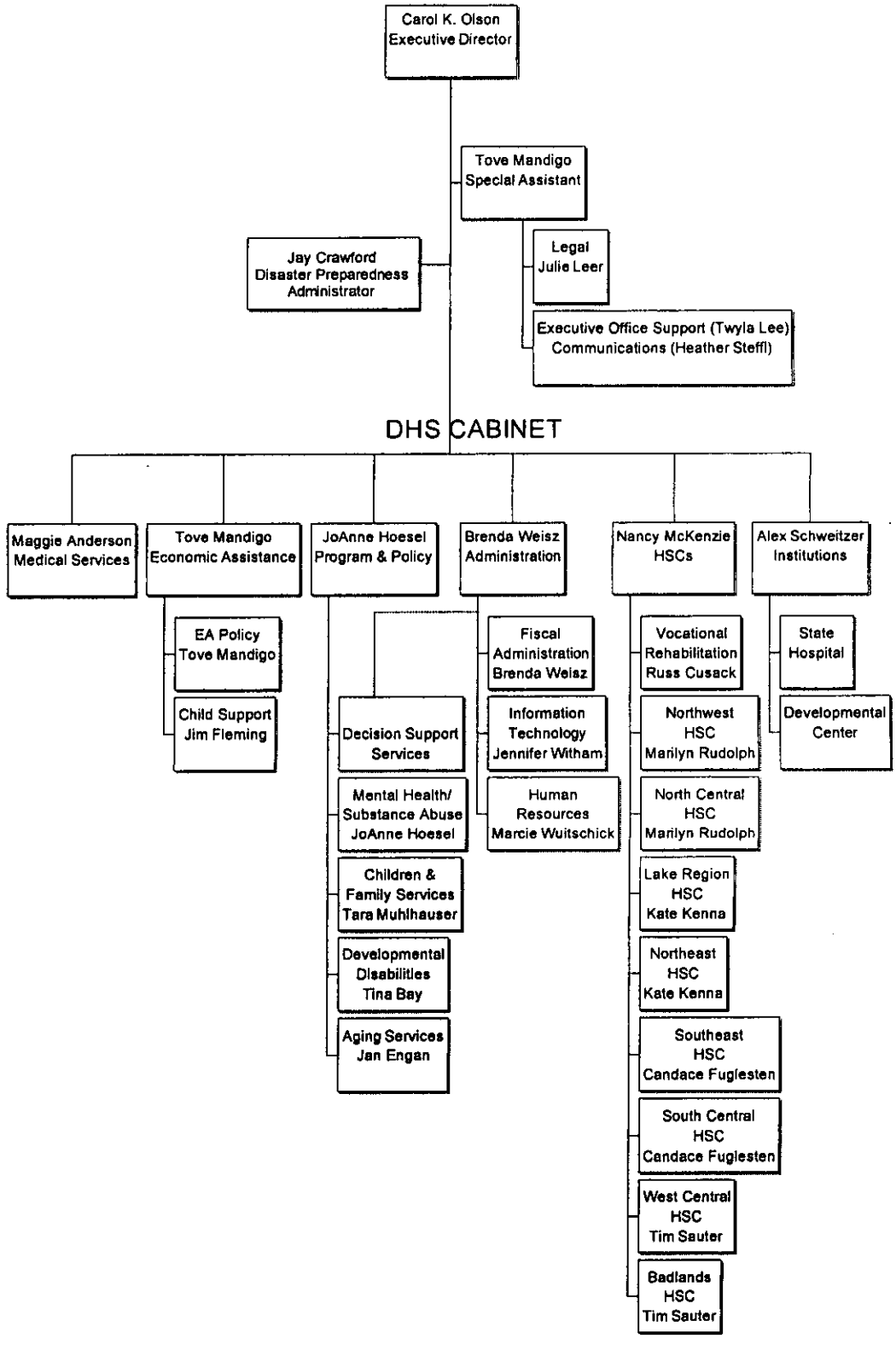
The Operating line item decreased by $612,059 and is a combination of the increases and decreases expected in the next biennium. Some of the significant changes are noted below:

- $200,000 decrease to remove the funding for a receivables study.
- $159,579 decrease to remove the funding for a collaboration grant that has been completed.
- $436,918 decrease to remove ARRA one-time funding.
- $167,000 increase in federal funds for judicial services obtained from the ND judicial system.

Eligible IV-D expenditures are matched with 66% federal funds and 34% state funds. The other funds contained in the budget include the State's share of fee revenue ($319,566) and $2.6 million in federal incentive funds which must be reinvested in the program. Incentive funds are no longer eligible for federal match, so you will note a corresponding increase in general funds.

This concludes my testimony on the 2011 – 2013 budget request for the Child Support Enforcement Division of the Department. I would be happy to answer any questions.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES



Effective 11/3/10

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs; they are Medicaid and the Children's Health Insurance Program (Healthy Steps). This area of the budget for Medicaid and Healthy Steps provides health care coverage for qualifying families and children, pregnant women, the elderly, and disabled citizens of North Dakota. Attachment A lists the Medicaid Mandatory and Optional Services, and Attachment B lists the current services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last twenty-four months.

The 2009-2011 appropriation included funding to increase the income level for Healthy Steps to 160 percent of the federal poverty level (net). This increase was implemented July 1, 2009. The Executive Budget for

Healthy Steps was built on an average caseload of 4,256 children. Attachment D shows the number of children enrolled each month in Healthy Steps for the last twenty-four months, and also provides the number of children enrolled in Medicaid for the same time period.

Currently, children eligible for either Healthy Steps or Medicaid coverage are approved for twelve months of coverage; and the twelve-month continuous coverage is included as part of the Executive Budget. When Medicaid continuous eligibility was implemented in June 2008, there were 25,914 children enrolled in this coverage. For June 2009, the enrollment was 31,780 and for June 2010, it was 33,921. The average amount paid by Medicaid per child per month prior to June 2008 was $205.65; the average from July 2008-June 2009 was $221.01; and the average from July 2009 – June 2010 was $233.75. The averages include the increases to provider reimbursement rates.

Program Trends / Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- The **funeral set aside** for Medicaid was increased to $6,000 on July 1, 2009.

- The **Medically Needy income levels** were increased to 83% of poverty, effective July 1, 2009.

- The first payment under the **critical access hospital supplemental payment** was made in March 2010. The second payment will be made in April 2011. This was one-time funding, and the funding to continue the payments was not included in the Executive Budget.

Medicare Savings Programs

The Medicare Improvements for Patients and Providers Act of 2008, which was signed into law on July 15, 2008, increases the federal asset allowance for individuals who apply for coverage under the Medicare Savings Programs (QMBs, SLMBs, and QIs), to be equal to the asset allowance for LIS (low income subsidy) recipients of Medicare Part D. These new asset levels were effective January 1, 2010. In 2010, the asset allowance level for a one person household increased from $4,000 to $6,600 and is increasing to $6,680 in 2011; and from $6,000 for a couple to $9,910 in 2010 and is increasing to $10,020 in 2011. This allows current recipients to save more assets and allows additional individuals to qualify for coverage. The expected increased enrollment was accounted for in the 2011-2013 Executive Budget request. We do not know the exact levels yet for 2012 and 2013 as they are increased each year by the Consumer Price Index (CPI). The above Act also prohibits estate recovery collections for Medicare Savings Programs costs paid by Medicaid after January 1, 2010. This will reduce estate recovery collections over time; however, the impact is unknown at this time.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Demonstration Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions

that serve individuals with developmental disabilities in transitioning to home and community-based settings. The passage of the Affordable Care Act extended the grant through 2020. CMS has authorized 100 percent federal administrative funding to address housing barriers, nurse quality assurance, increase awareness of Home and Community-Based Services (HCBS), and transition coordination capacity. Three Requests for Proposal have been issued for:

1. Housing Assistance: to assist MFP Grant consumers in securing safe, affordable, and accessible housing opportunities through such activities as helping them assess and update their current housing plan and options, working with community agencies to eliminate systemic barriers and to create improved pathways to appropriate housing, helping consumers and their families access income such as housing subsidies, and working with housing providers to improve consumer access.
2. Nurse Quality Assurance: to provide nursing input, assessment and recommendations to the Centers for Independent Living in all four quadrants of the state as they transition individuals from nursing facilities or other designated institutional settings to assure all health related aspects of services that will be needed in the community are addressed.
3. HCBS Marketing: to develop and implement a marketing plan to promote awareness of Home and Community Based Services in North Dakota.

Six additional transition coordinators will be hired by the Centers for Independent Living to enhance the efforts for outreach and transition coordination activities for individuals choosing to move from institutions to their communities.

I will provide additional information on the transitions in the Long-Term Care Services overview.

Health Care Reform

As I cover the Administrative Budget portion of this testimony, you will see there are five new full-time equivalents (FTE) that were included in the Executive Budget. These five FTE will assist the Division in the implementation and operation of the Medicaid provisions related to health care reform, and I will provide the details for each position later in my testimony.

The Affordable Care Act (ACA), or "health care reform" includes a significant expansion to the Medicaid program. This expansion would require Medicaid programs to cover the population often referred to as "childless adults." The Medicaid coverage would extend to all individuals under the age of 65 below 133% of the Federal Poverty Level (plus a 5% income disregard); and would be **effective January 1, 2014**. To date, there has been little guidance from the Centers for Medicare and Medicaid Services (CMS) about the details states need to move forward with the implementation; however, based on feedback received from CMS, we expect to receive some of the needed guidance in 2011.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	8,416,259	10,139,971	1,723,712
Operating	23,813,704	34,236,842	10,423,138
Grants	515,394,985	663,715,079	148,320,094
Total	547,624,948	708,091,892	160,466,944
General Fund	148,519,693	239,977,645	91,457,952
Federal Funds	365,011,673	433,243,028	68,231,355
Other Funds	34,093,582	34,871,219	777,637
Total	547,624,948	708,091,892	160,466,944

FTE	67.5	73.5	6.0

The Salaries line item increased by $1,723,712 and can be attributed to the following changes:

- $496,027 in total funds, of which $217,159 is general fund, is due to the Governor's salary package for state employees.
- $168,882 in total funds, of which $115,447 is general fund, is needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $30,807 to cover an underfunding of salaries from the 2009-2011 budget.
- $293,010 in total funds, of which $99,395 is general fund for an increase in temporary salaries for additional claims staff needed to ensure timely processing of provider payments. The Department expects to retain the temporary staff until implementation of the

new Medicaid Management Information System, scheduled for June 2012.

- $123,341 in total funds, of which $63,322 is general fund, for temporary salaries to assist with the review of service limits requests, administrative support, and primary care provider questions and oversight.
- During the interim, the Department recognized a need for an additional FTE to assist with the volume of management duties within the Division. An FTE was transferred from within the Department to the Medical Services Division. The new position serves as the Deputy Director of Medical Assistance. The transfer of this position represents an increased need of $59,554.
- $16,724 in total funds, of which $4,066 is general fund, to provide for the annual and sick leave lump sum payouts for three FTE expected to retire.
- The Budget includes a new FTE in the 2011 – 2013 biennium for the conversion of a claims analyst who has been a temporary employee working for the Department full time for over four years without benefits. This FTE was derived from the FTE no longer needed at the Developmental Center and was reduced in their budget request. Total budget need for adding benefits - $23,533, with $7,559 being general fund.
- The Executive Budget also added five FTE for Health Care Reform, totaling $312,609 of which $137,697 is general fund. The addition of the positions would be staggered based on our estimates of when the additional assistance would be needed.

Position	Start Date	Total Funds	General Funds
Eligibility Policy	July 1, 2011	$ 110,919	$ 55,460
Program Integrity	January 1 2012	$ 103,961	$ 51,980
Nurse	October 1, 2012	$ 52,896	$ 13,224
SURS Analyst	January 1, 2013	$ 24,221	$ 5,888
Administrative Support	January 1 2013	$ 20,612	$ 11,145

Eligibility Policy – This position would help develop policy for the rules surrounding Medicaid expansion. This position would also develop training for county staff and assist with defining business rules for the design of the eligibility system needed to convert from the current "net" income rules to the "modified adjusted gross income" rules required by the health care law.

Program Integrity – The expectations for Medicaid program integrity are increasing significantly and with an expanded number of individuals enrolled in the program, additional staff are needed to ensure all program integrity efforts can keep up with the increased Medicaid enrollment

Nurse – This position will be responsible for managing the increased prior authorization requests expected with an expansion of Medicaid.

Surveillance and Utilization Review System (SURS) Analyst – as the Medicaid enrollment increases, so does the need to analyze recipient "use" information and ensure services are being utilized appropriately.

Administrative Support – This position would provide administrative support for the new positions as well as assist in answering an increased volume of telephone and paper correspondence, which is expected because of an increased Medicaid enrollment.

- The remaining $199,225 is a combination of increases and decreases needed to sustain the salary of the 73.5 FTE in this area of the budget.

The Executive Budget for Operating Expenses is $34.2 million which is an increase of $10.4 million.

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $26.3 million for 2011-2013. This is an **increase of $6.9 million** over the current budget of $19.4 million, and was built based on an average of 10,825 individuals at an average payment of $101.26 per person per month. The Clawback payment is funded with 96 percent general fund and 4 percent estate collections.
- The Money Follows the Person (MFP) Demonstration Grant **increased $2.5 million**. This increase is primarily funded by Federal MFP Funds.
- Operating expenses also include contracts for services, such as: utilization review and prior authorization; drug pricing; Medicaid identification cards; nursing facility screenings; actuary services; and third party liability identification.

The Executive Budget for Grants is $663.7 million, which is an increase of $148.3 million.

Attachment E shows the changes in the Traditional Medicaid Grants Budget from 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

Attachment F is a cost and caseload comparison of the 2009-2011 Traditional Medical Grants Appropriation to the 2011-2013 Budget to the Senate for the top thirteen services. These services represent 94% of the Traditional Medicaid Grants.

Attachment G shows each Traditional Medicaid Service comparing the 2009-2011 Budget, 2009-2011 Projected Need, and the 2011-2013 Executive Budget request.

I would be happy to address any questions that you may have.

Attachment A

North Dakota Department of Human Services
Medical Services Division

MEDICAID MANDATORY AND OPTIONAL SERVICES

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services 65 and older in IMD
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services for MR
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services & Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy Related Services and services for other conditions that might complicate pregnancy	Dental & Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy & Occupational Therapy	Nursing Facility Services Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

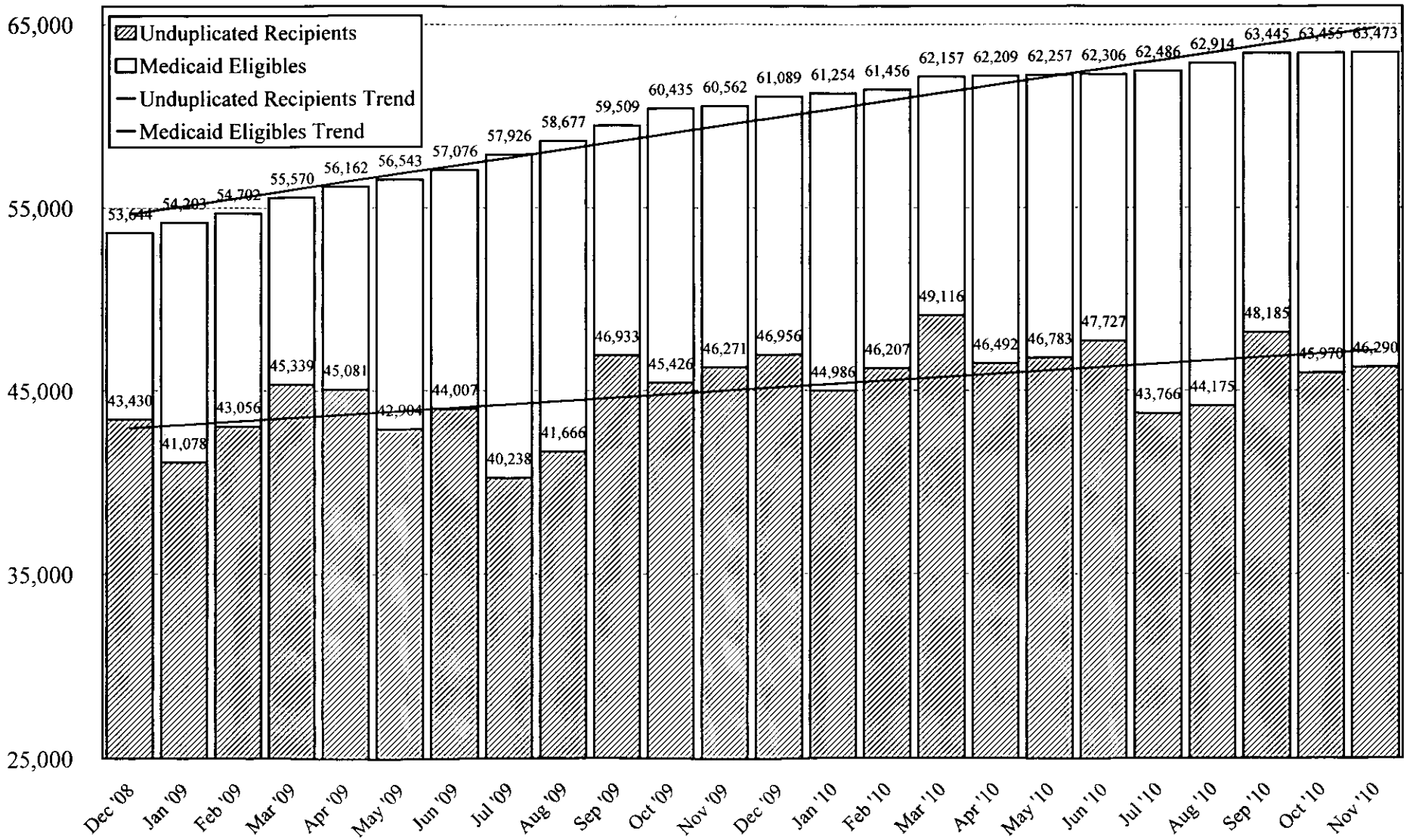
North Dakota Department of Human Services
Medical Services Division

CURRENT MEDICAID SERVICE LIMITS AND COPAYMENTS

SERVICE LIMITS	COPAYMENTS
Chiropractic Manipulations 12/year	$2 Occupational Therapy
Chiropractic X-rays 2/year	$2 Optometry Service
Physical / Occupational / Speech Therapy Evaluation 1/year	$2 Psychological Service
Occupational Therapy 20 visits/year	$1 Speech Therapy
Psychological Testing 4 hours/year	$2 Physical Therapy
Psychological Therapy 40 visits/year	$3 Podiatry Service
Speech Therapy 30 visits/year	$2 Hearing Test
Physical Therapy 15 visits/year	$3 Hearing Aid
Eyeglasses for Individuals 21 & Older once every 2 years	$75 Inpatient Hospital
Eye exams for Individuals 21 & Older once every 2 years	$3 non-emergent use of Emergency Room
Ambulatory Behavioral Health – limited based on level of care	$2 Physician Visit
Inpatient Psychiatric – 21 days per admission, not to exceed 45 days per year	$3 Federally Qualified Health Center / Rural Health Center Visit
Inpatient Rehabilitation Services – 30 days per admission	$3 Brand Prescriptions
Nursing facilities – 15 days hospital leave; 24 therapeutic leave days per year	$1 Chiropractic Services
Wheelchairs – limited to once every 5 years	$2 Dental Services
Nebulizers limited to once every 5 years	
Dentures – limited to once every 5 years	
Dietitian – 4 visits per year	
Biofeedback – 6 visits per year	

Attachment C

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients December 2008 - November 2010



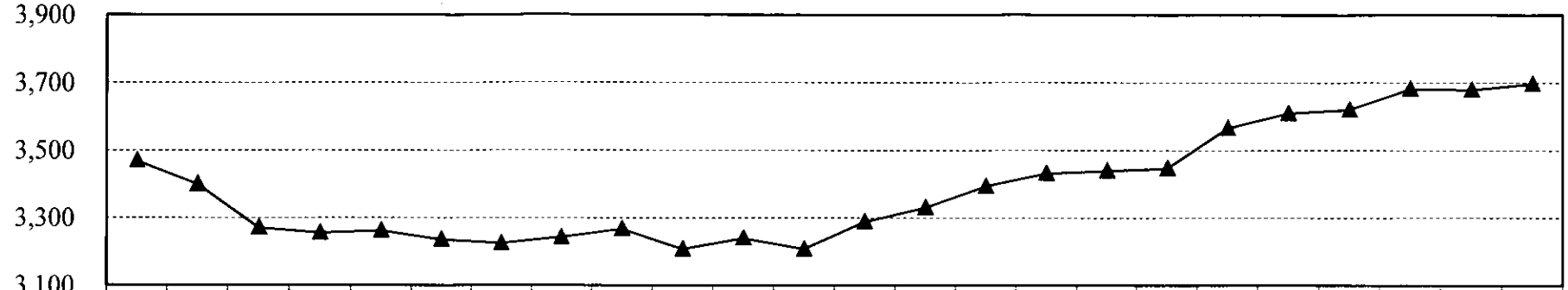
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North Dakota Department of Human Services

Attachment D

Healthy Steps Premiums Paid by Month

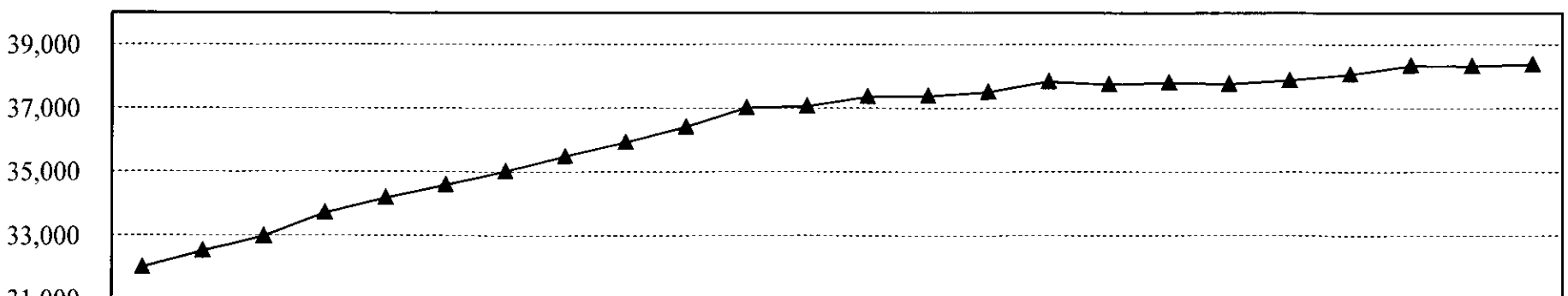
December 2008 - November 2010



Dec '08	Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10
3,468	3,399	3,270	3,255	3,262	3,235	3,224	3,242	3,267	3,207	3,239	3,207	3,288	3,330	3,393	3,431	3,439	3,446	3,565	3,609	3,620	3,680	3,678	3,696

Children Enrolled in Medicaid by Month

December 2008 - November 2010



Dec '08	Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10
31,986	32,504	32,964	33,694	34,168	34,577	35,012	35,480	35,916	36,399	37,002	37,058	37,358	37,385	37,499	37,824	37,739	37,797	37,761	37,876	38,056	38,337	38,313	38,375

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North Dakota Department of Human Services
Changes in Medical Assistance Services from 2009-2011 Appropriation to 2011-2013 Budget To SENATE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP Changes	Decrease in Premium Rates	3/3 Inflation	Total Changes	2011-2013 Budget To Senate
Inpatient Hospital	136,073,409		21,714,395	1,190,244			6,579,444	29,484,083	165,557,492
Outpatient Hospital	61,913,737		(11,417,821)	23,004,432			2,368,572	13,955,183	75,868,920
Supplemental Rural Critical Access Hospitals	400,000		(400,000)	0				(400,000)	0
Physician Services	99,606,658		(8,933,002)	14,061,208			4,700,204	9,828,410	109,435,068
Drugs - NET (Includes Rebates)	50,911,883		11,993,334	(12,391,662)				(398,328)	50,513,555
Premiums	24,089,464		11,951,650	504,322		(7,361,653)		5,094,319	29,183,783
Dental Services	17,026,199		962,593	4,995,320			1,045,408	7,003,321	24,029,520
Psychiatric Residential Treatment Facilities	25,112,375		(514,340)	(1,716,413)				(2,230,753)	22,881,622
Durable Medical Equipment	6,682,391		(149,984)	1,257,457			357,592	1,465,065	8,147,456
Psychological Services	3,795,618		1,791,598	900,672			295,160	2,987,430	6,783,048
Ambulance Services	5,649,154		31,774	(431,728)			238,616	(161,338)	5,487,816
Indian Health Services ^	26,845,632		13,378,602	(10,744,022)				2,634,580	29,480,212
Electronic Health Records Incentive Payment ^			64,895,312					64,895,312	64,895,312
Other Services	33,258,518		215,317	5,882,531	0	0	1,092,186	7,190,034	40,448,552
Chiropractic Services	878,852		155,645	188,303			55,700	399,648	1,278,500
Disease Management	2,891,208		(183,948)	(39,384)				(223,332)	2,667,876
Federally Qualified Health Centers	2,939,309		816,901	1,413,258				2,230,159	5,169,468
Foster Care Family Support	713,976		52,504	281,216			47,676	381,396	1,095,372
Home Health Services	3,104,835		(435,675)	437,320			93,934	95,579	3,200,414
Hospice Services	746,991		(28,221)	0				(28,221)	718,770
Laboratory & Radiology	1,806,074		(43,842)	231,544			91,148	278,850	2,084,924
ND Health Tracks - EPSDT Screenings	4,978,635		(235,195)	468,880			236,540	470,225	5,448,860
Occupational Therapy	746,001		64,399	372,776			53,372	490,547	1,236,548
Optometry Services	3,375,527		751,203	741,394			145,360	1,637,957	5,013,484
Physical Therapy	1,196,429		112,203	6,920			59,924	179,047	1,375,476
Rural Health Clinics	3,990,120		333,784	(303,752)				30,032	4,020,152
Special Education ^^	2,060,004		(172,020)	1,564,848			156,516	1,549,344	3,609,348
Speech & Hearing Services	1,049,817		(11,073)	287,336			60,152	336,415	1,386,232
Targeted Case Mgt - DJS Alt Care ^^	0		0	536,960			21,520	558,480	558,480
Targeted Case Mgt - Pregnant Women	81,732		(1,404)	(29,936)			2,308	(29,032)	52,700
Transportation Services	2,699,008		(959,944)	(275,152)			68,036	(1,167,060)	1,531,948
Total (Excluding Healthy Steps)	**491,365,038**	**0**	**105,519,428**	**26,512,361**	**0**	**(7,361,653)**	**16,677,182**	**141,347,318**	**632,712,356**
Healthy Steps	21,632,536		4,286,590	2,071,395				6,357,985	27,990,521
Total Medical Assistance	**512,997,574**	**0**	**109,806,018**	**28,583,756**	**0**	**(7,361,653)**	**16,677,182**	**147,705,303**	**660,702,877**
General Funds	**124,804,375**	**5,406,444 ***	**3,993,111**	**12,695,390**	**58,011,392**	**(3,049,336)**	**7,004,116**	**84,061,117**	**208,865,492**

* BND Loan Funds of $4,616,429 and Tobacco Money of $790,015 were replaced with General Funds.

^ Indian Health Services & Electronic Health Records Incentive Payments are 100% federally funded.

^^ Only federal funds are in the DHS budget. The matching funds are in other state agency budgets.

Attachment E

Cost and Caseload Comparison

2011-2013 Biennium To Senate

Compared to 2009-2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case	2011-2013 Budgeted Avg Monthly Cost per Case	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference: Increase (Decrease)
Inpatient Hospital	902.17	1,216.82	314.65	6,294	5,669	(625)
Outpatient Hospital	19.41	16.87	(2.54)	133,029	187,412	54,383
Physician Services	24.73	19.63	(5.10)	168,224	232,254	64,030
Net Drugs (Includes Rebates)	45.33	39.09	(6.24)	46,800	53,840	7,040
Premiums	111.54	133.36	21.82	8,987	9,118	131
Dental Services	60.86	65.94	5.08	11,657	15,183	3,526
Psychiatric Residential Treatment Facilities	382.38	372.64	(9.74)	90	84	(6)
Durable Medical Equipment	1.94	1.99	0.05	143,221	170,877	27,656
Psychological Services	67.88	103.98	36.10	2,331	2,718	387
Ambulance Services	14.01	14.74	0.73	16,809	15,513	(1,296)
Indian Health Services	661.87	148.02	(513.85)	1,690	8,298	6,608
EHR Incentive Payment Program			-			-
Healthy Steps	228.71	274.03	45.32	3,941	4,256	315

Attachment F

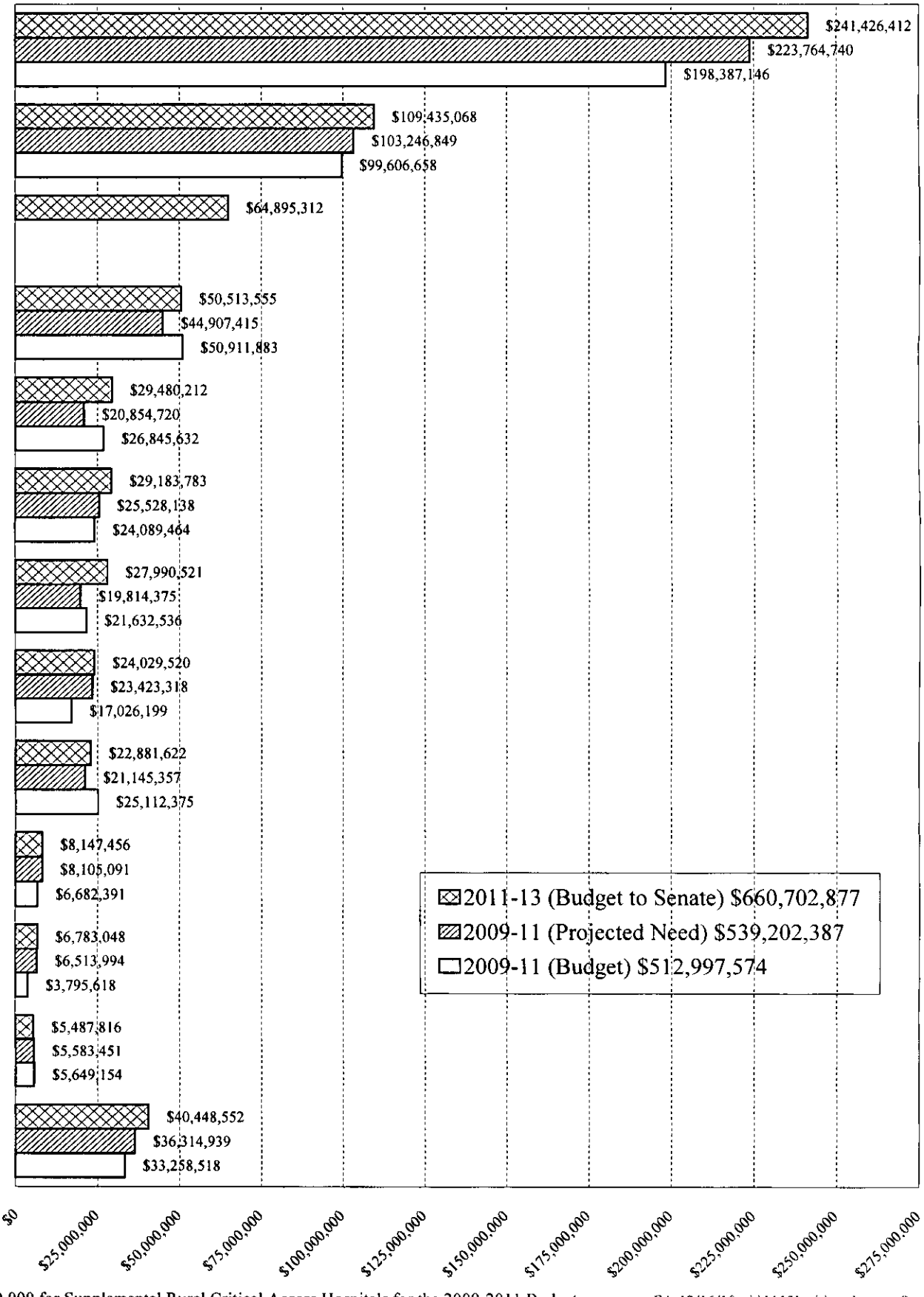
North Dakota Department of Human Services

Attachment G

Medical Services

2009-11 and 2011-13 Biennium Comparisons

Senate Bill 2012 (2011 - 2013 Biennium)



1/ Includes $400,000 for Supplemental Rural Critical Access Hospitals for the 2009-2011 Budget.

FA-12/16/10-cj-\1113legis\med comp S



North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: SB 2012
Senate Appropriations Committee
Appropriations for Department of Human Services
January 17, 2011

Chairman Holmberg and Members of the Senate Appropriations Committee.

I am Jerry Jurena, President of the North Dakota Hospital Association (NDHA). I am presenting Testimony in support of SB 2012.

I believe the Governor's recommendation of a 3% inflator each year of the biennium for Medicaid reimbursement for Hospitals is appropriate and fair.

I believe the recommendations made by the Governor regarding additional funding for Mental Health Services is long overdue. The additional funding in the proposed budget for the Department of Human Services will enhance reimbursement which will increase access and maintain quality Mental Health Services across the State. Access to Mental Health Services is an ongoing issue for rural Hospitals creating difficultly in placing patients for qualified services. Urban Hospitals do not have the necessary staff to meet the demand in urban areas let alone provide assistance to rural hospitals. The result of not funding Mental Health Services is patients are seen repeatedly costing more than appropriate treatment.

I believe the Interim Studies completed on Mental Health Services this last year by the Department of Health is right on in addressing the need to increase providers and services. Again I believe the Governor's recommendations to add additional funding is appropriate.

I am In support of SB: 2012. I am here to address any questions.

Jerry E. Jurena, President
North Dakota Hospital Association.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

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Robert A. Thompson, MD
Immediate Past President

Gaylord J. Kavlie, MD
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AMA Delegate

Robert W. Beattie, MD
Grand Forks
AMA Alternate Delegate

Bruce Levi
Executive Director and
General Counsel

Leann Tschider
Director of Membership
Office Manager

Annette Weigel
Administrative Assistant

Testimony on SB No. 2012
Senate Appropriations Committee
January 17, 2011

Chairman Holmberg and Committee Members, I'm Bruce Levi and I serve as executive director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

First of all, on behalf of North Dakota's physicians I thank you for your major efforts last legislative session. Your rebase of Medicaid payments for medical services provided a significant increase in payments bringing those payments closer in line with what it actually costs to provide those services. With respect to physician payments, the rebase accomplished 75% of what it would take to bring payments to 100% of cost, using the methodology adopted prior to the last session by the ND Department of Human Services. Since 2002, we had expressed the concern of North Dakota's medical community that the Medicaid payment methodology had resulted in payments being substantially less than the actual cost of providing medical services to our Medicaid patients.

Our physicians in North Dakota provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from the services physicians are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we also have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – and our costs for medical equipment, new technology and supplies continue to increase. The rebase accomplished in the last session and again reflected in the 2011-13 executive budget provide substantial assistance toward helping to address some of these issues.

The North Dakota Medical Association supports the 2011-13 executive budget and the 3% inflationary increases. At the same time, we encourage you to consider further investments that would better reflect the intent to rebase to 100% of cost pursuant to the statement of legislative intent adopted in the Department's 2009 budget bill (2009 HB 1012), and a legislative commitment to ensuring future access to physician services for Medicaid patients. Section 13 of 2009 HB 1012 provided:

> **SECTION 13. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set Medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

The Department budget included an optional adjustment request for an appropriation of state and federal funds to do additional work to develop methodologies that would support an additional rebase to cost. As one option, NDMA supports the inclusion of the optional adjustment request in the 2011-13 budget.

Physicians in North Dakota continue to do their part in providing good access to quality medical care for Medicaid beneficiaries and showing their ongoing commitment to the long-term sustainability of the Medicaid program. We look forward to working with the Committee in addressing the future needs for Medicaid medical services. Thank you.

Testimony
Senate Bill 2012
Senate Appropriations Committee
Senator Holmberg, Chairman
January 17, 2011

Chairman Holmberg and members of the Appropriations Committee:

My name is Dawn Hoffner. I reside in Fargo. I serve as a volunteer on the Board of Directors of the North Dakota Chapter of the American Foundation for Suicide Prevention, Mental Health America North Dakota's South Valley Council, and the Cass County Justice and Mental Health Collaborative. I am employed as the Community Liaison Department & Development Director for Prairie St. John's Hospital and I am a lifelong resident of our great state. Thank you for the opportunity to testify before you today in support of the Psychiatric Demonstration Project (OAR) Optional Adjustment Request for inclusion into SB 2012.

As you know, many North Dakotans suffer with very serious untreated or undertreated mental illness.

Psychiatric care delivered in hospitals (both general and freestanding psychiatric) is an integral component of community-based care for persons with mental illnesses. But with a 30% decline in inpatient psychiatric beds over the past two decades, it can be extremely difficult to find beds for individuals needing immediate mental health care services. Individuals with serious mental health needs are frequently initially transported to emergency rooms and often must travel long distances to receive appropriate care. And we know that many times now in our state, this takes law enforcement, ambulance and other first responder's availability away from other potentially urgent needs.

A 2009 Government Accountability Office report (GAO-09-347) on hospital emergency departments, reported that difficulties in transferring, admitting, or discharging psychiatric patients from the emergency department were factors contributing to emergency department overcrowding.

Community-based psychiatric hospitals could help relieve this access problem; however, due to a Medicaid provision called the Institution for Mental Disease exclusion, patients receiving care in these hospitals are not covered for their care if the patients are between the ages of 21-64. Accounting for more than 50% of state and local spending on mental health services, we know that Medicaid funding is vital for people with mental disorders.

Our state now has a tremendous opportunity.

This year Congress passed the
MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT

Organizations endorsing the demonstration project include:

American Academy of Child and Adolescent Psychiatry * American Association for Geriatric Psychiatry * American Association for Marriage and Family Therapy * American Association of Pastoral Counselors *American College of Emergency Physicians * American Counseling Association * American Group Psychotherapy Association * American Hospital Association * American Mental Health Counselors Association * American Psychiatric Association * American Psychiatric Nurses Association * Anxiety Disorders Association of America * Association for Ambulatory Behavioral Healthcare * Association for Behavioral Health and Wellness * Child Welfare League of America * Children and Adults with Attention-Deficit/Hyperactivity Disorder * Clinical Social Work Association * Eating Disorders Coalition * Emergency Nurses Association* Federation of American Hospitals * National Alliance on Mental Illness* National Association for Children's Behavioral Health * National Association of County Behavioral Health and Developmental Disability Directors * National Association of Psychiatric Health Systems * National Association of Rural Mental Health * National Association of Anorexia Nervosa and Associated Disorders * National Coalition of Mental Health Professionals and Consumers, Inc.* National Foundation for Mental Health* Therapeutic Communities of America

As well as the North Dakota Suicide Coalition and the North Dakota Hospital Association.

Please Approve the Psychiatric Demonstration Project OAR for inclusion into SB 2015.

Thank you for your time and attention today as well as your service to all the citizens of our state.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Long-Term Care Continuum budget.

Programs

The long-term care services included in this area of the budget are the Developmentally Disabled Community-Based Care grants; Nursing Facilities, Basic Care Facilities, and the Home and Community-Based Services Programs which have the following funding sources: (Service Payments for the Elderly and Disabled (SPED); Expanded SPED; the Medicaid Technology-Dependant Waiver; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; Children's Medically Fragile Waiver, Children's Hospice Waiver, and the Medicaid Home and Community-Based Services Waiver).

The Long-Term Care Continuum encompasses a wide range of medical and support services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.

I will provide an overview of the long-term care continuum budget, with the exception of the Developmental Disabilities grants, which will be provided by Tina Bay, Director of the Developmental Disabilities Division.

Program Trends

Nursing Facilities

As of September 30, 2010, the percentage of Medicaid-eligible individuals in nursing facilities was 52 percent. Attachment A shows the Licensed and Occupied Nursing Facility Beds since October 2008, and Attachment B shows the Medicaid occupied beds. Based on the September 30, 2010 occupancy reports, 24 facilities were below 90 percent occupancy. The average occupancy for these 24 facilities is 78 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. During the 2009-10 and the 2007-08 interims, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility beds that are being shifted through the state. The Department's 2011-2013 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

Basic Care

The Department continues to believe that a moratorium on the number of basic care beds should also remain. The process in place for requested exceptions to come before the Department of Health and the Department of Human Services continues to work well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the basic care beds that are being shifted and added throughout the state.

Home and Community-Based Services

Home and Community-Based Services (HCBS) continue to provide an array of services determined to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care. HCBS staff work closely with county case managers and providers to ensure clients have the services they need in a timely and efficient manner. Ongoing collaboration occurs between HCBS staff and the Centers for Medicare and Medicaid (CMS) to identify changes in federal requirements and to continually enhance quality measures to assure clients and families are receiving the appropriate services to meet their needs.

Major Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- Increased the **home delivered meals** offered in the HCBS waiver from 3 meals per week to 7 meals per week; effective January 1, 2010.

- 2009 House Bill 1433 authorized a **supplemental payment for at-risk nursing facilities.** No facility has requested reimbursement under this provision.

- 2009 House Bill 1327 authorized funding to **convert a nursing facility** into a basic care/assisted living facility. Funds to **operate**

a rent-subsidy pilot project were also included. The funding will expire June 30, 2011.

- Implemented **non-medical transportation** in SPED and ExSPED; effective January 1, 2010.

- The **SPED fee schedule** was updated, based on actual cost of living adjustments. This change was effective July 1, 2009.

- The **Adult Family Foster Care Point Split** was removed effective January 1, 2010.

- The **Hospice for Children Waiver** was implemented July 1, 2010, after receiving approval from the Centers for Medicare and Medicaid Services.

- The **third tier of Personal Care** was implemented January 1, 2010.

- The $20 **Personal Needs Allowance** for SSI only individuals was implemented January 1, 2010.

Money Follows the Person Demonstration Grant

As noted in the Traditional Medicaid testimony, the passage of the Affordable Care Act extended the Money Follows the Person (MFP) grant through 2020. The grant is now expected to transition 87 individuals with a developmental disability and 265 individuals who reside in a nursing facility to the community. To accomplish the new transition expectations,

CMS has authorized 100 percent federal administrative funding discussed previously.

The primary barriers to transition identified to date include the limited availability of affordable and accessible housing, shortage of qualified service providers in rural North Dakota, limited public awareness of the types of home and community based services offered in the home, varied availability of home health/hospice services across the state, and rural transportation capacity. Through December 2010, forty- four individuals were transitioned to the community. The transition goal for Calendar Year 2011 is thirty-nine individuals. Included with this testimony are two MFP brochures (one for each transition population) to provide additional information and detail.

Minimum Data Set (MDS) 3.0

On October 1, 2010, North Dakota, as well as other states began using Version 3.0 of the Minimum Data Set (MDS). MDS is part of the federally mandated process for clinical assessment of all residents in nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are completed for all residents in certified nursing homes, regardless of individual's source of payment. MDS assessments are required for residents on admission to the nursing facility and periodically thereafter, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the state Medicaid office, and is used as the cornerstone for establishing the resident's per day cost of care.

With the implementation of MDS 3.0, one of the modifications the Department made to the classification logic was to recognize a distinct classification period for therapies when the initiation or discontinuation of therapies results in a change in a resident's classification. A resident's classification period will remain as a 3-month period; however, during that 3-month period, if a resident was classified in a rehab category and therapies are discontinued the resident's classification will be changed as of the date all therapies were discontinued to the classification that would otherwise have been in effect at the beginning of the classification period had there been no therapies. Likewise, if therapies are started during the 3-month classification period, a resident's classification may be changed as of the start date of therapies.

Overall, the implementation of MDS 3.0 went smoothly. We continue to answer questions from providers and work on individual issues as needed.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Nursing Homes	425,713,210	459,123,033	33,409,823
Basic Care	18,113,925	25,972,395	7,858,470
SPED	17,495,327	13,782,988	(3,712,339)
Ex-SPED	726,578	976,724	250,146
Personal Care Services	25,044,599	29,149,905	4,105,306
Targeted Case Management	1,957,896	1,564,749	(393,147)
Home & Community Based Services Waiver	8,707,606	10,268,386	1,560,780
Children's Medically Fragile Waiver	1,147,844	318,780	(829,064)
Technology Dependent Waiver	532,608	500,136	(32,472)
PACE	7,393,711	9,370,980	1,977,269
Children's Hospice Waiver	856,410	1,770,430	914,020
Total	507,689,714	552,798,506	45,108,792
General Fund	172,803,502	247,849,336	75,045,834
Federal Funds	324,704,819	301,674,110	(23,030,709)
Other Funds	10,181,393	3,275,060	(6,906,333)
Total	507,689,714	552,798,506	45,108,792
FTE	-	-	-

Nursing Homes

The Executive Budget was based on Medicaid nursing home days paid. The monthly average days are projected to be:

97,832	-	Nursing Facility
449	-	Dakota Alpha
975	-	Geropsych Unit
1,310	-	Swing Bed
2,650	-	Hospice Room and Board
1,888	-	Out of State
105,104		Total

A "day" is the unit of service for nursing facilities. Basing the nursing facility budget on bed days more closely mirrors how claims are reimbursed by Medicaid. For example, if an individual enters the nursing home on the 20th of January. The facility may chose to bill Medicaid for January and February at the same time. This results in the "bed" only being counted once, even though the days are greater than 30.

Attachment C shows historical information on expenditures and average daily Nursing Facility Rates.

Upper Payment Limit

The Medicaid regulations contain a requirement that Medicaid payments to institutional providers, including nursing facilities, in the aggregate, cannot exceed what Medicare would pay, in the aggregate, for the same care. This is known as the Upper Payment Limit (UPL). The Upper Payment Limit must be calculated yearly for each type of facility: private; state-government owned, and non-state government owned. Historically, the gap between the Medicaid payments and the Upper Payment Limit has been large enough, where this has not been an issue

or something the Department needed to bring to your attention. However, the increases provided by the 2009 Legislature, have resulted in North Dakota approaching the Upper Payment Limit for the private facilities, and actually, for 2011, exceeding the Upper Payment Limit for the non-state government owned facilities. The Department is working with the non-state government owned facilities to ensure their rates for 2011 are in compliance with the Upper Payment Limit.

During session, when there are requests for fiscal impact related to nursing facility rates, the Department will be providing information on the estimated impact the proposed change will have on the upper payment limit and whether the proposed change will be able to be implemented by the Department under the Medicaid regulations.

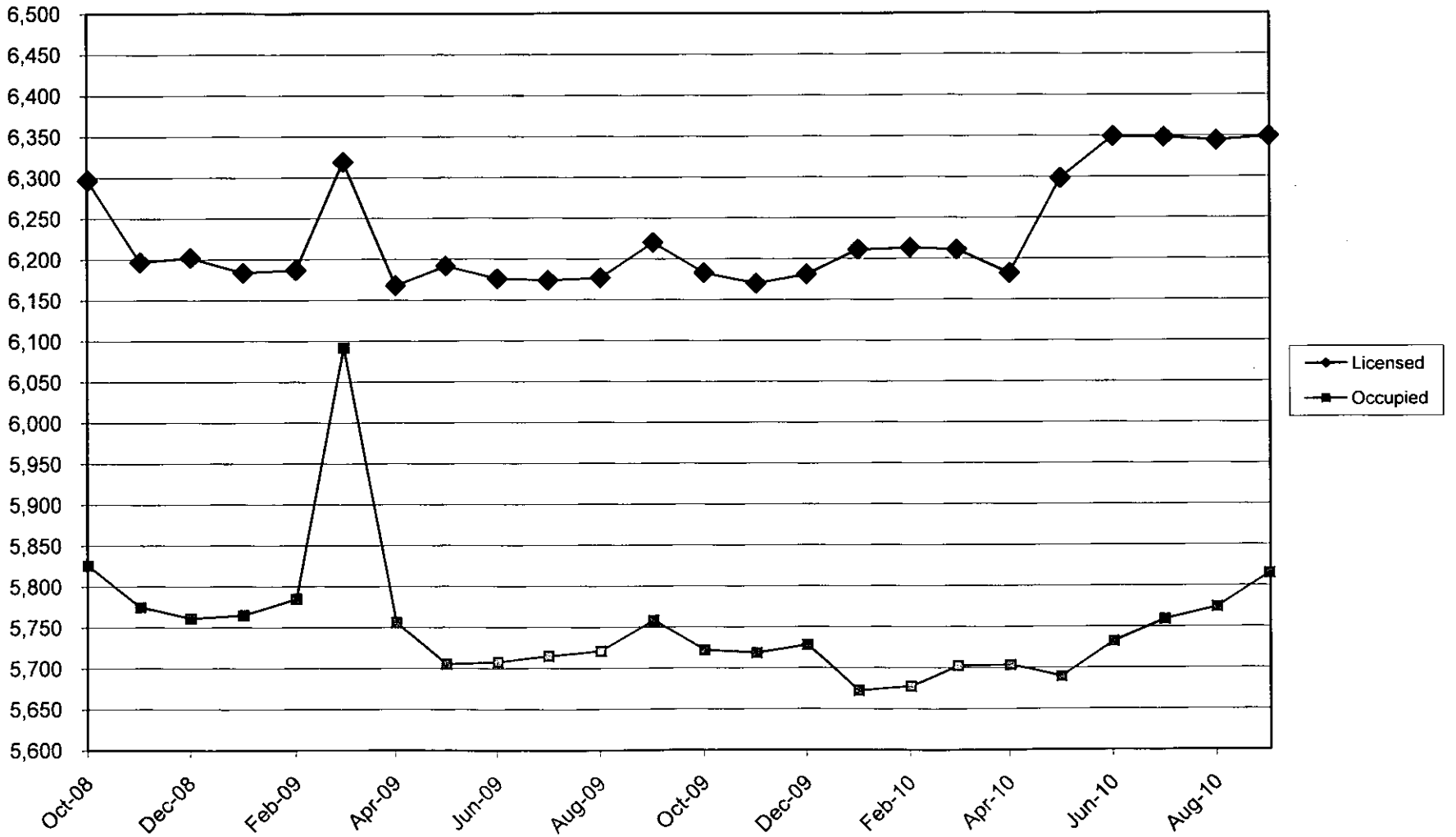
Attachment D shows the changes in the Long Term Care Continuum Budget from 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

Attachment E is a cost and caseload comparison of the 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

I would be happy to answer any questions you may have.

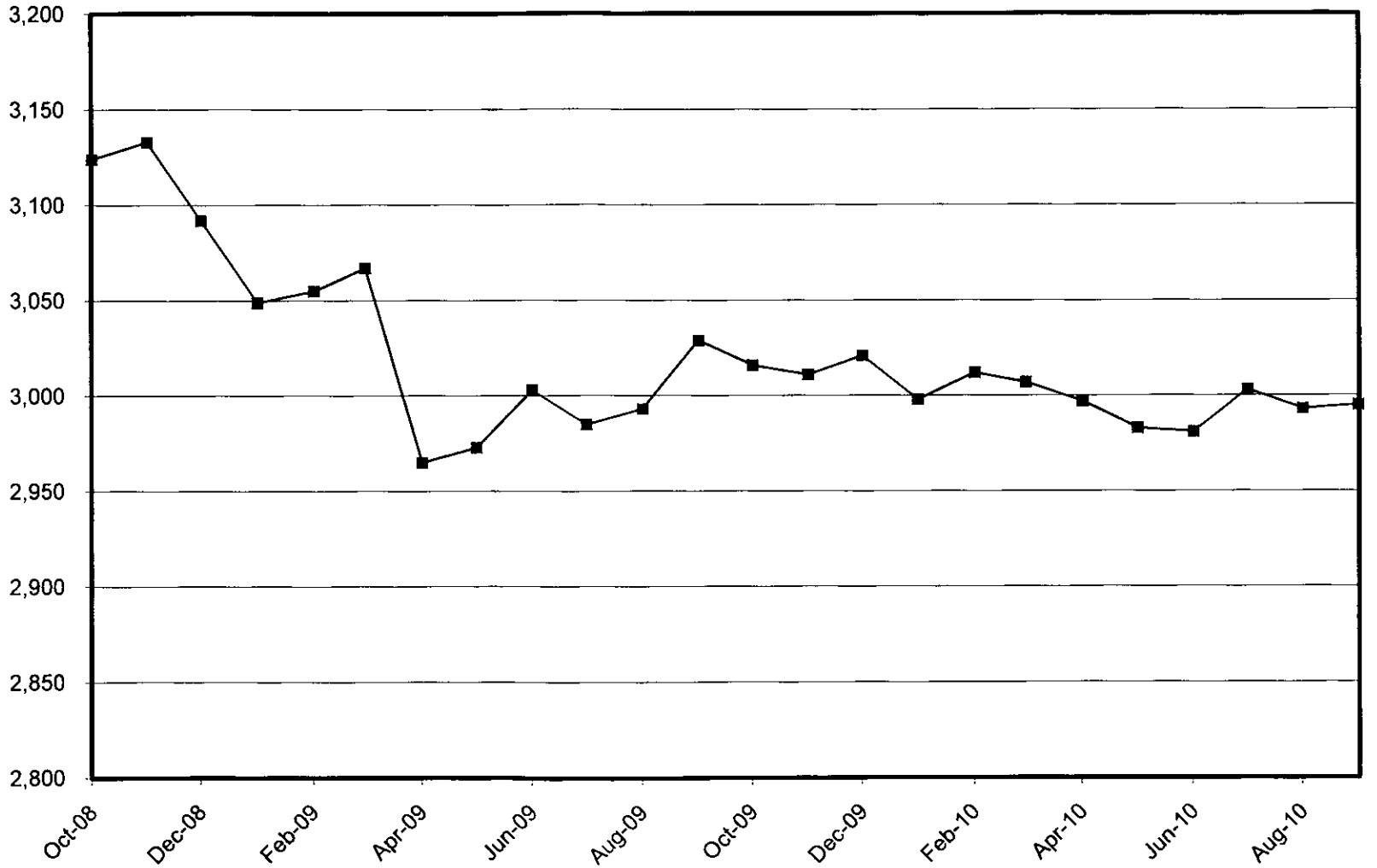
ATTACHMENT A

NF Occupancy at Month End



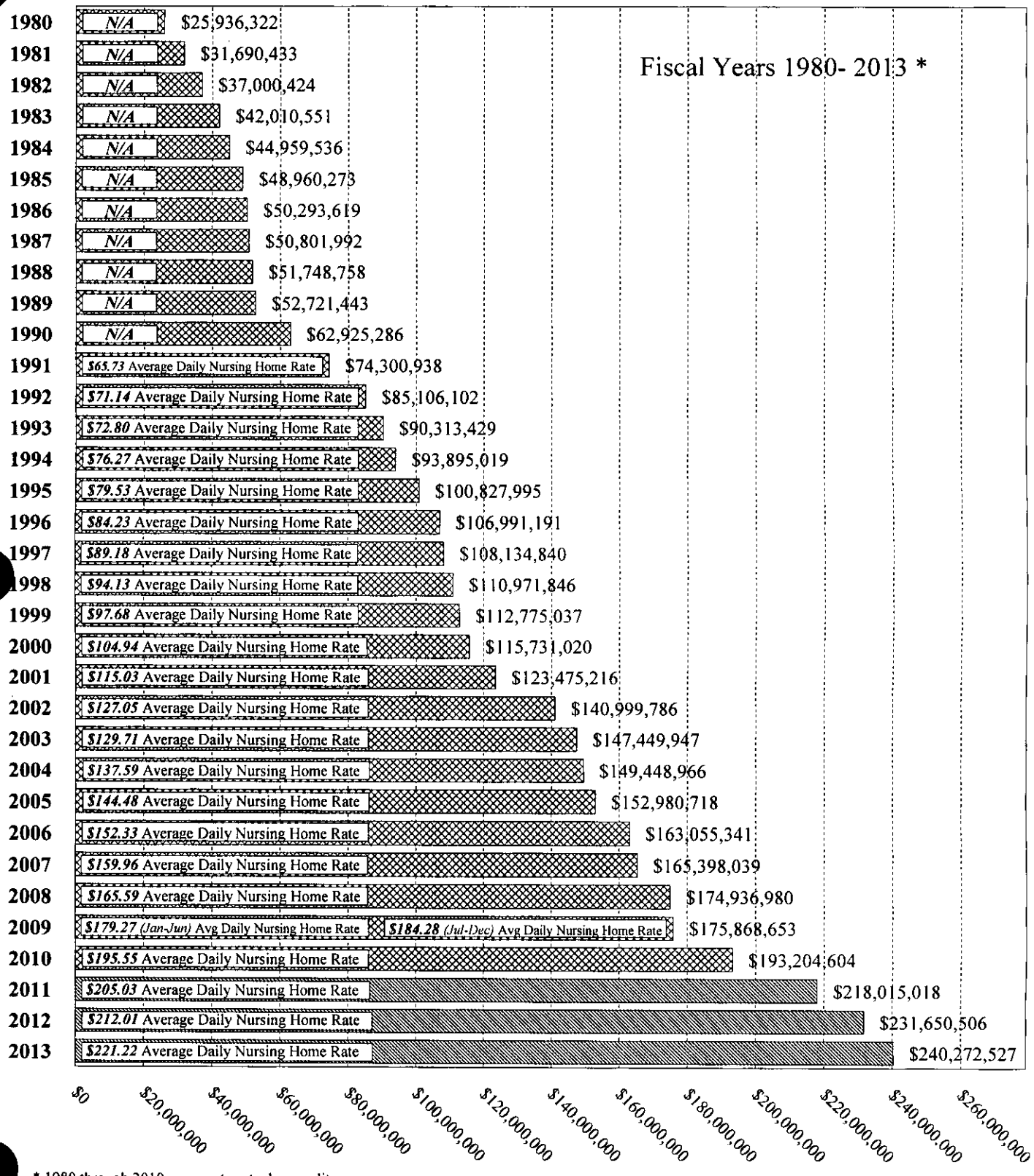
ATTACHMENT B

NF Occupancy at Month End Medicaid ONLY



North Dakota Department of Human Services
Nursing Home Facilities
Senate Bill 2012
2011 - 2013 Biennium

Attachment C



* 1980 through 2010 represents actual expenditures.
2011 represents one month actual and eleven months estimated expenditures.
2012 and 2013 represents estimated expenditures included in the Governor's budget.
The average daily nursing home rate is effective January 1 of each year as indicated.
NOTE: Budget amount for 2012 and 2013 reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

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North Dakota Department of Human Services
Changes in Long Term Care from 2009-2011 Appropriation to 2011-2013 Budget To SENATE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Offset for General Fund Carryover **	Total Changes	2011-2013 Budget To Senate
Nursing Homes	425,713,210		18,306,125	16,979,110		10,924,588	(12,800,000)	33,409,823	459,123,033
Basic Care ^	18,113,925		2,995,658	3,726,798		1,136,014		7,858,470	25,972,395
Home & Community Based Services	63,862,579		1,538,520	(248,688)		2,550,667		3,840,499	67,703,078
SPED ^^	17,495,327		(1,901,567)	(2,411,820)		601,048		(3,712,339)	13,782,988
Ex-SPED ^^^	726,578		121,856	85,229		43,061		250,146	976,724
Personal Care Services	25,044,599		2,830,627	(6)		1,274,685		4,105,306	29,149,905
Targeted Case Management	1,957,896		(552,024)	90,558		68,319		(393,147)	1,564,749
Home & Community Based Services Waiver	8,707,606		705,502	404,800		450,478		1,560,780	10,268,386
Children's Medically Fragile Waiver	1,147,844		(771,555)	(71,873)		14,364		(829,064)	318,780
Technology Dependent Waiver	532,608		65,376	(119,592)		21,744		(32,472)	500,136
PACE	7,393,711		1,049,983	927,286				1,977,269	9,370,980
Children's Hospice Waiver	856,410		(9,678)	846,730		76,968		914,020	1,770,430
Total	**507,689,714**		**22,840,303**	**20,457,220**	**0**	**14,611,269**	**(12,800,000)**	**45,108,792**	**552,798,506**
General Funds	**172,803,502**	**6,817,423 ***	**7,702,004**	**6,162,907**	**60,084,630**	**7,078,870**	**(12,800,000)**	**75,045,834**	**247,849,336**

Other Areas:

Community of Care Funds $120,000 for both the 09-11 and 11-13 Bienniums- 100% General funds

Personal Care Needs Allowance SSI $148,068 for the 09-11 Biennium and 108,000 for the 11-13 Biennium - 100% General Funds

Assisted Living Rent Subsidy $200,000 for the 09-11 Biennium and $0 for the 11-13 Biennium - IGT Funds

* BND Loan Funds of $2,692,917 and IGT Funds of $4,124,506 were replaced with General Funds.

** Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

^ Room & board costs are funded with general funds and retained funds.

^^ SPED is funded with 95% general funds and 5% county funds.

^^^ Expanded SPED is funded with 100% general funds.

Attachment D

Cost and Caseload Comparison

2011-2013 Biennium To Senate

Compared to 2009-2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case ^	2011-2013 Budgeted Avg Monthly Cost per Case ^	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload *	2011-2013 Budgeted Avg Monthly Caseload *	Difference: Increase (Decrease)
Nursing Homes (Daily Rates)	175.55	187.09 ^^	11.54	101,072	105,104	4,032
Basic Care (Daily Rates)	27.23	33.14	5.91	27,706	32,651	4,945
Personal Care	1,551.83	1,810.10	258.27	671	671	-
Technology Dependent Waiver	8,825.30	10,419.32	1,594.02	3	2	(1)
Children's Medically Fragile Waiver	4,276.19	1,473.38	(2,802.81)	11	9	(2)
SPED	456.02	425.40	(30.62)	1,597	1,350	(247)
Expanded SPED	235.13	287.61	52.48	129	142	13
PACE	4,053.57	4,620.80	567.23	76	85	9
Targeted Case Management	178.12	133.74	(44.38)	458	488	30.00
HCBS Waiver	1,084.98	1,215.48	130.50	334	352	18.00
Children's Hospice Waiver	2,378.91	2,458.93	80.02	30**	30	-

^ With the exception of Nursing Homes and Basic Care which are daily rates all other categories are average monthly cost per case.

^^ 11-13 Nursing Home rate above reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

* Nursing Homes and Basic Care caseload represents the number of "Days" paid in a month for recipients. All other categories represent the number of recipients paid for in a month.

** The Children's Hospice was budgeted to begin in the 2nd year of the 09-11 biennium at 30 persons per month. The average shown is for the 12 months of SFY 2011.

Attachment E

Transition Coordination Providers

Dakota Center For Independent Living
3111 East Broadway Avenue, Bismarck, ND 58501
Phone (Voice/TTY): (701) 222-3636
Toll Free: (800) 489-5013
E-mail: dcil@dakotacil.org

Options Resource Center For Independent Living
318 3rd Street NW, East Grand Forks, MN 56721
Phone (Voice/TTY): 218-773-6100
Toll Free: (800) 726-3692
E-mail: options@myoptions.info

Freedom Resource Center For Independent Living
2701 9th Avenue SW, Fargo, ND 58103
Phone (Voice/TTY): (701) 478-0459
Toll Free: (800) 450-0459
E-mail: freedom@freedomrc.org

Independence, Inc. Center For Independent Living
300 3rd Avenue SW, Suite F, Minot, ND 58701
Phone: (701) 839-4724, TTY: (701) 839-6561
Toll Free: (800) 377-5114
E-mail: agency@independencecil.org

North Dakota Department of Human Services, Medical Services Division
Jake Reuter, MFP Grant Program Administrator,
Phone: 701-328-4090, Fax: 701-328-1544
E-mail: jwreuter@nd.gov

MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

This document was developed under grant CFDA 93.779 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government. **Award # 1LICMS030171/01**

DN 1365 (10-10)

MFP
MONEY FOLLOWS THE PERSON

Program Information and Transition Services

north dakota department of human services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave a nursing facility and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in nursing facilities who are Medicaid eligible for one day, who have resided in an institutional setting for at least three months, who score 8 or higher on the MDS 3.0 cognitive assessment, and do not have an Alzheimer's diagnosis, and who meet the requirements for, and participate, in at least one of the following State programs:

- Home and Community Based Services waiver, (Determined to be in need of nursing facility level of care, and Age 16 and over and physically disabled or at least 65 years of age);
- Technology Dependent Waiver, (Determined to be in need of nursing facility level of care, Age 18 and over and physically disabled or at least 65 years of age, Medically Stable, Competent, and Vent dependent at least 20 hrs per day);
- Medically Fragile Children waiver (Determined to be in need of nursing facility level of care, 3 to 18 years of age, Greatest need as determined through a Level of Need ranking process, Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting, Lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than three months may be assisted with transition from a nursing facility by Centers for Independent Living staff through other programs, as appropriate (contact information on back).

How Does MFP Work?

The MFP Program can assist individuals interested in leaving a nursing facility (NF) by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, furniture, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end December 31, 2019.

MFP will fund services provided to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in a nursing facility and would like to learn about options available to return to the community please contact your local Center for Independent Living (contact information on back) or Jake Reuter, MFP Program Administrator at 701-328-4090.

MFP
MONEY FOLLOWS THE PERSON

north dakota department of human services

Developmental Disabilities
Case Management Service Providers

Human Service Center Contact Information

Bismarck – 701-328-8888
888-328-2662

Devils Lake – 701-665-2200
888-607-8610

Dickinson – 701-227-7500
888-227-7525

Fargo – 701-298-4500
888-342-4900

Grand Forks – 701-795-3000
888-256-6742

Jamestown – 701-253-6300
800-260-1310

Minot – 701-857-8500
888-470-6968

Williston – 701-774-4600
800-231-7724

North Dakota Department of Human Services, Medical Services Division

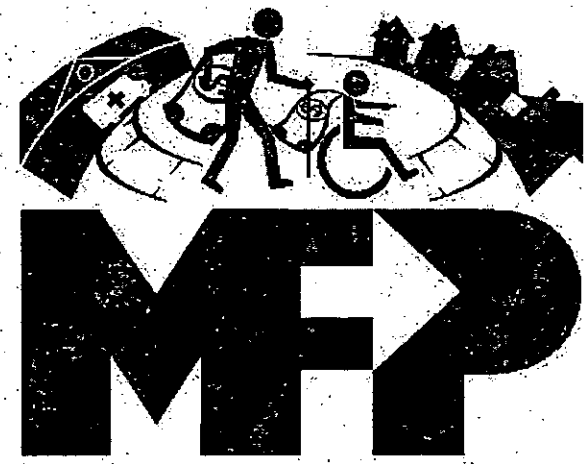
Jake Reuter, MFP Grant Program Administrator,
Email: jwreuter@nd.gov Phone: 701-328-4090,
Fax: 701-328-1544

MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

north dakota
department of
human services

This document was developed under grant CFDA 93.779 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.
Award # 1LICMS030171/01

DN 1364 (10-10)



Developmental Disabilities

Program Information and Transition Services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave the North Dakota Developmental Center or other intermediate care facility for persons with mental retardation (ICF/MR, institution) and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in ICFs/MR (institutions) who are Medicaid eligible for one day, who have resided in an institutional setting for at least three months, and who meet the requirements for at least one of the following programs:

- MR/DD waiver (Meets ICF/MR Level of Care, Requires supports for Health & Safety, and needs can be met through specific services for individuals with mental retardation),
- Self Directed Supports (ICF/MR Level of Care, Requires support for Health & Safety, Needs can be met through specific services for individuals with mental retardation, Person lives with a primary caregiver who is capable of self directing services or Person lives with a primary caregiver or independently and is Capable of self directing services)
- Medically Fragile Children waiver (Determined to meet nursing facility level of care, 3 to 18 years of age, Greatest need as determined through a Level of Need ranking process, Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting, Child lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than three months may be assisted with transition from an institution by Developmental Disabilities case management staff through other programs, as appropriate.

north dakota department of human services

How Does MFP Work?

The MFP Program can assist individuals interested in leaving an ICF/MR by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota's Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, home furnishing, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end December 31, 2019.

MFP will provide services to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in an ICF/MR and would like to learn about options available to return to the community please contact: Your local Human Service Center or Jake Reuter, MFP Program Administrator at 701-328-4090.

Testimony on SB 2012
Senate Appropriations Committee
January 17, 2011

Good Morning Chairman Holmberg and members of the Senate Appropriations Committee. My name is Shelly Peterson representing the North Dakota Long Term Care Association. We represent assisted living facilities, basic care facilities and nursing facilities in North Dakota. I am here to testify in support of SB 2012.

I am here to testify in support of the three percent inflator recommended for providers in SB 2012. This will help us address rising costs, recruit and retain quality caregivers and maintain outstanding quality service.

Rising Costs

Overall nursing facility costs increased from June 30, 2009 to June 30, 2010 by 10.2%. This increase is based upon nursing facility cost reports filed with the North Dakota Department of Human Services.

Recruit and Retain Quality Caregivers

The top issue facing nursing facilities is staffing. It is estimated long term care facilities employ a total of 14,434 people. On October 1, 2010 we estimated basic care and nursing facilities had 894 vacant positions. Almost two out of five nursing facilities used contract agency staff in 2010 to staff their facilities.

CNA turnover in nursing facilities is the second highest ever recorded at 62%. Nursing is the highest ever recorded at 32% for LPNs and 40% for RNs. Dietary is also at the highest ever recorded at 57% annually.

Job Service reports the average annual wage for long term care workers to be $23,348 as of the second quarter of 2010. This average wage is considerably lower (36%) than the statewide worker average of $36,972 per year.

Maintain Quality Service

We believe and data shows North Dakota providers give some of the most outstanding quality of care in the United States. According to satisfaction surveys of residents and families and quality measures of key outcomes, North Dakota ranks in the top.

On average our staffing ratios exceed national averages and we continually strive to exceed resident and family expectations.

Summary

A number of long term care facilities are experiencing financial stress. In 2010, Westhope Home closed a 25 bed skilled nursing facility and just two weeks ago the Good Samaritan Society announced the closure of Rock View at Parshall, a 30 bed skilled nursing facility and is seeking a new owner in New Town, a 16 bed basic care and 13 unit assisted living facility. In announcing their plans they indicated, "Both centers have struggled over the years with staffing and census problems that have led to financial issues."

On behalf of the 85 skilled nursing facilities and 64 basic care facilities and the 16,000 individuals receiving care this past year, we encourage you to fund the 3% annual inflator provided in SB 2012.

Elderly Vulnerable Adults

The North Dakota Long Term Care Association would like to voice our support for the OAR for guardianship services for vulnerable elderly adults. We see a great need for a comprehensive statewide service that addresses the issue of financial exploitation. An unknown number of senior adults in our communities and in our long term care facilities are being exploited and the system has not been responsive. On average one out of every six residents in a nursing facility has a payment issue associated with their account. Some of it is caused by children, guardians and strangers acquiring their assets and leaving them destitute. We need to intervene, stop it and help. As a beginning step to a bigger issue, please consider funding the OAR for guardianship services.

Thank you again for the opportunity to testify on SB 2012. I would be happy to answer any questions you may have.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street • Bismarck, ND 58501 • (701) 222-0660
Cell (701) 220-1992 • www.ndltca.org • E-mail: shelly@ndltca.org

Testimony

Senate Bill 2012-JoAnn Ferrie, ND Association for Home Care

Senate Appropriations Committee

Senator Holmberg, Chairman

January 18, 2011

Senator Holmberg and members of the Senate Appropriations Committee, my name is JoAnn Ferrie, I am a registered nurse and the Director of Professional Home Care, a Home Health Agency in Bismarck. I am here today as the Vice President of the ND Association for Home Care (NDAHC) and representing the association.

The NDAHC represents Home Health Care Agencies (Hospital-based, County, nonprofit, and proprietary) and their branches, providing care throughout ND, allowing clients to remain in their homes.

Home Health Care provides: Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, Certified Nurse Assistants (CNAs), Infusion Therapy, Medical Social Workers, Pediatric and Psychiatry Programs, as well as Home Health Aides and Homemaker services, or Personal Care Services assisting with activities of daily living and in certain circumstances, tele-health services. Today I will address the Skilled Nursing and Personal Care, or QSP (Quality Service Provider) services provided by Home Health agencies.

QSP services are provided by individuals, proprietary agencies, and Home Health Care Agencies. Home Health agency QSP services are provided within a medical model of care. These agencies are certified by Medicare and Licensed by the state of North Dakota. Agency QSP providers are generally CNAs, or minimally Nurse Assistants registered in the state, who are directly supervised by a registered nurse. These CNAs receive ongoing education and evaluation of their skills and abilities.

In late June of 2010, our association was informed that the Catholic Health Initiative (CHI) affiliated hospitals were looking at eliminating QSP services in their hospitals.

Originally, the CHI Affiliated Hospitals were planning to eliminate the QSP services at St. Joseph's hospital in Dickinson effective as of July 31, 2010 and were looking at possibly eliminating the services in their other affiliated hospitals as well. At the beginning of October we were informed that they had eliminated the QSP services at each of their hospitals.

The Dickinson hospital had 29 clients that were receiving QSP services through St. Joseph's. We talked with the representatives from that hospital and were informed that they had worked with the local County Social Service Office so that their employees who were providing the service could be licensed as

individual QSP's through the county. Although many of them did become certified as individual QSP's the hospital had to lay off many of them because there was no longer enough work for them to do to keep them employed. Additionally, another area we're concerned with is finding a nurse to verify that those who become individual QSP's are providing enough hours of the care necessary to maintain their CNA licensure. Also, in those situations, if those employee's choose not to become individual QSP's through the county, the hospital clients may be at risk of losing that service, and may be forced into more institutionalized care.

That being said, in October, NDAHC representatives met with the Department of Human Services to discuss how we might address the issue. As a result of the meeting, we were asked to put together some cost estimates on what it would take to address the issue. Based on information from our members, it seems the issue is with travel primarily. Essentially, any time the QSP is traveling more than 5-10 miles, the agency loses money on that service. The overall feeling from the meeting on how to address the issue was to create a travel differential for different mileage categories.

Our provider association is concerned about the economic viability of providing qualified service provider (QSP) services with access to nursing supervision.

We conducted a poll of 17 provider agencies and received replies from 16. Those providers serve 247 individuals in the QSP system, comprising the sample size, or "*n*." Among the sample, the percentage of individuals served in four mileage ranges are summarized in this chart.

	1-10 mi	10-25 mi	25-35 mi	35+ mi	Total
% of Total	76.92%	14.98%	4.05%	4.05%	100%

We then calculated the cost of providing services within those mileage ranges. We assumed a current QSP rate of $5.80 per quarter-hour unit, with a typical home health QSP visit being about 5 units, for a cost of $29.00. We then assumed staff could travel 60 mph, or 15 miles per unit, and factored the cost of staff travel time at twelve dollars per hour into the rate. We assumed mileage reimbursement of $.50 per mile, round trip, for the midpoint of each mileage range. The cost ratios and resulting proposed rates are summarized in this table.

COSTS & RATES	Current & 1-10 mi	10-25 mi	25-35 mi	35+ mi
Ratio of Cost to Current Rate	1.0	2.27	3.17	3.53
Proposed Unit Rate (includes $5.80, subtract $5.80 for diff.)	$5.80	$13.15	$18.38	$20.48

The number of individuals requiring substantial travel was 57 in our survey. The number of persons who might receive the service in question is elusive because providers don't have statistics on individuals turned away from QSP services. A recent survey of the members, with about half responding, anecdotally indicated about 40 people were turned away. Doubling this number of individuals to 80 should set the outside range of additional clients to be expected over time with more adequate funding.

This gives an estimated population of between 97 and 137. We have requested DHS and county assistance in verifying this estimate and have been informed that DHS will have these figures available to us soon.

To adequately reimburse a home health QSP would cost about $36.75 more for a five-unit visit in the 20-25 mile range. In exchange for this additional investment, nurse supervised services would be available to more North Dakotans in rural areas, and client choice of provider would be maintained.

Chairman Holmberg and members of the committee, thank you for the opportunity to testify before you today - I urge your favorable recommendation for reimbursement of a travel differential for nurse supervised QSP services by the State of North Dakota. I would be happy to answer any questions you may have.

Categories:	*Total*	1-10 mi.	11-25 mi	26-35 mi	35+ mi	All subt. mi	checksum	
		77%	15%	4%	4%			
Known		190	37	10	10	247		
Foreseeable		190	63	17	17	287	287	
Worst Case		190	89	24	24	327	327	
Per Unit Requested		$5.80	$13.15	$18.38	$20.48			
Per Visit Proj		$29	$65.75	$91.90	$102.40			
NF /Ind'l	159,551.2							
Per Bien /Ind'l		$9,048	$20,514	$28,672.80	$31,948.80			
Current	*$2,234,856*						DIFFERENCE	
Known Pop'n	**$3,079,824.23**	**$1,720,839.12**	**$760,043.70**	**$283,287.26**	**$315,654.14**		**$844,968.23**	
Foreseeable	$4,036,687.53	$1,720,839.12	$1,295,191.53	$482,750.22	$537,906.67		$1,801,831.53	
Worst Case	*$4,993,550.84*	*$1,720,839.12*	$1,830,339.35	$682,213.18	$760,159.19		*$2,758,694.84*	
Institutional $	*15,446,151.67*		10,073,577.18	2,686,287.247	2,686,287.247			

Actual cost to deliver services is $6.25 which may be addressed through inflation.

Travel Clients	
Known	*57*
Foreseeable	*97*
Worst Case	*137*

Estimated based upon 3 visits/wk & survey results; actual may be substantially lower

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Tina Bay, Director of the Developmental Disabilities Division of the Department of Human Services. I am here today to provide you an overview of the Long Term Care Developmental Disabilities Grants Budget, for the Department of Human Services.

Programs

The Developmental Disabilities Services grants are funded through the Medicaid State Plan, three Medicaid Home and Community-Based Waivers, Part C of IDEA (Individuals with Disabilities Education Act), and general funds.

Caseload / Customer Base

In SFY 2010, 5,341 individuals received developmental disabilities program management through the human service centers,

2,892 Individuals received family support program services, including family subsidy, infant development, family support, parenting support, and extended home health,

3,070 individuals received residential and/or days services, and

605 individuals received self-directed support services, which enable individuals and families to hire their own in home support staff and

access environmental supports/modifications and equipment and supplies.

According to the latest report from the University of Minnesota titled "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2009":

- The national average rate of placement in residential settings for persons with Intellectual Disabilities (ID)/Developmental Disabilities (DD) in 2009 was 143.1 people per 100,000 of the general population. North Dakota ranked number one with 318.8 per 100,000 state residents.

- Nationally, the combined average of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Based Services (HCBS) utilization was 196.3 per 100,000 of the population. North Dakota ranked number one with 654.6 per 100,000 state residents.

Program Trends / Major Program Changes

Services for young children with DD – Caseload growth continues in the number of young children with developmental disabilities needing support.

Autism Spectrum Disorder Waiver – On November 1st, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the state's request for a Medicaid waiver for Autism Spectrum Disorders. This waiver

will provide service options for individual's birth through four years of age, living with a primary caregiver. This waiver may serve up to 30 children per year. The services under the waiver are environmental modifications, equipment and supplies, in-home supports and intervention coordination. The goal of the waiver is to support the primary caregiver to maximize the child's development and prevent out of home placements.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Developmental Disability Grants	341,542,546	396,996,033	55,453,487
General Funds	110,730,341	174,231,307	63,500,966
Federal Funds	229,621,551	222,764,726	(6,856,825)
Other Funds	1,190,654		(1,190,654)
Total	341,542,546	396,996,033	55,453,487

FTE	-	-	-

Attachment A shows the changes in the Developmental Disabilities Grants from the 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

The majority of the caseload growth in the 2011-2013 budget is due to:

- 22 additional high school graduates expected to need services each year of the biennium, and;
- an increase of 5 children per month (120 for the biennium) expected to need infant development services.

This concludes my testimony on the 2011 – 2013 budget for Long Term Care Developmental Disabilities Grants area of the Department. I would be happy to answer any questions.

North Dakota Department of Human Services
Changes in DD Grants from 2009-2011 Appropriation to 2011-2013 Budget To SENATE

Description	2009-2011 Appropriation	Funding Shift *	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Total Changes	2011-2013 Budget To Senate
Family Subsidy	1,746,336		4,404,912	(5,289,240)	0	39,192	(845,136)	901,200
Intermediate Care Fac. for Mentally Retarded	113,446,346		6,146,123	4,556,953		5,342,697	16,045,773	129,492,119
DD Home & Community Based Services	217,483,407		10,529,469	17,174,815	(17,392)	11,149,463	38,836,355	256,319,762
Autism Waiver	1,038,000		(148,272)	889,728		80,868	822,324	1,860,324
DD Funding Buckets ^	7,828,457		227,996	0		366,175	594,171	8,422,628
Total DD Grants	341,542,546	0	21,160,228	17,332,256	(17,392)	16,978,395	55,453,487	396,996,033
General Funds	110,730,341	1,190,654	10,652,533	2,363,437	41,819,324	7,475,018	63,500,966	174,231,307

* BND Loan Funds of $1,190,654 were replaced with general funds

^ Enhanced funding for various critical needs provided to children and adults with disabilities.

Attachment A

TESTIMONY
Senate Bill 2012 – DHS Appropriations
Developmental Disabilities - LTC Continuum
Senator Holmberg, Chairman
Jan 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Barbara Murry, Executive Director of the North Dakota Association of Community Providers. I am here today to give brief testimony on the developmental disabilities section of the long term care continuum in SB 2012

The North Dakota Association of Community Providers is made up of 29 organizations across the state. We represent approximately 4,500 staff, 3,900 of whom are Direct Support Professionals, or DSP's. We serve approximately 4,500 individuals with developmental disabilities. Services are most often, lifelong. Ninety-nine percent of the typical provider funding comes through the Department of Human Services.

We are requesting your support in a number of areas of our platform, which I have attached. I will address the wages, turnover, and digital imaging. Sandi Marshall will discuss critical needs and transition. Jon Larson will testify on benefits. Catholic Charities will discuss guardianship needs. We have introduced you to some of our staff and the people we support in previous years, and are not repeating that testimony today. I have included a card with a description of a young woman who was earlier served at the Anne Carlsen Center, and is currently served by Enable to give you information on our services.

Wage Increases. We are requesting your support for the Governor's budget, which includes an increase of 3% each year of the biennium. We are also requesting a $1.46 per hour market adjustment for all staff in the organizations, which is the differential found in our October wage survey. With the support of the 2009 Legislature, developmental disabilities staff received a 6% increase each year of the biennium, along with a $.60 per hour increase the first year. This increase had a profound impact on our turnover, reducing it from 43% to 33%, as of 7-1-10, and we are very appreciative of this increase. While this has stabilized services, it is still a very high turnover rate, and we hope it can be reduced further with your support. I have attached a study of our turnover, "Recruitment and Retention of Direct Support Professionals in ND," completed by the CMS DSW Resource Center Technical Assistance Team out of the U of MN, for your review. I have also attached a graph of our turnover, since 2001, indicating the impact of raises given by the legislature. This report highlights several additional areas that are significant in reduction of turnover. Strategies include improving the capacity of supervisors to know and use effective supervision practices, improving hiring practices by implementing interventions to reduce unmet expectations for newly hired staff, and improving the status and image of the direct support profession.

We have been working hard since the last legislative assembly to implement strategies to impact our turnover. We partnered with the Department of Commerce and served as the beta organization to implement a Talent Pipeline Map, as a part of the Governor's strategies to impact the labor force needs in ND. The strategies selected in this pipeline map match those recommended in current research. We

have increased the training for our frontline supervisors, with a 36 hour training curriculum, as research indicates competent supervisors are a critical factor in reducing turnover. Ninety staff were trained with that curriculum. In a partnership developed through the DHS Money Follows the Person grant, we are in the process of developing a Realistic Job Preview video, which will help us hire those staff who understand the work in the job for which they are applying. Our improved data collection indicates our highest turnover occurs in the first year and this strategy should impact that initial turnover. We are also working with the Center for Persons with Disabilities at Minot State. They have long had a high quality module curriculum, which can lead to an associate's degree and a bachelor's degree. They are exploring an accreditation process which will give a nationally recognized certification to ND's DSPs. We have also begun to work with the Labor Department to explore an apprenticeship program with a national credential.

A Set-aside for Digital imaging – creation of employment options for people with disabilities: We anticipate a separate bill will be introduced regarding the digital imaging set aside and I will cover this platform item at the hearing for that bill.

Additionally, almost half of NDACP members provide agency QSP services. NDACP supports the same increases for QSPs, as well as support increased funding for travel.

Chairman Holmberg, this concludes my testimony. I would be happy to answer any questions.

NDacp NORTH DAKOTA ASSOCIATION OF COMMUNITY PROVIDERS

North Dakota Association of Community Providers

PUBLIC POLICY PLATFORM 2011 – 2013 BIENNIUM

Priority	Items:	Fiscal Impact
1	We support the Governor's request for 3% annual inflator for each year of the biennium.	Total: 397 Million General Funds: 63.5 Million
2	7.65% increase in the benefit multiplier to cover the increasing costs of health insurance.	Total: $19.1 Million General Funds: 8.3 Million
3	$1.46 an hour market adjustment for all staff	Total: $33 Million General Funds: $14.5 Million
4	Continuation of funding for the critical needs of individuals who are medically fragile and / or behaviorally challenged	Contained within priority #1 dollar amount
5	Transition from Developmental Center to the community, including increased community capacity development through use of flexible funding mechanisms (e.g., DD Loan Fund or other BND collaboration)	Managed through DHS (DC & DD Community Services) budget authority
6	State set-aside for digital imaging	No fiscal note
7	Increased Corporate Guardianship Capacity	Partially Funded within the DHS Budget

For more information, contact: Barb Murry 220.4778
Jon Larson 220.1892

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NDACF DIRECTORS' Contact Info for Public Use – 1/10/11
TELEPHONE NUMBERS (Alpha by Facility)

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Recruitment and Retention of Direct Support Professionals in North Dakota: Analysis of 2010 NDACP Data

In 2008, North Dakota provided services to 4, 242 persons with Intellectual and Developmental Disabilities living in the community in either Home and Community Based Waiver (HCBS) services or Intermediate Care Facilities (ICF-MRs) (Lakin, Larson, Salmi & Scott, 2009).

Direct support professionals (DSPs) receive monetary compensation to provide supports to people with disabilities so they can live and work in our communities. Finding and keeping qualified DSPs has been a long standing problem in types of long-term supports and service settings (Larson & Hewitt, 2005). These low wage low status careers are often occupied by women, with recent immigrants and racial minority groups disproportionately represented. During the last 30 years services for people with intellectual and developmental disabilities have moved nationally and in North Dakota from institutional to small community settings.

Research on the DSP workforce has reported turnover rates averaging 42% for organizations providing multiple types of services (e.g., residential and vocational; Hewitt & Larson, 2007). High turnover rates disrupt services and create hardships for both the people being supported and their families. Just as concerning are the demographic changes expected in the next decade as Baby-Boomers retire and the number of people living with disabilities increase dramatically. The number of working-age females (aged 25 to 54) is expected to remain constant between 2006 and 2016 (Toosi, November 2007), while the number personal and home care aides are expected to increase 46% and the number of home health aides are expected to increase 50% between 2008 and 2018 (Lacy & Wright, 2009). These national statistics are mirrored by North Dakota's estimates. The U.S. Census estimates that by 2030 North Dakota's elder population will increase by 61.3% while the workforce 25 to 44 years old will decrease by over 27%.

In 2009, the Centers for Medicaid and Medicare Services, Direct Support Worker Resource Center issued a paper recommending that state Medicaid Agencies collect annual data on the direct support workforce. The North Dakota Association of Community Providers (NDACP) has worked with its member organizations that provide supports to people with intellectual or developmental disabilities (IDD) to collect turnover and other workforce data since 2002. This report highlights some of the results from the FY 2010 data collection along with selected historical trends.

2010 Turnover, wage and benefits for North Dakota organizations supporting people with IDD.

In fiscal year 2010, 2,870 direct support professionals were employed by 25 provider agencies of the NDACP. The NDACP collects workforce outcome data for three position types: DSP, Professional, and Administrative. The DSP category consists of all staff whose primary responsibility is the care of a person with IDD. Professional staff includes the titles of Behavioral Analyst, Qualified Mental Retardation Professional (QMRP) and Nurse. The administration category includes all other job titles.

In Fiscal Year 2010, ND turnover rates (calculated here as crude separation rate) were 32.8% for DSPs, 9.8% for professional staff, and 5.4% for administrative staff (See Table 1). Vacancy rates (the proportion of the total positions vacant) at the end of the fiscal year was 2.6% for DSPs, 0.6% for professional staff, and 0.6% for administrative staff. DSPs earned an average of $12.51 per hour while professional staff earned an average $19.82 per hour, and administrative staff earned an average of $22.50 hour.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Table 1 Turnover, Wages and Benefits by Position Type for FY 2010

	DSP	Professional	Administrative
Turnover Stats			
Number of Staff	2,870	208	160
# Separations	964	15	9
# Vacancies	78	1	1
Crude Separation Rate	32.8%	9.8%	5.4%
Vacancy Rate	2.6%	0.6%	0.6%
Wages and Benefits			
Average Hourly Wage	$12.51	$19.82	$22.50
% Full-time	54%	92%	93%
% Earns paid Sick Leave or Vacation	50.2%	84.6%	82.8%
% Provider Paid Health Insurance	33.5%	50.1%	50.3%

In NDACP organizations, 54% of DSPs, 92% of professional staff, and 93% of administrative staff were considered full-time employees. Overall, 50% of DSPs, 85% of professional staff, and 83% of administrative staff were eligible to earn paid time off including sick leave or vacation. Overall, 34% of DSPs, and 50% of professional or administrative staff received health insurance paid for in full or in part by the provider organization.

Characteristics of DSPs who left their job in FY 2010.

The first part of this report summarized workforce outcome data for all employee groups for FY 2010. For the rest of the report, we will focus on workers in the Direct Support Professional job classification. While it is helpful to know the overall turnover and vacancy rates, designing interventions to improve those rates requires additional assessment. The NDACP collected detailed information for 941 DSPs who left their position in FY 2010 ("leavers"; See Table 2) to help with this task. DSP leavers in FY 2010 had worked in their positions an average of 1.8 years before separating. They earned an average of $11.21, were 31 years old, and 33% were considered full-time employees. Overall, 64% of all staff who left were 30 years old or younger. Compared to the current DSP staff contingent, those who left their positions earned $1.30 per hour less, and were less likely to be considered full-time (33% versus 54%). Of all the DSPs who left their position in FY 2010, 39% left within 6 months of hire, and an additional 20% left between 6 and 12 months after hire.

Table 2 Characteristics of ND Staff who left their positions in FY 2010

	Direct Support Professionals	
	Number	Mean
Number of Leavers	941	100%
Years Tenure		1.82
Hourly Wage		$11.21
Mean Age		31.4

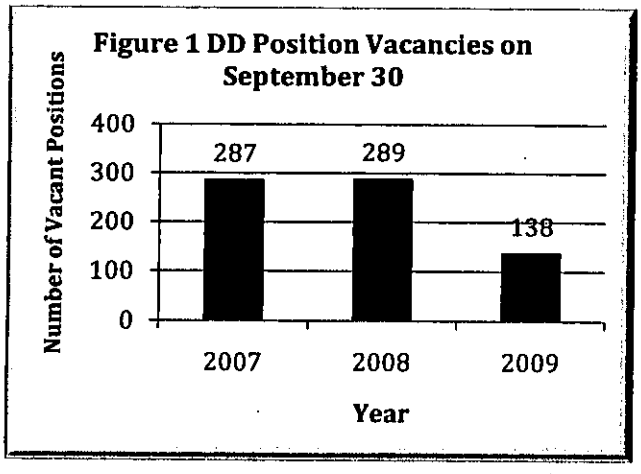
The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

% Full-Time	311	33%
Tenure Category		
0 to 6 months	364	39%
7-12 months	184	20%
13 - 24 months	173	18%
25 months or more	220	23%
Age Group		
18 to 30	600	64%
31 to 40	116	12%
41 to 50	108	11%
51 to 60	68	7%
61 +	49	5%

Together these data show that in ND those who left were younger, newer, more likely to be employed part time, and lower paid than those who remained. This picture, which is very similar to that in other states, suggests that interventions to retain DSPs for a longer period should focus, at least in part, on new employees. Several evidence based interventions are available for this purpose including improving hiring practices by using structured behavioral interviews, reducing unmet expectations by implementing realistic job previews, and better supporting new staff with training and effective supervision (Hewitt & Larson, 2007). The CMS DSW Resource Center technical assistance team has been working with NDACP and the North Dakota Medicaid office to develop a workforce development plan, and to craft specific interventions. One intervention that will be rolled out in 2010 is a North Dakota specific Realistic Job Preview. Additional interventions are also being considered.

DSP Workforce trends over time.

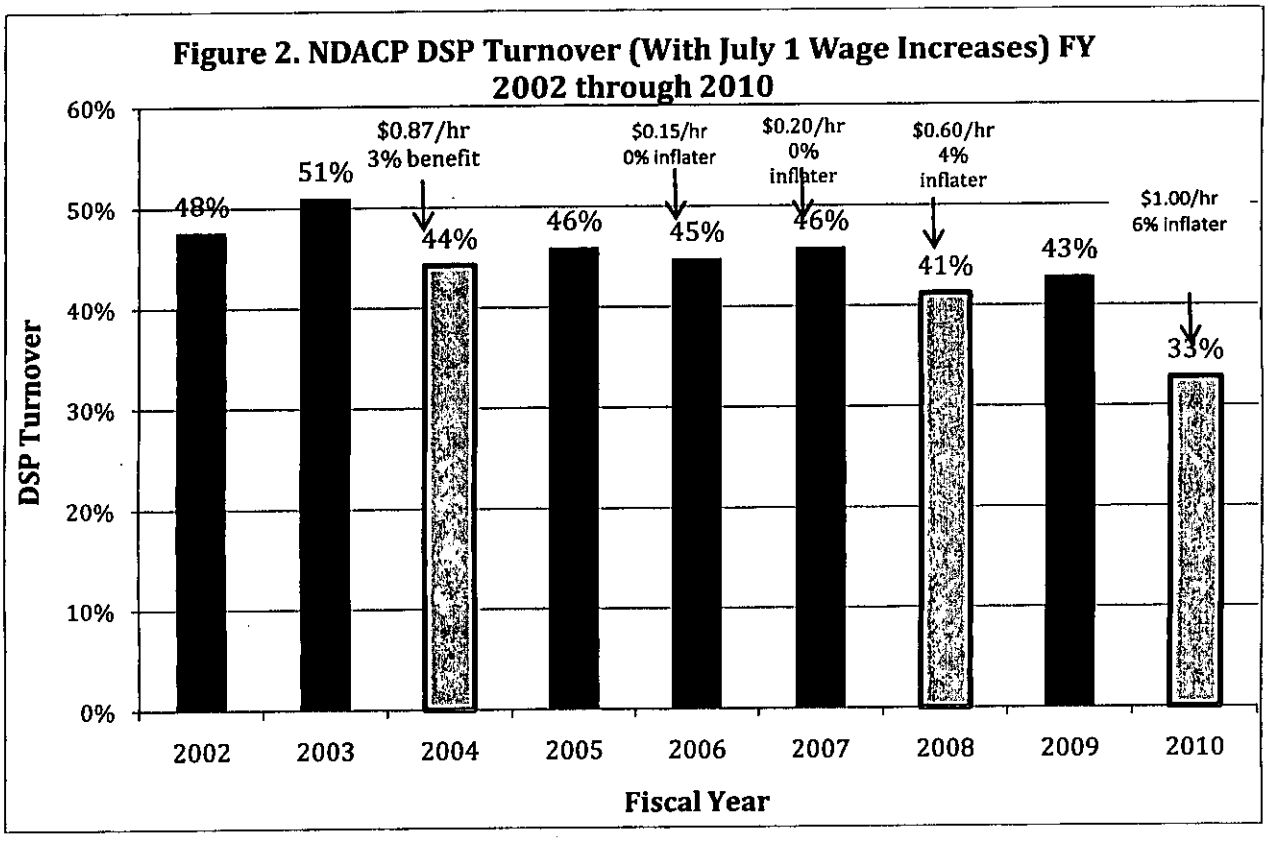
Data have been collected about vacancy rates and turnover for DSPs for several years. Three years of data are available on vacancy rates (See Table 3). While the total number of people with IDD served in ND increased between FY 2006 and FY 2008, the total number of vacant DSP positions at the end of the Fiscal Year declined from 287 on Sept 30, 2007 to 138 on Sept 30, 2009 (See Figure 1). On June 30, 2010, 78 DSP positions were vacant.



Data about DSP turnover in ND are available for 2002 through 2010 (See Figure 2). Figure two shows two separate trends. The bars reflect the crude separation rate in June 30 of the listed years. The text and arrows above the bars are legislatively authorized wage and benefit changes for DSPs. Overall, the turnover rate for DSPs in ND has declined from 48% in 2002 to 33% in 2010. During this period there were five wage and benefit changes. Three of those wage and benefit changes were for $0.60 per hour or greater (2004, 2008 and 2010). In each of the three years that included a large wage increase, turnover was notably lower than the previous year (44% in 2004 versus 51% in 2003; 41% in 2008 versus 46% in 2007; and 33% in 2010 versus 43% in 2009). The two small wage increases ($0.15 per hour in 2006 and $0.20 per hour in 2007) did not result in notable declines in turnover, and turnover increased in each of the years in which no wage/benefit increases were provided. This pattern of changes in turnover rates during years with large wage increases suggests that those wage increments had a measurable effect on turnover.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Data collected in Wyoming has shown a similar pattern. A decrease in turnover occurred when large wage increase were provided to DSPs supporting individuals with IDD in 2002 (Average wages were increased from $7.38 per hour to $10.32 per hour; turnover declined from 62% to37%). These findings, together with large research studies showing a robust correlation between wage and turnover for DSPs (See Hewitt & Larson, 2007), support the assertion that wages matter. It is possible to reduce turnover by implementing wage increases.



Note: N of Agencies Reporting in 2010 = 25

Research reviews support the association between wage and turnover rates. However, wages aren't the only thing that matters. Turnover can also be reduced by improving hiring practices, implementing interventions to reduce unmet expectations for newly hired staff, improving socialization and orientation and practices, implementing a robust system of competency based training, improving the capacity of supervisors to know and use effective supervision practices, and improving the status and image of the DSP profession (Larson & Hewitt, 2005).

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Conclusions and Recommendations

North Dakota like most states struggles to find, choose and keep qualified direct support professionals to support people with disabilities in community residential and vocational support settings.

The wage increments provided in FY 2004, FY 2008 and FY 2010 for DSPS supporting individuals with IDD resulted in notable reductions in turnover for this employee group, and the FY 2010 increase also was associated with a reduction in the number of vacant positions.

Continued efforts to measure workforce outcomes including turnover, vacancy rates and wages and benefits will support efforts to measure the impact of interventions chosen by the ND Medicaid authority and the provider organizations.

Efforts to measure workforce outcomes in North Dakota should be expanded include other sectors of the DSP workforce (such as services for people with mental health needs, physical disabilities, and for seniors).

Reducing turnover is one strategy to address the growing challenge of staff shortages in the direct support professional workforce in North Dakota.

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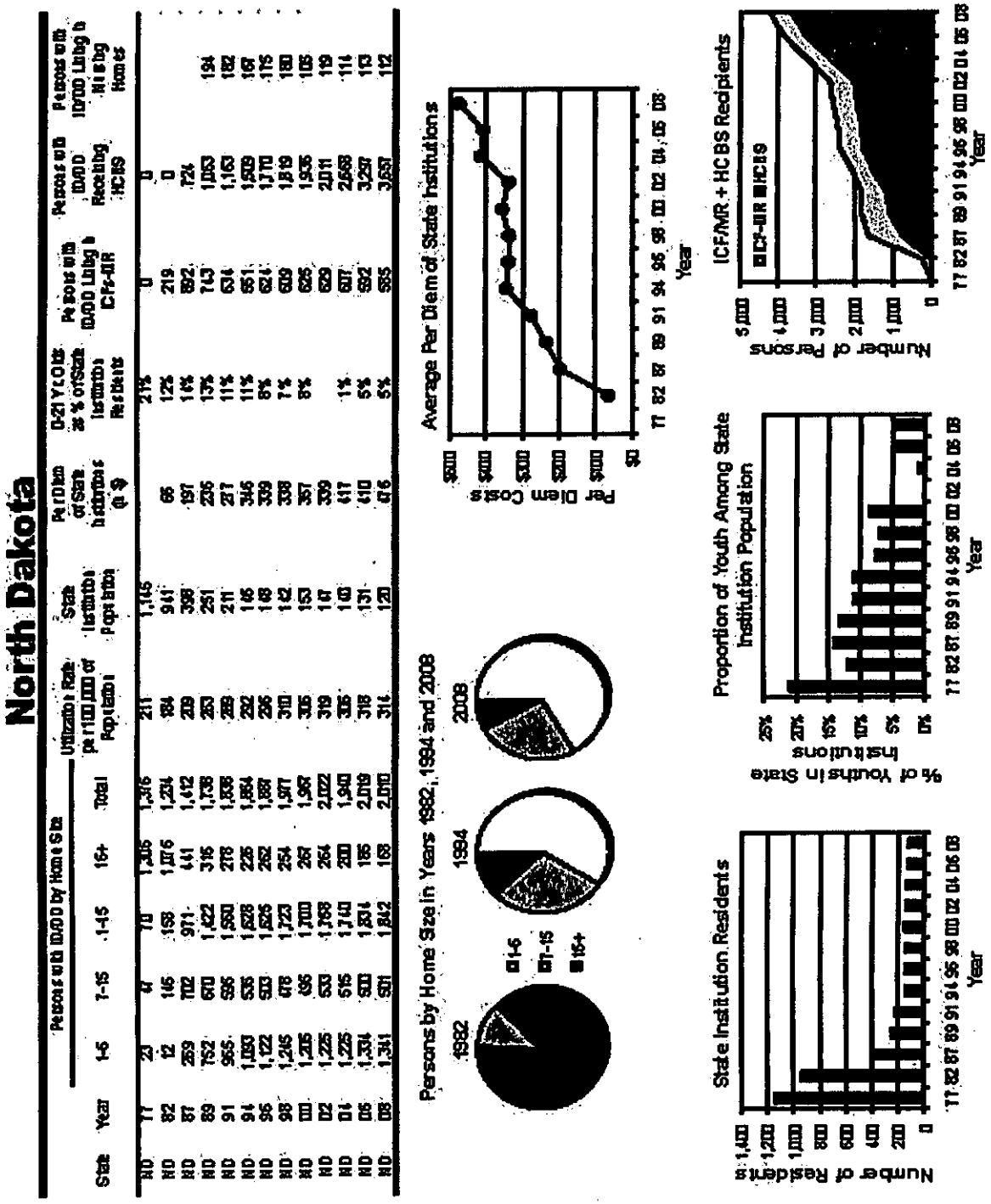
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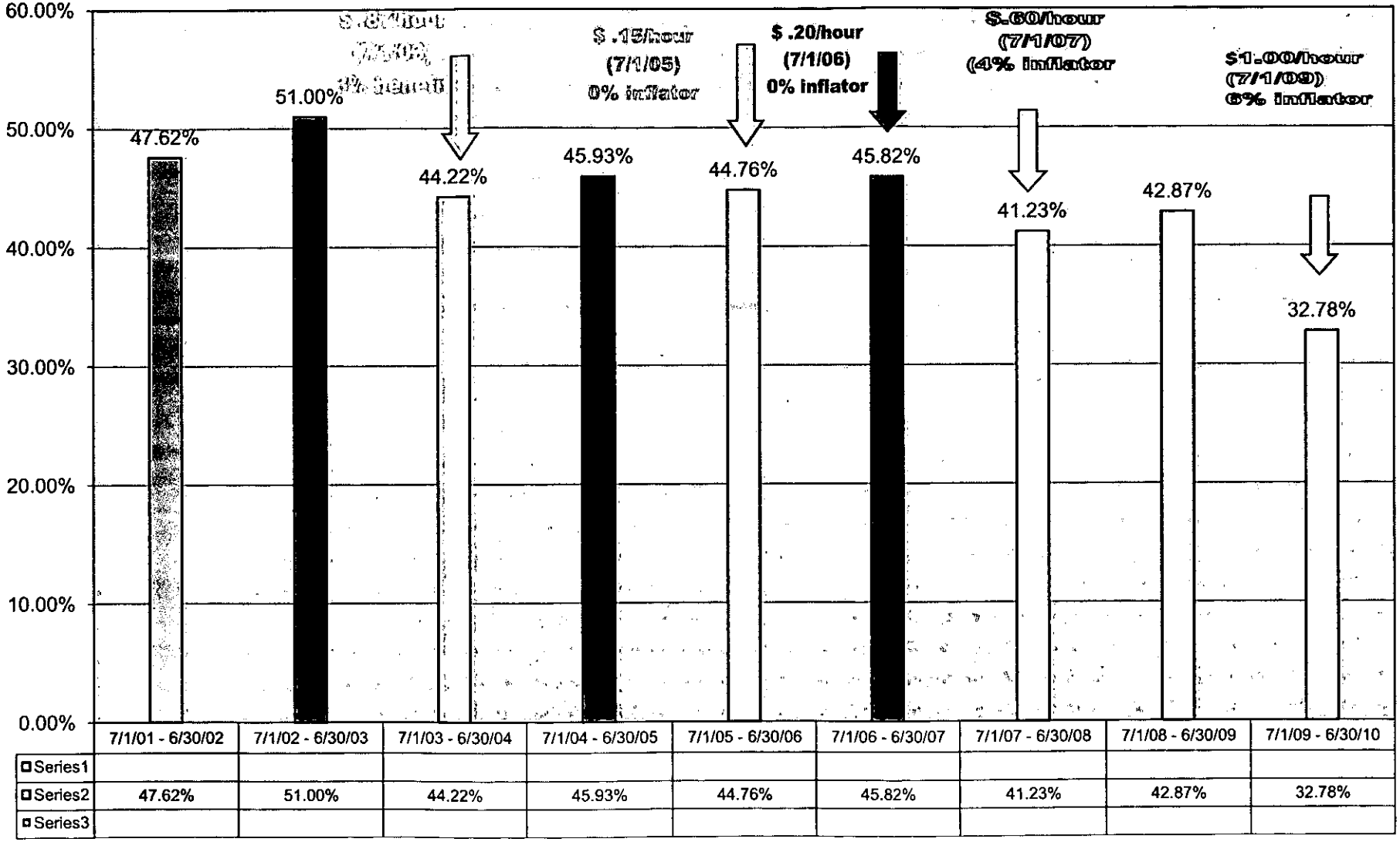
The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Appendix A: North Dakota's Medicaid Funded Service System in FY 2009



The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

NDACP TURNOVER
FY 2001 - 2010



	7/1/01 - 6/30/02	7/1/02 - 6/30/03	7/1/03 - 6/30/04	7/1/04 - 6/30/05	7/1/05 - 6/30/06	7/1/06 - 6/30/07	7/1/07 - 6/30/08	7/1/08 - 6/30/09	7/1/09 - 6/30/10
Series1									
Series2	47.62%	51.00%	44.22%	45.93%	44.76%	45.82%	41.23%	42.87%	32.78%
Series3									



VALUE OUR MOST VULNERABLE

NDacp

Meet Amber – a young lady from Bismarck who has cerebral palsy and requires a team of caregivers to support her daily activities. In 1988 Amber's family began using In-home Supports to assist her. In 2002 Amber graduated from school and moved into an apartment with support from the ISLA program. This is Amber's home today. Caring staff help Amber with her shopping, laundry, chores and all the simple daily things we take for granted.

Without the qualified and dedicated staff, Amber would not be the happy, social and healthy young lady that she is. She loves living independently and her family credits the outstanding direct support professionals who support her needs each and every day.

Our goal is to provide continuity and consistency for Amber and the thousands of additional people who need daily assistance. Amber and others in the same situation thrive and live fulfilling lives when there is consistency in the care and services provided.

Amber is supported by Enable in Bismarck.

Support an equity and inflationary increase in wages for developmental disabilities employees.

NORTH DAKOTA ASSOCIATION OF COMMUNITY PROVIDERS

Value our most vulnerable

Support increases of 3% and a 7.65% to cover health insurance for Employees working with people with developmental disabilities.

Support a $1.46 per hour equity increase to become competitive with the labor market in North Dakota.

We are more than 4,800 employees in North Dakota living in 90+ communities who provide support services for thousands of people with developmental disabilities. Our average employee is 36 years old and has a family to support.

Our goal is to continue giving quality and consistent support for people with developmental disabilities. Providing competitive wages will enable us to decrease employee turnover leading to better outcomes for the people we serve. With your support, turnover over has decreased from nearly 50% to 33%. However, that continues to be unacceptably high.

Wage Comparison

Average yearly wage in ND [illegible] $36,000

Average yearly wage for DD Providers [illegible] $26,020

Increase Needed $ 1.46

Current turnover rate for DD providers is 33%

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations Committee
Senator Ray Holmberg, Chair

Chairman Holmberg, members of the Appropriations Committee, I am Sandi Marshall, President of the North Dakota Association of Community Providers (NDACP), and Chief Executive Officer of Development Homes, a large non-profit DD provider agency in Grand Forks. Thank you for the opportunity afforded to NDACP to provide information today relative to the needs of our industry, particularly on behalf of both the people we serve and the many citizens of North Dakota that we employ to provide those services.

First, I would like to recognize the significant increases in support of this industry resulting from the 2009 legislative session. In addition to increases in provider reimbursement and hourly staff wages, the final appropriation included $4.2 million in additional new funds to address critical needs of people we serve who present the most severe medical and behavioral challenges. These funds have gone a long ways towards addressing the costs associated with the staffing and program needs of our most vulnerable citizens, and represent a real commitment to quality and humane supports.

NDACP supports the continuation of the critical needs funding for severe medical and behavioral needs that is included in the Governor's budget for the Department of Human Services. These funds are distributed to providers based on individual consumer scores obtained using a standard assessment

tool, and supplement the regular provider rate-setting mechanism. The funds,. called "bucket funds", allow for critical client needs to be met in a much more responsive manner than previously, and reduce the need for providers to augment state funds with other charitable donations to adequately serve people in the community.

The critical needs funding helps to address increased needs as the people we serve age and lose skills, or as medical conditions deteriorate. For example, many people with Down Syndrome become afflicted with Alzheimer's disease as they age, and require a greater level of care over time. Also, people we serve experience typical impairments of aging, and sometimes have specific medical and behavioral conditions that are progressive in nature and result in a need for a greater level of support staffing and programmatic considerations.

It is important that the critical needs funding is available in the 2011-2013 biennium, while the state continues to explore replacement of the current client assessment and rate-setting processes, as proposed in Senate Bill 2043.

NDACP supports enhancing the Department's budget as it relates to transitioning individuals from the Developmental Center to the community in the next biennium. It is anticipated that 95 individuals will reside at the center as of July 1, 2011, with plans to further reduce the population to 67 by July 1, 2013. Regrettably, the funds to support this movement are not included in the proposed budget, but are noted in un-funded OAR 407.

The 2005 legislature required the Department of Human Services to work with the DD provider community to develop a plan for further deinstitutionalization. A Transition to the Community Task Force was assembled and has supported the movement of many individuals into community life since its inception. There is a recognition that now our system is at a cross-roads, where the mechanisms for planning and implementing deinstitutionalization that were developed in the 1980's are no longer are adequate to create the community capacity needed to get to the next level. Consequently, the task force created a Centralized Project Development Team to encourage the development of this capacity.

Utilizing this team, the provider community has the ability to propose special projects in their communities designed around the specialized needs of small groupings of people with similar needs who now live in the institution. This is a much more focused effort than the old strategy of fitting people into existing living options. It allows for and facilitates state-of-the-art thinking in our field to be implemented that transcends the old models of 8-bed group homes, and provides for more specialized environments than typical apartments in the community.

For example, my agency, Development Homes, Inc. just opened a newly constructed apartment building designed to house 5 young adults with autism spectrum disorders. This project is extremely unique in North Dakota; no other program exists that is specially designed to serve adults with autism. The building is designed to take into consideration the significant sensory needs of people with autism, and the staff have specialized training in autism.

DHI was fortunate to have the construction of this project, called "Columbia Place" funded almost entirely by HUD, which includes a tenant rental assistance contract. This was a very competitive grant process that was very cumbersome and time-consuming, taking over 3 years from start to finish. In order to more quickly develop new housing, such as new or remodeled duplexes, small group homes, or specialized apartment buildings, we need creative funding sources. NDACP has been in contact with officials from the Bank of North Dakota to review options for low-interest loans to augment those available from local lenders. We are hopeful that between existing programs like Flex Pace or by renewing the DD Loan Fund, which helped providers build our original group homes in the 1980's, we will be able to build the community capacity needed to serve the more specialized needs demonstrated by the next wave of deinstitutionalization.

Governor Dalrymple stated in his budget address that a society is best measured by the way it treats its most vulnerable. We are appreciative of the recognition of the citizens we serve and the thousands of people who work in this industry in North Dakota. Our collective quality of life is well-served by supporting all our citizens to contribute to community life. Thank you.

Testimony on SB 2012
Senate Appropriations Committee
January 18, 2011

Chairman Holmberg and members of the committee, my name is Jon Larson. I am the executive Director of Enable, Inc, a licensed service provider for people with intellectual disabilities in Bismarck and Mandan. I am also here today to testify on behalf of the North Dakota Association of Community Providers (NDACP).

I have been in my present position at Enable for nearly 27 years and I have seen many changes during that time, most of them positive. I want to express my appreciation for all the support the North Dakota Legislature has given to developmental disability service providers, especially in recent years. I also want you to know that your support makes a difference. North Dakota has reason to celebrate when it comes to services to people with intellectual disabilities. I want to mention just a few of those reasons.

The population at the Developmental Center in Grafton is projected to meet our goal of 95 people by July 01, 2011. Plans are in place to continue to place people in community settings, further reducing the number of people served in institutional settings.

Employee Turnover in provider agencies has been reduced to an average of 32.78%, down from an average of nearly 43% just two years ago. This has and will continue to improve the quality of service our consumers expect from us. Consistency in staff and the relationship building this provides, in my opinion, is the single most important thing we can to for the people we support. We still have a ways to go in this area.

Providers continue to meet national accreditation standards and are recognized for the quality of services they provide. All ND DD Service providers are accredited by the Council on Quality and Leadership, a national accreditation entity.

Utilization of new technology has created a more efficient method of sharing information enabling provider and state staff to share information and allow for more time for direct service delivery and quality improvement strategies. DD provider staff and regional and

state staff will soon have access to the same information about the people we support through a web-based software package called THERAP.

A review is underway of our reimbursement system that promises to change one of the most complicated provider payment systems in the country. A new payment system, when properly implemented should enhance creativity and reduce the administrative burden of operating our programs.

A strong provider association where information, education and best practices are shared among member agencies. Our association, NDACF, provides a venue for peer support and education within our state and with the state surrounding us.

A positive, constructive relationship with the Department of Human Services. This has created a problem resolution process that benefits the entire service delivery system.

While there are many reasons to be optimistic about our service delivery system, there continue to be challenges. One that I would like to explain a bit about is employee fringe benefits. DD providers are given an allowance of 33% of approved salary dollars to provide benefits for our employees. From this 33% DD providers must pay several mandatory benefits such as FICA taxes (7.65%), Workforce Safety Insurance, and Unemployment Compensation. This leaves approximately 20% of approved salary dollars to pay for "optional" benefits such as health insurance and pension plans. The rapidly rising cost of health insurance, often increasing over 10% a year, over the past several years has dramatically affected the health insurance coverage our employees receive. DD providers have been forced to increase deductibles, co-insurance amounts and to shift ever larger portions of the premium to their employees. This problem, of course is not unique to DD providers, but our reimbursement system limits the amount available to pay for these increasing costs.

We are asking that you consider adding 7.65% to our fringe benefit allowance to stem the steady erosion of health insurance benefits to our employees.

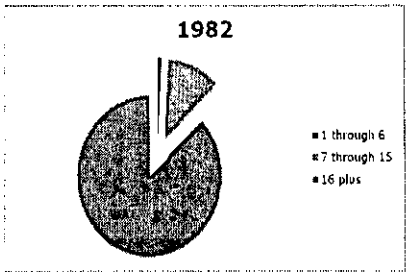
Again, thank-you for your continued support and for this opportunity to talk to you today. I would be glad to answer any questions you may have.

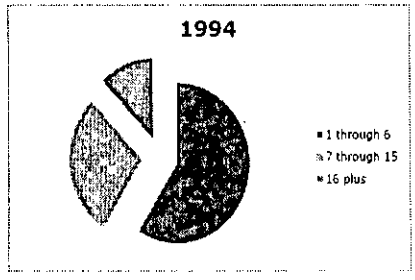
Jon Larson, Executive Director Enable, Inc.
North Dakota Association of Community Providers (NDACP)

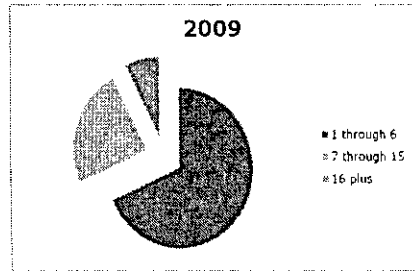
Senate Appropriations
January 18, 2011
SB 2012 – Department of Human Services
Testimony from Teresa Larsen, Protection & Advocacy Project

DEVELOPMENTAL DISABILITIES GRANTS

North Dakota's use of the Medicaid Waiver has expanded greatly over the years. This has been a good thing for people with developmental disabilities and the State, allowing for the use of federal dollars to help provide more residential services in non-institutional settings. As seen below, this has also meant the growth of smaller home sizes. In 1982, homes with 16-plus beds were "the norm". By 1994, these large homes became the smallest size of the total residential pie and their use has continued to shrink through fiscal year 2009. It is important to continue this trend with the goal of providing residential services to all individuals in small home settings.







Persons by Home Size				
	1-6 Persons	7-15 Persons	16-Plus Persons	TOTAL
1982	12	146	1,076	1,234
1994	1,093	535	226	1,854
2009	1,412	495	155	2,062

Residential Services for Persons with Developmental Disabilities: Status & Trends Through 2009; University of Minnesota; 2010

Regardless of the residential setting, providers for individuals with developmental disabilities have the goal of delivering quality services. In order to do so, adequate staff salaries and benefits are essential. Without these, we have seen turnover rates from 41% to 51% in the last ten years.

For the year ending June 30, 2010, salary increases were authorized at $1.00/hour along with a 6% inflationary increase for providers. This brought the turnover rate down under 33% and was a huge gain for providers and the individuals they serve. We need to stay on this path by providing another significant hourly increase as well as a benefit multiplier to cover increased health insurance premiums. Without this, we will go backwards, losing quality staff to other businesses.

P&A supports the $1.46/hour market adjustment for provider staff along with the 7.65% benefit multiplier. Thank you for your time and attention.

Categories:	*Total*	1-10 mi.	11-25 mi	26-35 mi	35+ mi	All subt. mi	checksum
		77%	15%	4%	4%		
Known		190	37	10	10	247	
Foreseeable		190	63	17	17	287	287
Worst Case		190	89	24	24	327	327
Per Unit Requested		$5.80	$13.15	$18.38	$20.48		
Per Visit Proj		$29	$65.75	$91.90	$102.40		
NF /Ind'l	159,551.2						
Per Bien /Ind'l		$9,048	$20,514	$28,672.80	$31,948.80		
Current	*$2,234,856*						DIFFERENCE
Known Pop'n	**$3,079,824.23**	**$1,720,839.12**	**$760,043.70**	**$283,287.26**	**$315,654.14**		**$844,968.23**
Foreseeable	$4,036,687.53	$1,720,839.12	$1,295,191.53	$482,750.22	$537,906.67		$1,801,831.53
Worst Case	*$4,993,550.84*	*$1,720,839.12*	$1,830,339.35	$682,213.18	$760,159.19		*$2,758,694.84*
Institutional $	*15,446,151.67*		10,073,577.18	2,686,287.247	2,686,287.247		

Actual cost to deliver services is $6.25 which may be addressed through inflation.

Travel Clients	
Known	*57*
Foreseeable	*97*
Worst Case	*137*

Estimated based upon 3 visits/wk & survey results; actual may be substantially lower

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Andrea Peña, Executive Director of the State Council on Developmental Disabilities. I am here today to provide you an overview of the Council's budget request.

Programs

The State Council on Developmental Disabilities administers the federal Developmental Disabilities Act Basic State Grant allocated to North Dakota. The Council directs this funding toward projects and activities that advocate policies and support programs which promote choice, independence, productivity, and inclusion for North Dakotans with developmental disabilities.

Program Trends / Major Program Changes

For the 2011-2013 biennium, the Council intends to continue to award grants to state and local private, nonprofit agencies and organizations. Activities under these grants will need to address at least one of four areas of emphasis identified as priorities in the Council's federally approved five-year plan. These priority areas include: Education and Early Intervention; Employment; Community Supports; and Quality Assurance. More specifically, grant-funded activities under these priority areas are intended to assist persons with Developmental Disabilities to:

- have access to services available in the community that affect their quality of life;

- get and keep employment consistent with their interests, abilities, and needs;
- reach their educational and developmental potential; and
- have the information, skills, opportunities, and supports needed to live free of abuse, neglect, exploitation, and violation of their human and legal rights.

Under its federally approved five-year plan for 2007-2011, the Council is responsible for tracking and annually reporting performance data on 26 performance outcome measures to the federal Administration on Developmental Disabilities. Among other performance outcome data, some of the Council's accomplishments for 2010 include:

- 148 people were trained in employment.
- 22 adults with disabilities in the state received jobs of their choice through Council efforts.
- 141 people became active in systems advocacy about community supports.
- 8 buildings/public accommodations became accessible.
- 819 people received training in quality assurance.
- 538 people were trained in leadership, self-advocacy, and self determination.
- 351 public policymakers were educated about issues related to Council initiatives.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	150,373	162,095	11,722
Operating	52,831	132,652	79,821
Grants	812,514	621,142	(191,372)
Total	1,015,718	915,889	(99,829)
Federal Funds	1,015,718	915,889	(99,829)

FTE	1.0	1.0	0

The DD Council's budget request is 100 percent federal funding.

The Salary and Wages line item increased by $11,722, which can be attributed to:

- $8,345 in federal funds to support the Governor's salary package for state employees.
- $1,711 in federal funds to support the second year employee increase for 24 months versus the 12 months that are contained in the current department budget proposal.
- $1,666 in federal funds which cover Council member meeting stipends. Stipends previously came out of the Operating line item.

The Operating line item increased by $79,821, which can be primarily attributed to:

- Personnel which will be contracted with to fulfill federal program requirements for the Council under the DD Act.

The greatest share of the Council's proposed budget continues to be allocated to the Grants line item. The grants line item decreased by $191,372, which can be attributed to:

- In the previous biennium, there were significant carryover monies which needed to be utilized or they would have been lost.

This concludes my testimony on the 2011 – 2013 budget request for the State Council on Developmental Disabilities. I would be happy to answer any questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Jan Engan, Director of the Aging Services Division with the Department of Human Services. I am here today to provide an overview of the Division's budget for the Department of Human Services.

Programs

The Aging Services Division provides home and community based service options to maintain individuals in their homes and communities and assists in protecting the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community. This includes administration of Older Americans Act federal funds, the Long-Term Care Ombudsman Program, the Guardianship Program for Vulnerable Adults, State Funds to Providers, Telecommunications Equipment Distribution Program, the Senior Community Service Employment Program, Qualified Service Provider Training, support for the Governor's Committee on Aging, Dementia Care Services, the Aging and Disability Resource-LINK, and the Aging and Disability Resource Center pilot grant.

The Aging Services Division is a federally designated single planning and services area, which requires the Division to carry out the responsibilities of the State Unit on Aging and the Area Agency on Aging as set forth in the Older Americans Act (OAA). Among the

28

requirements in the 2006 reauthorization of the OAA is the following: "require state agencies to promote the development and implementation of a state system of long-term care that enables older individuals to receive long-term care in home and community based settings in accordance with the individual's needs and preferences."

Caseload / Customer Base

The Graying of North Dakota brochure (Attachment 1) provides an outline of the aging demographic in North Dakota. More recent data taken from "Aging Is Everyone's Business" provides the following:

- In 2007, North Dakota counties ranked high in the percentage of population ages 60 and older.
- McIntosh County ranks number one in the nation among 3,142 counties for the highest percent of the population age 60 and older (42.8%) and number two in the nation for percent of population ages 85 and older (9.1%).
- North Dakota has 34% of the counties (18) with concentrations of 30% of individuals ages 60 and older compared to 4% of the counties nationwide.
- Between 2000 and 2020, the older adult population (60 and older) is expected to grow by about 43% while the child population (0-14 years) is expected to decline by 13.4% and the working population (15-64 years) is also expected to decline by 6.1%.
- A population shift of persons 60 years and older from rural North Dakota communities to urban North Dakota communities is expected from 2000 to 2030.

- In 2000, persons 60 years and older living in rural areas was 74,706 (63%) as compared to persons 60 years and older living in urban areas at 44,279 (37%).
- In 2020, this same age group will be about the same; 50% living in rural communities and 50% living in urban communities.
- By 2030, there is a population shift in this age group where 45% will be living in rural communities and 55% will live in urban communities.

- Growth is expected in the older population through 2050;
  - In 2011, the first Baby Boomer will reach age 65 (Baby Boomers include anyone born between 1946 and 1964).
  - In 2030, all Baby Boomers will be between ages 65 and 84 and the population 65 and older will comprise about 25% of North Dakota's total population.
  - In 2050, Baby Boomers will be age 85 and older.

In Federal Fiscal Year (FFY) 2009, 27,479 older persons received Older Americans Act funded services, which included home-delivered meals, congregate meals, information and assistance, outreach, health maintenance services, assistive safety devices, senior companion services, national family caregiver program services, legal services, vulnerable adult protective services, and long-term care ombudsman services.

See Attachment 2 for additional information about Older Americans Act Services.

FFY 2009 Program Utilization

Older Americans Act – Title III Programs		
SERVICE	UNITS OF SERVICE	
Congregate Meals	690,570 meals	1 unit= 1 meal
Home Delivered Meals	508,155 meals	1 unit= 1 meal
Health Maintenance	139,688 units	Set unit/procedure
Information & Assistance	1,655 units	1 unit = 1 contact
Legal Assistance	3,984 units	1 unit = 1 hour
Assistive Safety Devices	2,168 units	1 unit = 1 device
Outreach	86,145 units	Set unit/procedure
Senior Companion	4,534 units	1 unit = 1 contact

Family Caregiver Support Program	
Unduplicated Caregivers Served	453
Unduplicated Grandparents Served	7
Respite Care Provided	56,182 hours

Vulnerable Adults Program	
New Cases	530
Closed Cases	456
Information/referral	395
Brief Services (2 hrs or less)	231
Hours	5,689

Long-Term Care Ombudsman Program	
Number of Complaints	715
Number of Cases Opened	518

- The Qualified Service Provider (QSP) training program, under contract with Lake Region State College has trained 125 QSPs from July 2008 to June 2009 for the provision of in-home care. The training is provided by 29 nurses statewide. To enroll as a Qualified Service Provider, the individual must obtain documentation of competency. Documentation of competency requires a signature of a health care professional. Many QSPs choose to participate in the approved training program provided by Lake Region State College. Successful completion of the program provides the documentation of competency as signed by the nurse trainer. As of November 2010 there were 1,778 QSPs statewide which included 145 agencies. Of the 1,778 QSP's statewide, family home care or family personal care is provided by 368 QSPs, which means that those QSPs provide services to only one client (a family member).
- The Senior Community Service Employment Program (SCSEP) provided on-the-job training to 71 low-income individuals over the age of 55. The Division is contracting with Experience Works (formerly Green Thumb) to provide direct service to the enrollees. From July 1, 2009 to June 30, 2010; there were 26 placements to unsubsidized employment settings. Experience Works serves an additional 287 enrollees in North Dakota through a national contract with the Department of Labor.
- Dementia Care Services was implemented in January 2010 through the passage of House Bill 1043. The Division is contracting with the Alzheimer's Association of MN/ND to provide resources, assistance and support for citizens across North Dakota, in all geographic areas.

DEMENTIA CARE SERVICE January – September 2010	
Public Awareness/Training Activities	2,578 Individuals
Assessment/Care Consultations	344 Individuals
Caregiver Training	1,608 Individuals

The Alzheimer's Association has contracted with the Center for Rural Health to conduct the study and report the outcomes of the program; including the estimated long-term care and health care costs avoided, and the improvement in disease management and caregiver assistance.

- Implementation of the Aging and Disability Resource LINK (ADRC) www.carechoice.nd.gov (Attachment 3) completed the first phase of the "No Wrong Door" or single point of entry approach to services for older adults and persons with disabilities in North Dakota. Receipt of the Aging and Disability Resource Center – Options Counseling grant opened the second phase of this model implemented through a 3-year pilot starting in Region VII. This service delivery model is a process that does not duplicate existing services; nor does it replace the functions of other agencies, but instead strengthens the lines of communication (referral), establishes criteria for follow-up and brings community agencies together to build on existing services; to cross-train staff; to educate and inform the public; to network and enter into collaborative agreements that results in more effective and efficient service to older persons and persons with disabilities and to their families by providing a single point of entry for all persons seeking information and services. The ADRC process addresses gaps, avoids duplication and improves consumer access to service options and information. The roll-out of ADRC Options Counseling throughout the state will take place over the next two years; January 2011, Region II

will transition the outreach system to options counseling and this will be followed by Region I and VIII in January 2012; Region VII in September 2012 and Regions III, IV, V and VI in January 2013. The ADRC concept uses the person centered approach with three main functions: 1) information and awareness through public education and information on long-term support options; 2) assistance through long-term support options including counseling, referral, crisis intervention and planning for future needs; and 3) access through pre-eligibility screening for public pay services, comprehensive assessment and access to private pay services.

AGING & DISABILITY RESOUCE CENTER Pilot OPTIONS COUNSELING (9 mo. 4/10 - 12/10)	
Contacts made to ADRC	369
Contacts by Consumers	170
Contacts by Caregivers	73
Contacts by Professionals	123
Contacts by Other	3
Options Counseling Clients	70

Program Trends / Major Program Changes

- The increasing costs of providing nutrition services to include raw food costs and supplies; compliance with federal dietary requirements for congregate and home delivered meals; transportation costs for meal delivery; population shifts from rural to urban, as well as service needs in the sparsely populated rural and frontier communities; along with fairly flat federal funding have increased the burden on contract providers to meet expenses in providing services to older adults, specifically in the area of nutrition services.
- Through the expansion of various initiatives including Money Follows the Person and changes in the Minimum Data Set (MDS 3.0)

individuals needing long-term care services and support now have more choice in care options through home and community based services. Many studies have shown that consumers of long-term care services prefer to remain at home; to live with or near family; and to have the opportunity to maintain independence as supported by the ND Real Choice Systems Change Grant Rebalancing Initiative (9/04-9/07). The trend to keep persons in their homes and communities has increased the demand in the labor market for qualified service providers as evidenced by the increased use in the QSP program provided at Lake Region State College. During 2010 there is an average of 35 to 40 new QSP applications per week. The numbers support a significant turnover in this occupation as there is an increase in applications and persons trained yet the number on the QSP list does not fluctuate. The focus to provide services in the home and community is supported by increased federal initiatives such as Lifespan Respite, ADRC Nursing Home Transition and Diversion Program and the Veterans Directed Home and Community Based Services.

- As increased numbers of North Dakotans reach 80 years of age and older and since the incidence and prevalence of Alzheimer's disease and other related dementias increase with age, it is expected the number of individuals with these conditions will also grow rapidly. Estimates indicate there are about 18,000 North Dakotans with Alzheimer's disease being cared for by some 17,000 family members. Alzheimer's disease impacts the health and well-being of the recipient and also impacts the caregiver who report experiencing high levels of stress and negative effects on their health, employment, income and financial security. Continued efforts to provide access to assessments, referrals and information on services, caregiver training and

community education will be needed to sustain the ability of caregivers in their efforts to provide care needed in the home setting.

- The long-term care ombudsman program provides services to protect the health, safety, welfare and rights of residents living in nursing facilities, assisted living, swing bed, transitional care units and basic care facilities. State and Federal law address the requirements of the program. There has been an increase in both nursing facility and basic care beds and assisted living units in North Dakota. For example: Bismarck-Mandan increased nursing facility and basic care beds 21% from 2008 to 2009 with an additional increase of 14.5% in 2010; this community also increased assisted living units by 105% from 2008 to 2009 with an additional 4% increase expected in 2010.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	1,380,188	1,461,314	81,126
Operating	13,040,730	13,762,611	721,881
Grants	2,935,668	2,906,942	(28,726)
Total	17,356,586	18,130,867	774,281
General Funds	3,784,842	4,676,276	891,434
Federal Funds	13,261,552	13,174,591	(86,961)
Other Funds	310,192	280,000	(30,192)
Total	17,356,586	18,130,867	774,281
FTE	10	10	-

The Salary and Wages line item is increased by $81,126:

- An increase of $78,694 in total funds of which $78,696 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $25,750 in total funds of which $15,228 is general fund needed to fund the second year employee increase for 24

months versus the 12 months that are contained in the current budget.

- A decrease of $19,579 of federal funds which were included in salaries to cover a portion of existing salaries which will be moved from the ADRC demonstration project salaries to cover additional ADRC operating fees related to the purchase of services.
- The remaining net decrease of $3,739 is a combination of increases and decreases needed to sustain the salary of the 10 FTE in this area of the budget.

The Operating line item increased by $721,881 and is mainly a combination of the following increases and decreases:

- Travel increase of $49,716 ($17,099 general fund) is mainly attributed to the following:
  - An increase of $24,673 of federal funds for the ADRC demonstration project due to an increase of on-site visits;
  - An increase of $5,537 of federal funds related to increased activity in Ombudsman services due to additional Assisted Living facility visits;
  - An increase of $9,250 in Senior Employment due to additional federal funds available to complete mandatory training and increased monitoring activities;
  - An increase of $8,167 of which $4,718 is general fund in Administration due to increased training needs and monitoring activities.
- Net increase of $14,152 of which $7,849 is general fund for the Division and ADRC demonstration project expenses that include office supplies, printing, office equipment, repairs, insurance, IT, postage and telephone.

- Prairie Hills Plaza rent increase and office space for ADRC demonstration project for a total increase of $19,160 of which $16,043 is federal funds.
- Operating Fees and Services has a net increase of $642,402 that mainly includes the following:
  - An increase in federal funds of $99,967 related to the ADRC demonstration project (the $99,967 increase includes the $19,579 moved from salaries to operating fees and services);
  - An increase in federal funds of $35,000 related to increasing the funding available for QSP training;
  - A general fund increase of $83,468 for State Funds to Providers to continue the inflationary increase provided for in the 2009-2011 biennium and to provide a 3% per year inflationary increase in the 2011-2013 biennium;
  - An increase in federal funding of $115,607 in Title III-B Support;
  - An increase in federal funding of $235,796 for Home Delivered Meals;
  - An increase in federal funding of $71,454 for Family Caregiver Support;
  - An increase of $526,502 for congregate nutrition, $300,000 of the increase is from the general fund;
  - A decrease in federal funds of $485,000 due to the removal of ARRA funds of $325,000 related to congregate nutrition and $160,000 for home delivered nutrition;
  - A decrease in federal funds to the Nutrition Services Incentive Program of $45,384.

The Grants line item decreased by $28,726 and is a combination of the following increases and decreases:

- A federal funds increase of $41,274 in the Senior Employment program comprised of a decrease of $143,288 due to the removal of ARRA funds and an increase of $184,562 due to increased federal funding.
- A general fund increase of $10,000 for the Silver Haired Assembly.
- A decrease of $30,000 of other funds in Telecommunications Equipment because less authority is needed this biennium as a result of less tax being collected for distribution.
- A federal funds decrease of $50,000 due to Senior Legal Hotline federal grant ending.

This concludes my testimony on the 2011 – 2013 budget request for Aging Services Division of the Department. I would be happy to answer any questions.

Challenges for the Future

- Addressing healthy aging through disease prevention and health promotion.
- Continuing to support the needs of family caregivers.
- Providing an array of quality long-term care options, especially home and community-based services which many people report they prefer.
- Addressing the mental health needs of older persons.
- Providing consumers and their families easier access to services through information and development of "one stop shop" programs.
- Addressing the issue of the direct care service workforce and the value of older workers.

For Additional Information Contact
North Dakota Department of Human Services
Aging Services Division
1237 West Divide Avenue, Suite 6
Bismarck, ND 58501
www.nd.gov/dhs

To Locate Services:
ND Aging and Disability Resource-LINK:
1-800-451-8693
Searchable database:
www.carechoice.nd.gov
Email: carechoice@nd.gov

DN425

Attachment 1

The Graying of North Dakota

2000 - 2020

December 2008

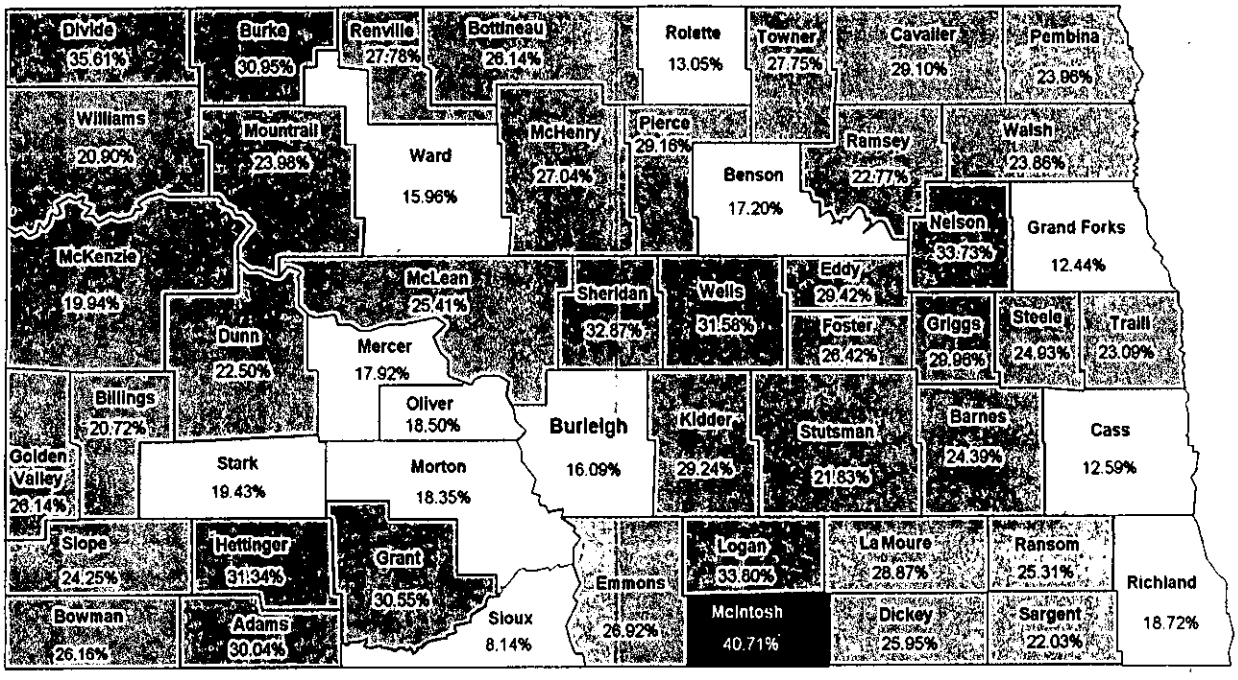
Percent Population Age 60 and

White: < 20%

Light Blue: 20 - 29%

Medium Blu

2000



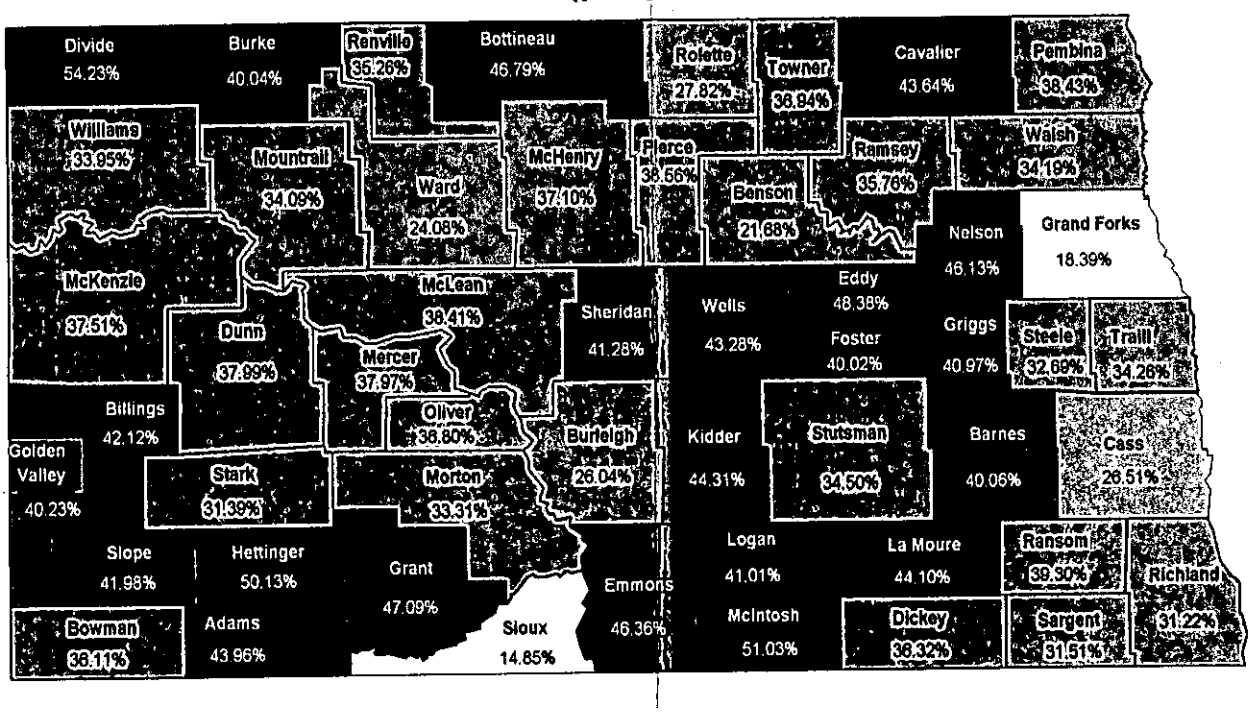
- **NORTH DAKOTA's** total popu[illegible]n in 20[illegible] was 642,200.
- **In 2000**, 118,985 (18.5%) persons in North Dakota were 60 years of age or older.
- **In 2000**, 16.3% of the U.S. population was 60 years of age or older.
- **In 2000**, fewer than 30% of persons in each of 43 counties in North Dakota were age 60 or older.
- **In 2000,** fewer than 20% of persons in each of 12 counties in North Dakota were age 60 or older.
- **In 2000**, only one county had more than 40% of its population age 60 or older.

SOURCE: File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July 1, 2004 to 2030, U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

Older in North Dakota Counties

30 - 39% Dark Blue: 40 - 49% Navy Blue: 50+ %

2020 (projected)



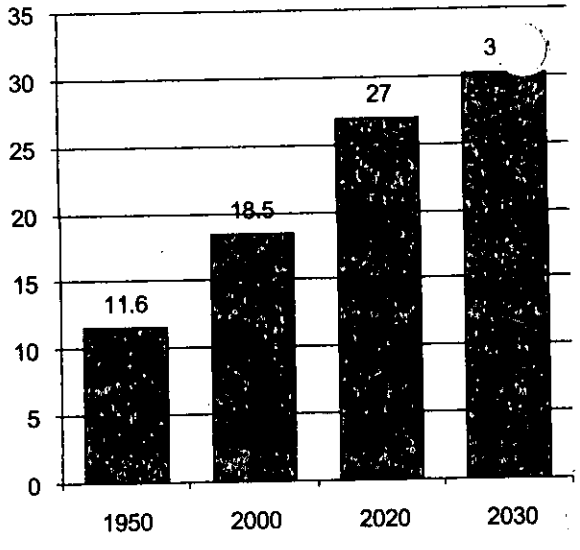
- **NORTH DAKOTA's** total populati[illegible]n 2020 [illegible]projected to be 630,112.
- **In 2020,** it is projected that 170,117 (27%) persons in North Dakota will be 60 years of age or older.
- **In 2020,** it is projected that 22.5% of the U.S. population will be 60 years of age or older.
- **In 2020,** only seven counties will have fewer than 30% of their population aged 60 or older. In two of those counties the percent of persons age 60 and older will be under 20%.
- **In 2020**, 22 counties will have more than 40% of their population aged 60 or older.
- **In 2020,** three counties will have more than 50% of their population age 60 or older.

Percent of the North Dakota Population 60 Years of Age and Older and 85 Years of Age and Older

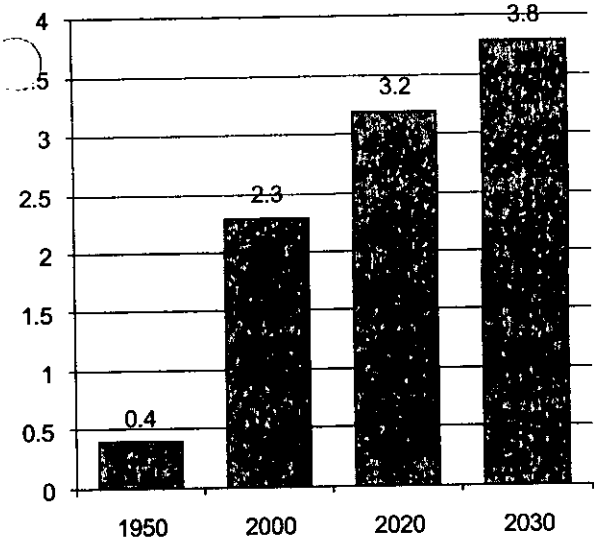
- **In 1950,** 72,050 (11.6%) of North Dakota residents were age 60 and older.
- **In 2000,** 118,985 (18.5%) of North Dakota residents were age 60 and older. The U.S. percent of residents age 60 and older was 16.3.
- **In 2020,** it is projected that 170,117 (27%) of North Dakota residents will be age 60 and older.
- **In 2030,** it is projected that 183,897 (30.3%) of North Dakota residents will be age 60 and older.

- **In 1950,** 2,262 (0.4%) of North Dakota residents were age 85 and older.
- **In 2000,** 14,726 (2.3%) of North Dakota residents were age 85 and older. The U.S. percent of residents age 85 and older was 1.5.
- **In 2020,** it is projected that 20,106 (3.2%) of North Dakota residents will be age 85 and older. The U.S. percent of residents age 85 and older is projected to be 1.9.
- **In 2030,** it is projected that 23,302 (3.8%) of North Dakota residents will be age 85 and older.

Percent ND Population Age 60 and Older



Percent ND Population Age 85 and Older



north dakota department of human services

Older Americans Act Services

Federal Fiscal Year 2009

Background

The Older Americans Act was signed into law July 14, 1965, for the purpose of improving the lives of older individuals in relation to income, housing, employment, long-term care, retirement, and community services. In addition to creating the Administration on Aging (AoA), the Act authorized grants to states for community planning, programs and services, and research, demonstration, and training projects in the field of aging.

The Department of Human Services' Aging Services Division serves as the single planning and service agency for older persons in North Dakota, as designated by the U.S. Department of Health and Human Services, AoA.

Eligibility

The Older Americans Act (OAA) provides funding for services for individuals age 60 and older. Services are not tied to income. Individuals must have an opportunity to contribute to the cost of the service, but no one can be denied service due to inability or unwillingness to contribute toward the cost.

Priority is given to serve older individuals who:

- Reside in rural areas
- Have low incomes/greatest economic and social needs
- Are considered to be of a minority
- Have limited English proficiency
- Have severe disabilities
- Are diagnosed with Alzheimer's disease and related disorders (*as well as, the caretakers of such individuals*)
- Are at risk of institutional placement

Individuals Served

- During Federal Fiscal Year 2009, a total of **27,479 older individuals** in North Dakota received services funded under the Older Americans Act.

OAA Requirements

Under this federal law, states are required to develop a comprehensive and coordinated system of home and community-based services that allows older individuals to lead independent, meaningful, and dignified lives in their own homes and communities.

To accomplish this, Older Americans Act funds, state funds, and local funds are coordinated to avoid duplication and maximize service. The Department of Human Services' Aging Services Division contracts with local providers for services.

OAA Services Provided

Assistive Safety Devices – A service that provides adaptive and preventive health aids that will assist individuals in their activities of safe daily living.

Senior Center/Congregate Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual eating in a group setting.

Home-Delivered Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual who is homebound and unable to prepare an adequate meal.

Health Maintenance Services – Services provided to assess and maintain the health and well being of older individuals. Services include blood pressure/pulse/rapid inspection, foot care, home visits, and medication set-up.

Outreach Services – Efforts to seek out older individuals and identify their needs and to then make appropriate referral and linkage to available services.

Senior Companion Services – A service that offers periodic companionship and non-medical support by volunteers (who receive a stipend) to older individuals that require assistance.

Continued on other side →

OAA Services (*Continued*)

Legal Assistance Services - Legal advice and representation are provided by an attorney to older individuals with economic or social needs and includes: 1) to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and 2) counseling or representation by a non-lawyer where permitted by law.

Information and Assistance - A service provided by the Department's **Aging and Disability Resource-LINK**, a nationwide toll-free number (**1-800-451-8693**), that provides information on a wide range of home and community-based and long term care and support services, volunteer opportunities, and benefits. Information can also be accessed on-line at http://www.carechoice.nd.gov/.

Senior Community Service Employment Program - Provides part-time employment opportunities in community service activities for unemployed low-income persons who are 55 years or older and who have fewer employment prospects.

Older Americans Act funds are also used to provide services through the:

- North Dakota Family Caregiver Support Program
- Long-Term Care Ombudsman Program
- Vulnerable Adult Protective Services Program

Separate fact sheets are available for each of the programs.

The Division also administers an **Aging and Disability Resource Center** demonstration grant funded by the Administration on Aging.

Federal Fiscal Year 2009 Older Americans Act Services

Number of Individuals Served/Units of Service Provided

Service	Individuals Served	Units of Service	
Assistive Safety Devices	1,397	2,168 devices	1 unit = 1 device
Congregate Meals	13,910	690,570 meals	1 unit = 1 meal
Home-Delivered Meals	5,364	508,155 meals	1 unit = 1 meal
Health Maintenance	4,579	139,688 units	Set billing units per service
Information & Assistance	1,655	1,655 units	1 unit = 1 contact
Legal Assistance	955	3,984 units	1 unit = 1 hour
Outreach	12,501	86,145 units	Set billing units per activity
Senior Companion	210	4,534 units	1 unit = 1 contact

Produced by: **N.D. Department of Human Services - Aging Services Division,** 1237 W Divide Ave, Suite 6, Bismarck N.D. 58501 Ph: 701-328-4601 TTY: 800-366-6888 www.nd.gov/dhs

12/2010

Attachment 3

NORTH DAKOTA AGING and DISABILITY Resource-LINK

Your Care Choice Connection to Aging and Disability Resources

What Options and Choices are Available for Seniors and Adults with Disabilities?



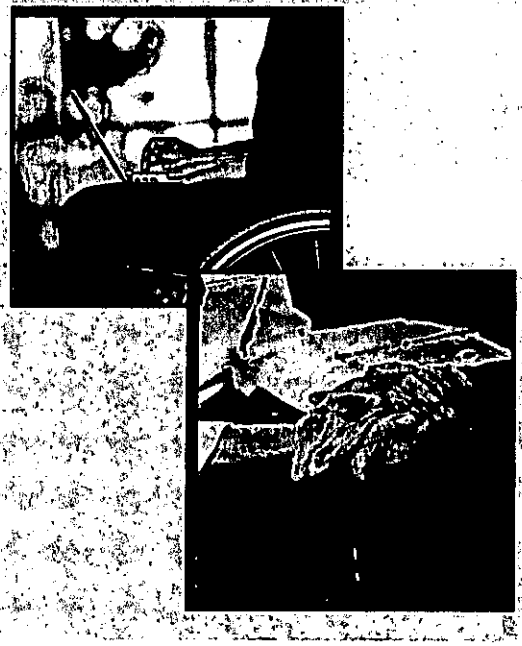
The North Dakota Department of Human Services' Aging and Disability Resource-LINK gives you and your family access to current information regarding the services available in your area.

Independence. Choice. Self-Direction.

What is the Aging and Disability Resource-LINK?

The Aging and Disability Resource-LINK is a free service to help you make decisions regarding the type of care you or your loved one might need and it links you to available services in your community to help meet those needs.

This service is available by phone (nationwide toll-free) from 8:00 AM until 5:00 PM CST, Monday through Friday. The phone is answered by an individual who has met the requirements of a Certified Information Resource Specialist for Aging (CIRS-A) through the national Alliance for Information and Referral Systems.



The Aging and Disability Resource-LINK also maintains a website which is updated on a regular basis and provides the same information available through our toll-free phone service.

Contact the North Dakota Aging and Disability Resource-LINK

Finding Care and Support in your Home and Community

What options are available?

Not all services listed in this brochure are available in every community. Some programs may be paid for by county, state or federal funds, while others may not. Our specialist can help by reviewing options available in your community so you can make informed decisions.

In - Home Care:



- Medication Management/Administration
- Health Monitoring
- Home Health Care
- Parish Nurse Programs
- Physical, Occupational and Speech Therapy Training
- Transfers and Mobility
- Meal Planning and Preparation
- Help with Eating, Bathing, Dressing, Toileting and other Personal Care Tasks



Homemaking Services:

- Shopping Assistance
- Meal Preparation
- Housekeeping

1.800.451.8693 or www.carechoice.nd.gov

Nutrition Services:

- Senior Dining Programs
- Home Delivered Meal Services
- Food Pantries



Delivery Services:

- Groceries
- Library Books
- Prescription Drugs

Federally Funded Program for Caregivers:

- ND Family Caregiver Support Program

  Provides counseling, training, respite care services



Federal, State and County Funded Programs for Individuals and Caregivers:

- Home and Community Based Services Programs

  Assistance with in-home services such as: personal care needs, housekeeping, money management, shopping, etc.



Resources for Coordinating Services:

- Information and Assistance
- Case Management
- Outreach
- Options Counseling

Contact the North Dakota Aging and Disability Resource-LINK



Adult Day Services:

- Adult Day Care Programs
- Respite Care Services
- Health Monitoring and Medication Administration
- Health, Nutritional and Social Services

Safety:

- Telephone Reassurance
- Home Injury Prevention
- Emergency Response Services
- Home Security Systems/Police or Fire Alert





Transportation:

- Public Transportation
- Non-Medical Transportation
- Senior Center Transportation Services
- Social Services Transportation Services
- Medical Transportation

1.800.451.8693 or www.carechoice.nd.gov

Social and Community Services:

- Senior Centers
- Services Sponsored by Religious Groups
- Special Interest Groups or Clubs
- Community Recreation Centers
- Counseling Centers and Support Groups
- Employment
- Volunteer Opportunities
    - ◊ Senior Companion Program
    - ◊ Foster Grandparent Program
    - ◊ Retired and Senior Volunteer Program (RSVP)



Home Maintenance and Modifications:

- Weatherization Program
- Chore Services
    - ◊ Lawn Care
    - ◊ Home Repairs
    - ◊ Snow Shoveling
- Home Accessibility
    - ◊ Ramps
    - ◊ Safety Bars
- Assistive Technology



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Housing Options:

- Independent Living Options
  - ◊ Accessible Housing Resources
  - ◊ Retirement Complexes
  - ◊ Supported Housing
- Low Income Housing
- Assisted Living Options
- Adult Family Foster Care
- Basic Care
- Skilled Nursing Home Care

Other types of assistance:

- Ombudsman Services (*Advocate for people in alternative care settings*)
- Vulnerable Adult Protective Services
- Legal Assistance
- Protection and Advocacy
- Consumer Assistance and Protection
- Financial Assistance
- Energy Assistance Program
- Prescription Drug Programs



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ND Department of Human Services
1237 W. Divide Avenue, Suite 6 • Bismarck, ND 58501

DN 938 (8/08)

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Tara Lea Muhlhauser, and I am the Director of Children and Family Services (CFS) in the Department of Human Services. I am here today to provide an overview of Division of Children and Family Services for the Department of Human Services.

Programs

- **Child Protective Services**: provides protection for children who have been or are at risk of being neglected and/or abused. Services provided include child protection assessments, case management, child fatality review, institutional child protection services and child abuse and neglect prevention programs.

- **Family Preservation Services**: provides therapeutic intervention to families whose children have been or are at risk of abuse, neglect and out-of-home placement. Services include parent aide, prime time child care, intensive in-home treatment services, respite care, family team decision making, family group conferencing and safety/permanency funds to prevent placement. This program places emphasis on preventing removal of children from their homes.

- **Foster Care Services**: provides a substitute temporary living environment for children who cannot safely remain with their families. Services include recruitment and retention of foster

homes; and licensing and placement services for relative homes, family foster homes, group homes, and residential child care facilities and licensed child placing agencies. This also includes foster care eligibility determination and payment, case planning and reviews, subsidized guardianship, and Interstate Compact on the Placement of Children, and services for Unaccompanied Minors. Independent Living services to assist transitioning youth, including skills assessment, training and stipends is another program area within foster care.

- **Adoption Services**: provides permanent adoptive homes for eligible children. Services include recruitment, adoption assessment, placement, follow-up services, post adoption services, adoption subsidy, birth family services, adoption search, licensure of child placing agencies, and the Interstate Compact on the Placement of Children for Adoption.

- **Early Childhood Services**: coordinates activities, establishes standards, and provides training to providers of early childhood care and education. Services include licensing, child care resource and referral, providing consultation to the tribes on licensing, and coordination through the Head Start Collaboration Office.

All these services are **provided either by the county social service agencies or through contracts with non-profit providers** with a focus on the safety, permanency, and well-being of children and their families.

Caseloads/Customer Base

The number of **Child Abuse and Neglect assessments** completed for federal fiscal year (FFY) 2010 was 3887, a slight decrease from FFY 2009.

The daily snapshot of **children in foster care** on 9/30/10 was 1,131 children in comparison to the daily snapshot on 12/31/09 which included 1,018 children. This snapshot includes tribal IV-E cases, Division of Juvenile Services (DJS) youth placed in foster care, and pre-adoptive placements. Approximately 35.5% of these children are Native American (402 children) in the most recent daily snapshot.

As of December, 2010, 25 youth were placed out-of-state in institutional care. This number has varied slightly throughout the year with a low of 24 and a high of 32. This number has continued to decline in the past two years.

The number of foster children gaining permanency through subsidized adoption has increased over the last three years and this trend is projected to continue through the 2011-13 biennium. Of the 160 finalized adoptions in FFY 2010, 109 were special needs adoptions with 71% of these children adopted by foster parents.

At current, there are an average of 39 guardianship payments per month during state fiscal year (SFY) 2010. In both 2008 and 2009, payments were made to 36 children (average) a year.

At present we have 33 youth receiving foster care services as unaccompanied minors. In the past year, CFS transferred administration of the Refuge Services Program to Lutheran Social Services of North

Dakota. Federal requirements provide that the state foster care administrator must retain administration of the Unaccompanied Minor Program.

Program Trends/Major Program Changes

CFS continues to place emphasis on safety, permanency and well-being of children across all programs in the division. **Family preservation programs** and **involvement of relatives and kin** when children are in need of placement, during service delivery and during reunification efforts are central to our work in achieving this emphasis. In September 2008, a new federal law, P.L. 110-351 "Fostering Connections" brought us several new federal requirements. These requirements related to notification of relatives when a child is placed in care, and guidance for involving school, medical providers, relatives and other services providers in providing a comprehensive plan for a child while in care, and at the time of transition to adulthood from care. This requirement also placed emphasis on placing siblings together and working diligently to locate and maintain family connections for children involved with child welfare services.

The second **Federal Child and Family Services Review (CFSR) in North Dakota took place in April 2008.** North Dakota did not reach "substantial conformity" (e.g. we did not pass). The second national round of the reviews was just completed in 2010 and no state has yet passed the CFSR in either the first or second round of federal reviews. All states in this category must develop a Performance Improvement Plan (PIP) in negotiation with federal partners. While we were noted in this recent round to have many strengths and a few challenges, our performance did require a PIP. The ND PIP was formalized in June of 2010 and we have two years to complete the work in this plan. Work of

this plan is focused around further refinement of the Wraparound Case Practice Model for child welfare practice. North Dakota was recently notified by our federal partners in December that we have met all the national data standards, a significant indicator of positive changes in practice outcomes for the state.

Family Preservation programs and prevention services (to prevent child abuse and neglect or to prevent child placement) continue to be a primary focus of the work of CFS. When foster care placements occur we emphasize placement with relatives and reunification efforts to keep the child(ren) connected with families and in close proximity to relatives.

Services in this program area include **Family Group Decision Making** available to most county social services agencies, the Division of Juvenile Services and the tribes. This service brings family members to the table to develop a plan for children who are either in foster care, at risk of being placed in foster care, or children who are being cared for by their extended family. This also brings significant people in the life of the child(ren) together to discuss how to maintain and build family connections. In 2009-2010 there were 215 referrals with 136 conferences completed. A new pilot program, Family Team Decision-making (FTDM), recently began and will provide an early opportunity (either immediately prior to placement or immediately upon removal) to bring families and agency personnel to the table with a neutral facilitator to make plans and seek opportunities to maintain safety and reduce the need for removal. The pilot sites for this work are in Burleigh/Morton and Cass counties. This differs from Family Group Decision Making in that it is an expedited process that can happen more quickly to address emergent issues such as emergency removals. This is a promising practice

nationally with positive outcomes targeted to reducing foster care placements and enhancing the engagement of parents in protecting and maintaining relationships with their children.

Over the past three years we have worked hard with our IT partners to develop a new component to our **child welfare data system**. This new system, FRAME, allows us to take the current individual program applications, streamline and connect them. Development was targeted to reduce duplication and create ease in using all the programs developed for safety, permanency and well-being together; enhancing program and data links. FRAME and the data warehouse will also support the generation of usable and accessible data to assist with data-driven decision making for child welfare programs in the Division. This new system was launched in December of 2009 and is in use for all child welfare programs. While the overall development and rollout went smoothly, we continue to work with the community of FRAME users to troubleshoot and resolve FRAME system issues.

There are still significant challenges in the **availability of child care** across the state. There are currently 1422 licensed early childhood programs in the state (Family-394, Group-844, Center-139, School-age-45) with a licensed capacity of 33,100 children. The proportion of North Dakota mothers (with children ages 0 to 5) in the labor force was 76.1% and rises to 84.9% for mothers with older children (ages 6 to 17) in 2009. Current national and state-level data indicate that these proportions have changed little since 2000. This has created a demand for assurances of safety in childcare settings and the need to provide training opportunities for this large workforce industry in North Dakota.

This industry includes workers in home-based and center-based care settings.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Salary and Wages	2,578,175	2,555,408	(22,767)
Operating	5,817,823	5,744,630	(73,193)
Grants	120,930,241	126,793,961	5,863,720
Total	129,326,239	135,093,999	5,767,760
General Fund	25,060,229	31,053,237	5,993,008
Federal Funds	85,194,925	82,978,058	(2,216,867)
Other Funds	19,071,085	21,062,704	1,991,619
Total	129,326,239	135,093,999	5,767,760
FTE	17.0	17.0	0.0

The Salary and Wages line item decreased by ($22,767) and can be attributed to the following:

- $129,923 in total funds of which $65,838 is general fund to fund the Governor's salary package for state employees.
- $50,357 in total funds of which $33,085 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- A decrease of ($30,117) due to retirement payouts during the 2009-2011 biennium. There are no retirements anticipated for the 2011-2013 biennium.
- A decrease of ($82,904) due to appropriations for child care background check fees to be paid to the Attorney General's office from Senate Bill 2162 in the 2009-2011 legislative session inadvertently included in the salary line. A

corresponding increase is included in the operating line later on in my testimony.

- A decrease of ($90,026) is the result of transitions in key positions and retirements of key personnel as well as a combination of increases and decreases needed to sustain the salary of the 17.0 FTE in this area of the budget

The Operating line item decreased by ($73,193) and is a combination of the increases expected next biennium which are offset by decreases, with the majority of changes as follows:

- A decrease in travel ($93,068). This decrease is attributed to use of technology tools to facilitate meetings without travel costs, including polycom and webinar meetings.
- A decrease in professional development ($67,862) was made using creativity and internal resources to conduct a peer review process.
- An increase in background checks $95,988 for adoption, foster care and child care checks, with a corresponding decrease in salaries and wages.

The Grants line item increased by $5,863,720 which can be mainly attributed to the following:

- An increase in subsidized adoption caseload and cost per case, as well as a 3 % inflationary increase each year of the biennium for an overall program increase of $2,361,638 of which $2,156,749 is general fund. The large general fund increase is mainly due to the change in FMAP, and an increase in caseload for non IV-E eligible adoptions.
- An increase in the foster care caseload and cost per case, as well as a 3% inflationary increase for foster care providers

each year of the biennium for an overall program increase of $8,761,251 of which $5,160,076 is general fund.

- Increase of $377,253 of which all are general fund for 5 additional child abuse and neglect assessments per month and a 3% inflationary increase for each year of the biennium.
- A ($4,514,667) decrease of one-time ARRA funding for Foster Care Subsidized employment ($870,667) and Child Care Grants (House Bill 1418 of the 2009-2011 legislative session appropriated $3,644,000 for the Quality Rating Improvement System).
- A ($2,722,300) decrease of federal Refugee Assistance grants that were moved to Lutheran Social Services.
- A $1,689,992 increase for County administration reimbursement all of which are federal and other funds.
- Attachment A lists all the grants and compares the cost & caseload of the 2009-2011 appropriation to the 2011-2013 budget to the Senate for Foster Care & Adoption grants.

The general fund request increased by $5,993,008 with 44% of that increase ($2,662,910) related to the 3% inflationary increase. The remaining increase of $3,330,098 is associated with the increase in the grant changes described above.

The net change of the federal and other funds is a result of the increases & decreases noted above.

This concludes my testimony on the 2011-2013 budget requests for CFS. I would be happy to answer any questions.

Children & Family Services

Listing of All Grants:

Child Abuse & Prevention Activities	$	2,200,000
Independent Living Programs	$	1,100,000
Refugee Grants	$	1,200,000
Child Care Licensing Payments to Counties	$	700,000
Child Care grants to nonprofit Agencies	$	3,000,000
Child Abuse/Neglect Assessment Payments to Counties	$	6,000,000
Reimbursement to Counties for Administration of Child Welfare Programs	$	11,700,000
Family Preservation & Family Services Grants	$	11,200,000
Training Child Welfare Professionals and Family Foster Parents	$	1,900,000
Subsidized Adoption Grants	$	20,200,000
Foster Care Maintenance, Therapeutic and Subsidized Guardianship	$	67,600,000

Cost & Caseload Comparison
2011-2013 Biennium to Senate
Compared to 2009-2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference - Increase (Decrease)	2009-2011 Budgeted Avg Monthy Cost per Case	2011-2013 Budgeted Avg Monthy Cost per Case	Difference - Increase (Decrease)
Therapeutic Foster Care	242	245	3	1,095.20	1,080.65	(14.55)
Services Foster Care	196	217	21	545.15	688.51	143.36
Foster Care - Family Homes	523	597	74	1,677.99	1,705.35	27.36
Foster Care - RCCF & GH	252	264	12	4,755.12	5,238.70	483.58
Subsidized Adoptions	992	1,073	81	749.11	785.11	36.00

Attachment A

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am JoAnne Hoesel, Division Director from the Department of Human Services. I am here today to provide you an overview of the Division of Mental Health & Substance Abuse Services.

Programs

The Division of Mental Health & Substance Abuse provides regulation, grants management, reporting, technical assistance, training, and development and implementation of appropriate mental health & substance abuse services throughout the state. This division also is charged with department-wide data analysis and research support. In addition, I serve as the Chairperson of the Governing Board of the North Dakota State Hospital. Division staff provide support to the Mental Health Planning Council in its required oversight for the statewide plan for mental health services. The division is also charged with writing both annual federal block grants for mental health treatment and promotion and substance abuse prevention and treatment, and the grant for individuals in transition from homelessness. The division is responsible for the annual Synar study and report which measures compliance in tobacco sales.

Service programs directly managed by the Division are compulsive gambling treatment, community-based high-risk sex offender treatment, statewide prevention specialists, and long-term methamphetamine & other controlled substance residential treatment.

The Division manages the Governor's Prevention Advisory Council and I serve as the chairperson. This Council, established by executive order in 2007, leads multisystem prevention efforts drawing upon the resources and talents at the community, state, and federal levels. The Division also manages the Autism Spectrum Disorder (ASD) Task Force formed through 2009 legislation and as its chairperson, facilitated the initial state plan for ASD in 2010. The Prevention Resource & Media Center (PRMC) is a clearinghouse and library providing free materials and resources to North Dakota residents regarding substance abuse prevention.

Caseload / Customer Base

During SFY 2010 the public mental health system provided services to 14,465 children, youth, and adults and the public substance abuse system provided services to 4,542 adolescents and adults. The Division licenses 81 substance abuse treatment programs, 37 DUI seminar providers, eight regional human service centers, and six psychiatric residential treatment facilities for children and adolescents.

Program Trends

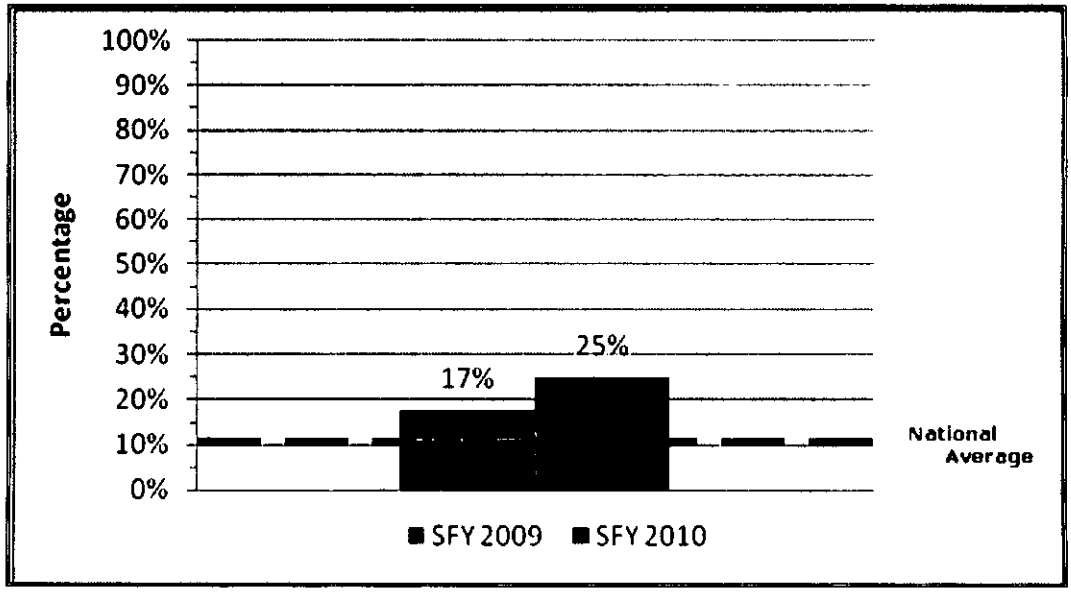
Individualized treatment approaches and outcome reporting

With the advancement of research, effective medication management, public education, targeted services methods, focus on service outcomes, North Dakota's public system offers a broad array of services many of which can be individualized to best meet the needs of the clients leading to best outcomes.

What we know about effective treatment services has expanded greatly over the last years. Several of these evidenced-based methods are implemented and showing positive results. Methods are

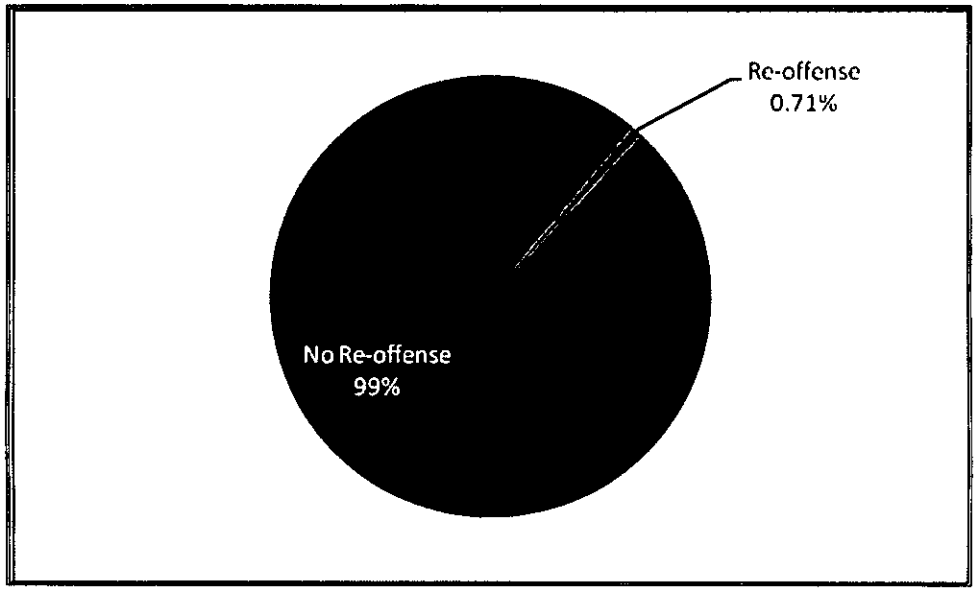
currently in place to treat individuals addicted to methamphetamine and opiates, those who have experienced traumatic situations, those with both a severe mental illness and a chronic substance abuse disorder, those who have never had employment due to their mental illness or substance abuse disorders, and those who are new to recovery.

Employment increases for individuals with serious mental illness.



Percent of adults in North Dakota who receive public mental health services, are diagnosed with a serious mental illness, and are employed. Source: FY 2011 Community Mental Health Services Block Grant Application for the State of North Dakota.

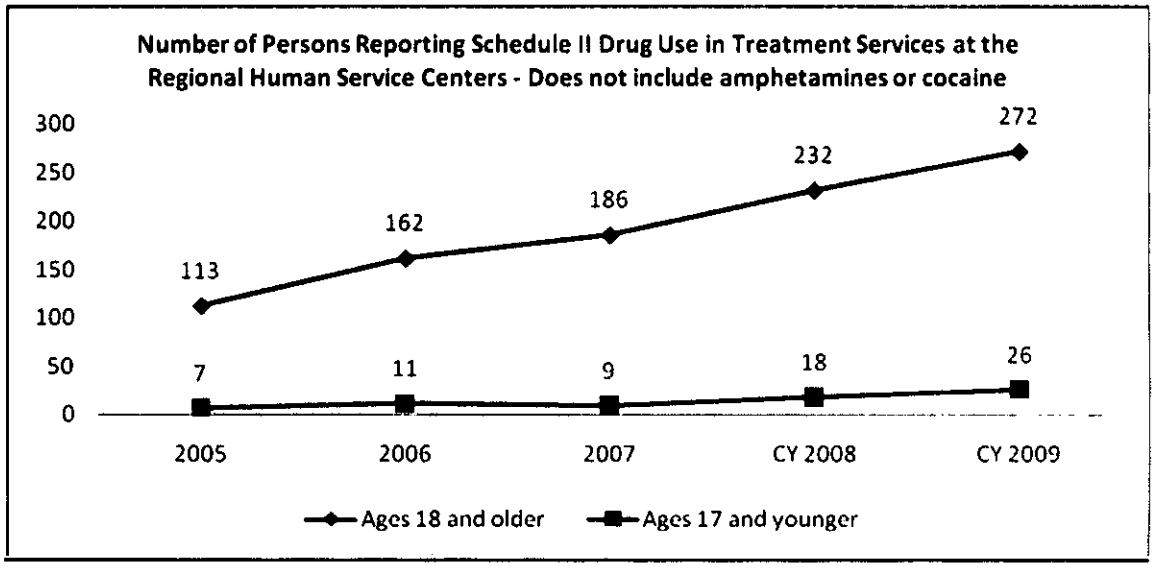
High Risk Sex Offender Treatment Program – Recidivism Rate

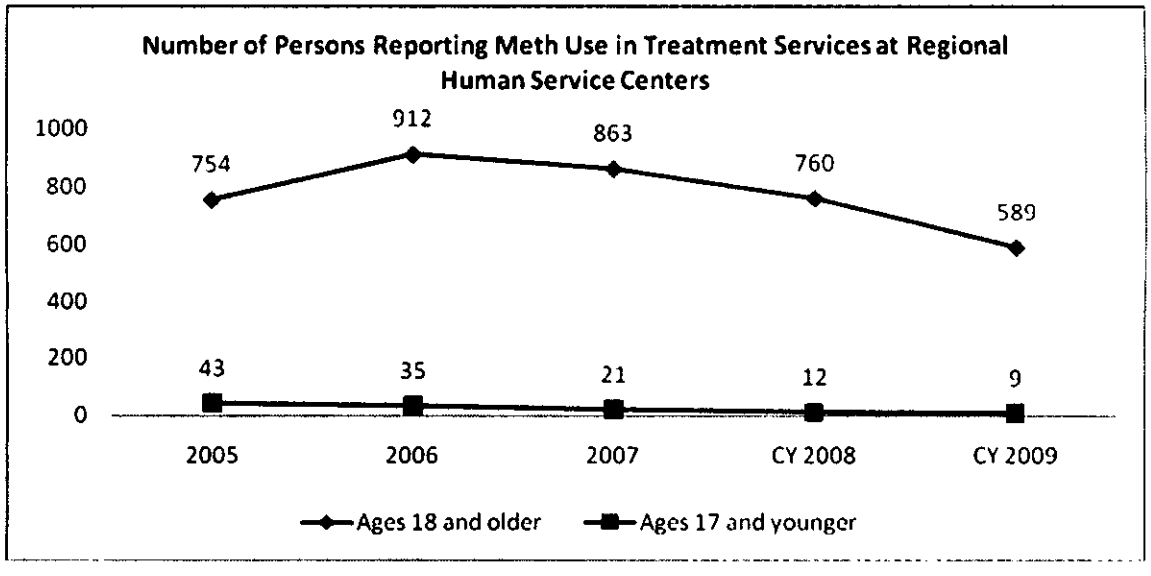


Since the program's inception, 1 out of 140 individuals in the program have had a sexual re-offense. That is 0.71% of the total population involved with treatment.

Prescription Drug Abuse Climbing

Prescription drugs that are abused or used for nonmedical reasons can alter brain activity and lead to dependence. Commonly abused classes of prescription drugs include opioids (often prescribed to treat pain), central nervous system depressants (often prescribed to treat anxiety and sleep disorders), and stimulants (prescribed to treat narcolepsy, ADHD, and obesity).


Number of Persons Reporting Schedule II Drug Use in Treatment Services at the Regional Human Service Centers - Does not include amphetamines or cocaine
300
250
200
150
100
50
0
113
162
186
232
272
7
11
9
18
26
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger


Number of Persons Reporting Meth Use in Treatment Services at Regional Human Service Centers
1000
800
600
400
200
0
754
912
863
760
589
43
35
21
12
9
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger

Substance Use Trends

Rank	1/1/2005-12/31/2005		1/1/2008 – 12/31/2008		1/1/2009-12/31/2009		1/1/2010-9/30/2010	
#1	Alcohol	55.6%	Alcohol	59.6%	Alcohol	59.3%	Alcohol	58.3%
#2	Marijuana	21.4%	Marijuana	25.8%	Marijuana	27.8%	Marijuana	27.4%
#3	Meth	13.3%	Meth	7.3%	Meth	5.2%	Opiates	6.1%
#4	Other Amph	4.6%	Opiates	4.1%	Opiates	4.8%	Meth	5.6%

Using 2005 as the baseline year, alcohol continues to be the primary substance reported by those in treatment. Marijuana continues to hold second place but in 2010 opiates are now in third place followed by methamphetamine.

This trend line reflects regional trends except for Northwest, Southeast, and Southcentral, where methamphetamine is in third place and opiates in fourth.

Major Program Changes

1. Extended Services

This division, along with the Vocational Rehabilitation Division, is reviewing the current method of providing employment supports for those with mental illness, traumatic brain injuries, and types of autistic disorders. Over the next months, the Division will work with consumers and providers to arrive at best methods to support individual employment goals. Most people who work show improvement in their mental health and greater satisfaction with their lives. With the national unemployment rate for persons with serious mental illnesses hovering at 90 percent, the goal is to positively impact this outcome for North Dakotans with targeted adjustments to this program.

2. Substance Abuse Prevention System Changes

North Dakota has among the highest rates in the nation in recent alcohol use and binge drinking, regardless of age group. For example, among North Dakotans aged 12 to 20 years old, 40 percent consumed alcohol in the past 30 days and 29.5 percent engaged in binge drinking use in the last 30 days (Hughes et al., 2009) North Dakotans rank near the bottom among U.S. states regarding the percentage of persons who perceive great harm associated with consuming five or more drinks at a time once or twice a week (Hughes et al., 2009).

Alcohol Consequences

- In 2009, 5,819 arrests were made for driving under the influence of alcohol.
- It is estimated that 23 percent of assaults, 30 percent of physical assaults, and three percent of burglaries are related to alcohol use. (SAMHSA, 2006b).
- In March 2010, upon admission to the ND State Penitentiary, 77% of males and 74% of females had a drug and/or alcohol abuse/dependence diagnosis. (DOCR)
- 46.1% of all arrests in 2008 were for DUI, liquor law, and drug abuse violations. (BCI, 2009)

Domestic violence, alcohol spectrum disorder (fetal alcohol syndrome), alcohol-related motor vehicle crashes and fatalities, school expulsions, and mortality rates all have significant ties to alcohol use.

North Dakota's underage drinking and binge drinking numbers are not changing. There is a saying that "If you keep doing what you've been

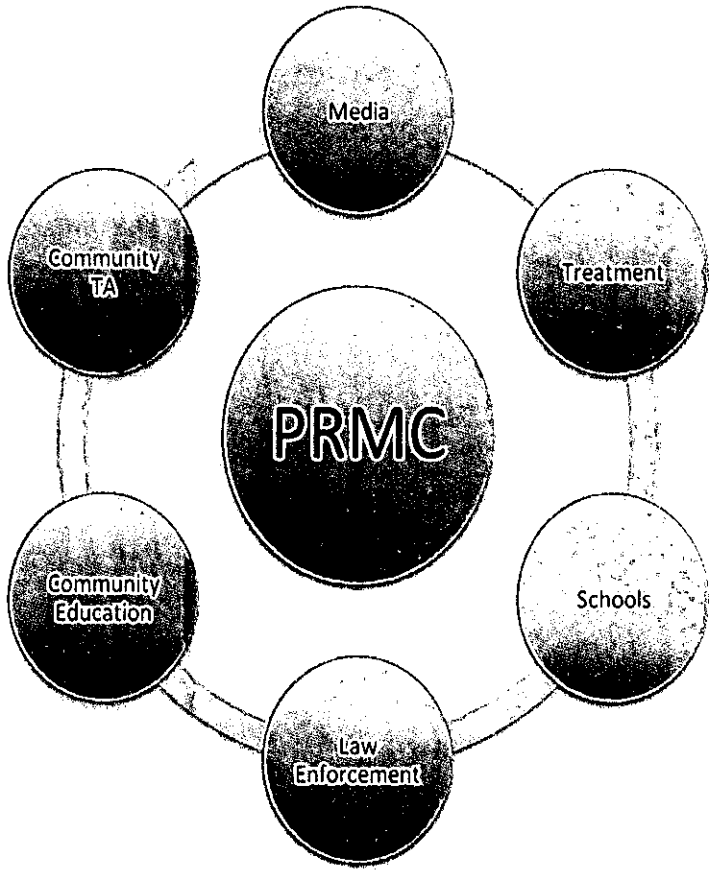
doing, you keep getting what you've been getting". So we have changed the entire prevention system. This is what's happening:

Completed a Statewide readiness survey

- The readiness survey showed that some North Dakotans hear these numbers and recognize that alcohol and other drug use is a local problem, but there is no immediate motivation to do anything about it.
- From this survey and related information, each region and Tribal area will have their own data booklet to drive decisions on the best prevention strategies.

Transformed from a regional –based system to a role-based prevention system

- The substance abuse prevention system has been coalition-based for over 15 years. Prior to 2004, there were 75 substance abuse community coalitions in North Dakota, in 2010, there were 22 coalitions statewide. The previous infrastructure was based on locating one coordinator in each of eight regions. This coordinator was identified as the overall expert in prevention. With the current system, communities have the time and talents of staff in the areas of law enforcement, media, treatment, education, and local level expertise. The specialists are able to identify and implement effective prevention strategies customized to each communities needs.



Transformed the prevention resource and media center (PRMC) from a passive library to an active media and resource-rich center for communities

- The PRMC has campaigns, toolkits, and resource guides on alcohol, prescription drugs, server training, refusal skills, community prevention ideas, plus supplies and information for prevention activities held around the state.

Use of environmental prevention strategies

- Historically, alcohol education and prevention has focused on changing behavior of individuals. The thought being: if people know risks, they will change behavior. This is not the case.

- Environmental prevention targets entire communities rather than individuals. It has the potential to bring sustainable reductions to problems. (Attachment A)
- By making changes in the environment, people are given better choices. Tobacco use reduction uses environmental prevention strategies. By reducing where people can use tobacco, significant reductions in tobacco have occurred.
- A 14 year old, if given a choice between an apple and a Snickers bar, will most likely choose the Snickers bar. But if the choice is between an apple and a cheese stick, they have been provided with better choices. This is an environmental strategy.
- A Serving-Size campaign planned for this spring is based on environmental change. A drink is not a drink – is not a drink. By choosing a 6 oz glass of wine versus a Long Island tea, a person has consumed one drink versus the equivalent of five drinks.
- Currently, five communities are involved in the 'targeted' community initiative, where the resources from the statewide team are individualized to their culture and needs.
- 40 communities chose to participate in new ways to address the culture of drinking in North Dakota.

This was all done with cost neutrality and the entire process involves tracking impact and outcomes.

<u>Strategic Prevention Framework State Incentive Grant</u>

- DHS was recently awarded a prevention grant applied for three years ago, that was initially denied. The strategic prevention framework state incentive grant's (SPF-SIG) will move 85% of

the grant funds to targeted communities using prevention strategies. With this national grant award, all 50 states now have a SPF-SIG grant. The SPF-SIG is advised by the Governor's prevention advisory council. The grant's structure requires the prevention process described earlier but will help condense the time to implement across the state and enable significant resources to move to communities. Communities will walk through five phases of strategic planning, implementation and evaluation grounded in prevention science.

- This one time grant and the prevention framework described will impact the state by combining strategic consultation, training, and research-based tools.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase/ Decrease
Salary and Wages	2,489,443	3,592,202	1,102,759
Operating	8,637,130	11,687,985	3,050,855
Grants	2,382,446	4,445,584	2,063,138
Total	13,509,019	19,725,771	6,216,752
General Fund	6,180,518	7,128,641	948,123
Federal Funds	6,743,842	12,026,270	5,282,428
Other Funds	584,659	570,860	(13,799)
Total	13,509,019	19,725,771	6,216,752
FTE	18.00	24.00	6.00

The Salary and Wages line item increased by $1,102,759 and can be attributed to the following:

- $189,556 in total funds of which $63,938 is general fund needed to fund the Governor's salary package for state employees.

- $49,827 in total funds of which $32,764 is general fund needed to fund the second-year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $837,637 in federal funds represents a move from the operating-purchase of service contract area in the 2009-2011 biennium to six (6) FTE in salary for prevention specialists.
- The remaining increase of $25,739 includes a combination of increases and decreases needed to sustain the salary of 24 FTE in this area of the budget.

The Operating line item shows a net increase of $3,050,855 for a variety of reasons:

- Increase in travel of $82,944 driven by the move from the operating-purchase of service contract area for the prevention specialists. All federal funds.
- Decrease of $155,717 in supplies and a decrease of $88,569 in miscellaneous supplies are both driven by the loss of the Safe & Drug Free Schools and Communities grant and increased use of electronic and web-based resources which is all federal funds.
- Increase of $60,340 in printing is driven by the change in the prevention system previously paid through contract which is all federal funds.
- Decrease of $43,274 in Professional Development driven by the loss of the Safe and Drug Free Schools and Communities grant which is all federal funds.
- Increase of $3,180,088 of federal funds in operating fees and services which is a result of being awarded the strategic prevention framework grant.

Grants

The Grants line shows a net $2,063,138 increase of which 86.6% is federal funds. The increase is mainly due to a combination of reasons; with the major driving force being spending authority for the next traumatic brain injury grant ($1,069,397) anticipated to be submitted in the next biennium and an increase in extended services which purchases job coaching for individuals with serious mental illness ($755,383). In addition, $230,923 is due to contracts previously in the operating line being more correctly reflected as grants.

This concludes my testimony on the 2011 – 2013 budget request for Division Mental Health & Substance Abuse Services. I would be happy to answer any questions.

ENVIRONMENTAL PREVENTION

Environmental Prevention involves changing the environment in which alcohol-related problems (such as drinking and driving, binge drinking, and underage drinking) occur. But what does it mean to "change the environment?" One way to explain the concept of Environmental Prevention is to first identify what it is ***not***:

- It is ***not*** focused on changing individual behavior(s) through education and treatment.
- It is ***not*** "prohibition" of alcohol in the community.
- It is ***not*** condemning those who drink or sell alcohol responsibly.
- It is ***not*** eliminating personal responsibility for those whose behavior causes damage or injury to others.

Instead, the Environmental Prevention approach works to modify community conditions that condone and/or encourage unhealthy and unsafe behaviors.

Environmental Prevention requires a new way of thinking on the part of prevention professionals. In this case it involves:

- Rejecting the assumption that, "We can't change things because this is how it is, and always will be!"
- Critically examining those aspects of our society that support or sustain alcohol-related problems.
- A willingness to do things differently.
- Insisting that policy makers and law enforcement work together with community groups so changes will have significant and sustainable effects on the problem.
- Holding accountable all those who profit from irresponsible alcohol sales and use.
- Supporting those responsible for making and enforcing alcohol-related laws/policies.
- No longer solely blaming kids for underage drinking and related problems.

Ultimately, Environmental Prevention is based on the fact that people's behavior is powerfully shaped by their environment. Environmental Prevention considers four areas of concern or causal factors: social availability of alcohol, retail availability of alcohol, criminal justice, and promotion of alcohol.

Just look at the change in public attitudes toward seatbelts and smoking. Environmental Prevention Campaigns related to both these issues have created a dramatic cultural shift in thinking and behavior that has had a positive effect on public health and safety throughout the United States.

Environmental Prevention targets entire communities rather than individuals. That way, it has the potential to bring about enduring reductions in the problems. Still, it is not a quick fix; it may require several years or even a generation to see the changes occur, but these changes are generally permanent and dramatic.

north dakota department of human services

North Dakota Prevention Resource and Media Center

Institute for Public Strategies for the Montana Community Change Project (March 2009)
"Environmental Prevention: An Approach to Reducing Drinking and Driving and Binge Drinking in Montana"

north dakota department of human services

MISSION:

The ND prevention system provides innovative, quality, and culturally appropriate substance abuse prevention infrastructure, strategies, and resources to the individuals and communities in North Dakota.

SERVICES:

Prevention specialists are available to provide technical assistance to:

COMMUNITIES

LAW ENFORCEMENT

SCHOOLS

CRIMINAL JUSTICE ENTITIES

MEDIA

WORKPLACES

SUBSTANCE ABUSE PROFESSIONALS

FOCUS:

North Dakota data identifies six priorities:

1. Increasing awareness of substance abuse issues
2. Alcohol abuse among adults
3. Alcohol use/abuse among underage youth
4. Inhalant abuse
5. Prescription drug abuse
6. Marijuana

To contact a specialist, visit
www.nd.gov/dhs/prevention

NORTH DAKOTA PREVENTION RESOURCE AND MEDIA CENTER

We are a **FREE** resource to North Dakota residents

OUR MISSION IS TO:

Increase community awareness of substance abuse prevention by providing innovative, quality, and culturally appropriate information to the residents of North Dakota

WHAT WE OFFER:

Pamphlets • Activity Books • Posters • DVDs
Games • Kits • Toolkits • and more!

VISIT OUR WEBSITE:

www.nd.gov/dhs/prevention

PREVENTION E-NEWSLETTER:

A timely e-mail newsletter covering substance abuse prevention news briefs, new resources, and event announcements

To sign up, go to: **www.nd.gov/dhs/prevention**

CONTACT US AT:

Prevention Resource and Media Center
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P: 701-328-8919
F: 701-328-8979
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www.nd.gov/dhs/prevention

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Tina Bay, Director of the Developmental Disabilities Division of the Department of Human Services. I am here today to provide you an overview of the Developmental Disabilities Division, for the Department of Human Services.

Programs

The Developmental Disabilities Division is made up of 9 FTEs who are responsible for the needs assessment, staff training, development of policy, quality assurance, compliance with federal oversight agency rules, and service monitoring functions relating to the provision of home and community based services for individuals who have a developmental disability, as well as children who are at risk of developmental delays.

Division staff interact regularly with the developmental disability staff at the regional human service centers, the Developmental Center, federal agency representatives, school systems, universities, consumer advocates, and a variety of public and private entities that play a vital role in the delivery system and monitoring of services.

Caseload / Customer Base

In SFY 2010, 5,341 individuals received developmental disability program management through the human service centers, and

7,746 Right Track screenings were completed for infants and toddlers birth to three years of age at risk for developmental delays.

412 wards were served through the Catholic Charities Corporate guardianship for SFY 2010.

Program Trends / Major Program Changes

Increased federal accountability requirements and oversight – Centers for Medicare and Medicaid Services (CMS) has placed greater emphasis on providing evidence of compliance with the health and welfare assurances required in the Medicaid waivers. CMS has become more prescriptive, requires more state reporting, and requires more oversight of providers on the part of the state.

During the 2009 Legislative Session, HB 1556 directed the Department to contract with an independent contractor to study the methodology and calculations for the rate setting structure used by the Department to reimburse public and private providers. Through workgroups that included the independent contractor, stakeholders and Department staff, a recommendation was made to change from a cost-based reimbursement system to a prospective reimbursement system.

ARRA Funding – the Division will continue work on 3 contracts that are utilizing ARRA Funding through September 30, 2011, if approved by the Legislature. The contracts are for a data base for the Right Track program, technical assistance which includes the development of training modules and the development of informational materials for families and other stakeholders concerning the importance of early intervention.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase/ Decrease
Salary and Wages	1,186,236	1,387,140	200,904
Operating	7,573,440	7,350,535	(222,905)
Grants	166,767	438,207	271,440
Total	8,926,443	9,175,882	249,439
General Fund	2,947,015	3,151,429	204,414
Federal Funds	5,969,513	5,874,450	(95,063)
Other Funds	9,915	150,003	140,088
Total	8,926,443	9,175,882	249,439
FTE	9.00	9.00	0.00

The Salary and Wages line item increased by $200,904 and can be attributed to the following:

- $66,260 in total funds of which $23,980 is general fund needed to fund the Governor's salary package for state employees.
- $24,731 in total funds of which $17,199 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- During the biennium, the Department recognized an increased need in this division and moved an FTE internally to accommodate this priority. Increased federal requirements from CMS led to this need. The position resulted in an additional need of $115,989 in total funds for salary and fringes of which $39,149 is general fund.
- The remaining decrease of $6,076 includes a combination of increases and decreases to sustain the salary of 9 FTE in this area of the budget.

The Operating line item decreased by $222,905 and can be attributed to the following:

- Increase in travel of $226,309, of which $200,075 is for Part C, which is all federal funds and the remaining $26,234 of which $8,820 is general fund. This increase reflects additional visits and monitoring of regions and additional training for DD Program Managers working with the Part C program.
- Increase of supplies/material-professional of $47,500 of which $46,500 is for Part C for resource library materials, which is all federal funds.
- Increase in other equipment under $5,000 of $136,917 for additional equipment to allow for in home hearing screenings, which are all federal funds.
- Increase of repairs of $29,283 for maintenance agreements for the equipment described above, which is all federal funds.
- Increase in rental/leases of $15,335 due to an increase in rent at Prairie Hills Plaza and the addition of new office space due to the restructuring of the division, of which $4,517 is general fund.
- Decrease of $651,600 in operating fees and services. The increases and decreases are as follows:
    - Decrease of $1,690,000 due to the reduction of ARRA funds, which is all federal funds
    - Increase of $76,740 for other miscellaneous contracts, of which $25,803 is general fund.
    - Increase of $273,279 for the Catholic Charities Corporate Guardianship contract for the 3% and 3% inflationary increases, and for additional staff needed due to new accreditation rules, and to fund the second year of the 6% inflationary increase for 24 months versus the 12 months that

were contained in the current budget, of which all is general fund.

  - $122,227 increase in our fiscal agent contract as the demand for self directed supports continues to rise.
  - $65,690 increase for Right Track screenings due to an increase in assessments, which is all federal funds.
  - Increase of $500,464 due to contracts being added to the Divisions budget that were previously paid at the human service center level, of which is all federal funds.
- Decrease of $16,977 for professional fees due to the cost for administrative hearings being included in the department's legal unit. $6,642 of this decrease is general fund.
- Decrease of $9,672 in supplies, printing, postage and other office administrative costs.

The Grants line item increased by $271,440 due to the following reasons:

- Increase of $200,000 to reflect contracts that were previously included in the operating line but are more correctly reflected as grants. The authority has been moved from the operating line to grants. All of these funds are federal funds.
- Increase of $71,440 due to an increase in an agreement with Protection and Advocacy to conduct follow up investigations, all of which is federal funds.

This concludes my testimony on the 2011 – 2013 budget request for Developmental Disabilities Division area of the Department. I would be happy to answer any questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 18, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Russell Cusack, Vocational Rehabilitation Director with the Department of Human Services. I am here today to provide an overview of programs and services that make up the budget request for the Vocational Rehabilitation Division for the Department of Human Services.

Programs

The Division of Vocational Rehabilitation contains two units: Vocational Rehabilitation and Disability Determination Services.

The Vocational Rehabilitation Unit (VR) is made up of 11 FTEs responsible for the administration of Titles I, VI and VII of the Rehabilitation Act as amended. As such, the staff is responsible for the needs assessment, staff training, state plan development and outcome monitoring, development of policy, quality assurance, client advocacy through the Client Assistance Program, oversight of expenditure of federal VR funds, and compliance with federal rules. To carry out these responsibilities, the VR policy division staff interact regularly with the Vocational Rehabilitation staff residing in the human service centers, and with community businesses, schools and universities, Job Service, the State Rehabilitation Council, the State Independent Living Council, centers for independent living, federal oversight agencies, and other private and public entities involved in rehabilitation service. The services are funded through federal funds received through the U.S. Department of Education and Rehabilitation Services Administration, along with the required

general fund match. The federal portion of the funding is over 78.7%; the state match comprises just under 21.3% of the budget.

The Disability Determination Unit includes 24 FTEs responsible for individual eligibility determination for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) statewide. The staff review claims from the local Social Security offices, gather supporting data, and determine whether an individual meets the criteria to receive federal benefits. The funding for this program is 100% federal funds.

Caseload / Customer Base

Vocational Rehabilitation – Federal Fiscal Year 2010

- 6,992 individuals received employment services through VR.
- 10,662 individuals received independent living services.
- 1,074 individuals were served through the Older Blind Program.
- 170 is the average caseload size for a VR counselor.

Disability Determination Unit

- 5,898 eligibility determinations were made for SSDI/SSI benefits.

Program Trends / Major Program Changes

Vocational Rehabilitation continues to see a high percentage of youth apply and receive services. Thirty five (35) percent of the DVR caseload are youth that experience disabilities. The percentage of youth served remained consistent during the past five years. The division has actively outreached to school districts, community providers, the Department of Public Instruction, and Job Service to develop outreach efforts to teach these youth about the employment possibilities in North Dakota. The emphasis of this outreach has been tailored to connecting youth with the support services they need to be successful in job training and to realize

that many occupations are available with two years or less vocational training. The division proposes to continue this activity as well as support the efforts of the human service center transition coordinators to enhance the independence of youth.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase/ Decrease
Salary and Wages	4,244,123	4,672,532	428,409
Operating	2,065,906	2,049,230	(16,676)
Grants	21,396,891	20,558,631	(838,260)
Total	27,706,920	27,280,393	(426,527)
General Fund	4,844,905	4,859,126	14,221
Federal Funds	22,770,553	22,326,268	(444,285)
Other Funds	91,462	94,999	3,537
Total	27,706,920	27,280,393	(426,527)
FTE	35.00	35.00	0.00

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $428,409 and can be attributed to the following:

- $247,351 in total funds of which $17,614 is general fund needed to fund the Governor's salary package for state employees.
- $57,114 in total funds of which $13,377 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $32,741 to provide for the annual and sick leave lump sum payouts for three FTE expected to retire of which $27,120 is federal funds and $5,621 general fund.
- $38,880 which is all federal funds to provide for salary increase for four FTEs that underwent reclassifications.

- The remaining $52,323 includes a combination of increases and decreases needed to sustain the salary of 35 FTE in this area of the budget.

The Operating line item decreased by $16,676 (.8%) and is a combination of the increases expected next biennium which is offset by decreases as follows:

- Increase of $39,976 for medical consultant contracts for DDS in order to complete the number of disability claims required by the federal Social Security Administration.
- Increase of $15,185 for professional development activities for non-state and state employees to attend regional and national meetings.
- Increase of $50,191 in rent at Prairie Hills Plaza.
- Increase of $56,797 in travel to required federal meetings.
- Decrease of $32,164 in the purchase of assistive technology devices for client use.
- Decrease of $8,309 in office supplies, office technology service and postage.
- Decrease of $31,264 in other one-time equipment purchases.
- Decrease of $95,019 in operating fees and services reflecting the removal of one-time ARRA contracts.
- Decrease of $12,069 lease cost for copiers.

The Grants line item decreased by $838,260 (3.9%). This funding is used to support the efforts to increase awareness of Assistive Technology; to continue focus through Vocational Rehabilitation on outreach to youth; and, to support the efforts of the DDS to make timely eligibility determinations for North Dakotans with disabilities.

- Increase of $187,522 to support the Interagency Program Assistive Technology (IPAT). All federal funds due to the availability of carryover federal funds.
- Increase of $260,000 for contractual services that provide soft-skill training and vocational assessment activities to clients. This training serves to improve skills that include communication, problem-solving and time management.
- Increase of $102,500 for youth transition activities that support summer youth employment.
- Increase of $151,944 for client service related to increased cost for academic and vocational technical school training.
- Increase of $257,100 for DDS payments due to the increase in the volume of claims. This is all federal funds.
- Increase of $80,000 for extended service based on the increase in number of clients that require this current method of providing employment supports. These clients are the most significantly disabled experiencing a mental illness, traumatic brain injuries, and intellectual disabilities.
- Increase of $110,000 for supported employment because of increased usage of providers. This is all federal funds.
- Increase of $5,000 to support the blind vendor program.
- Decrease of $18,501 to purchase equipment for the administration of the older blind program.
- Decrease of $1,976,995 in one time ARRA funding.

This concludes my testimony on the 2011 – 2013 budget request for the Vocational Rehabilitation area of the Department. I would be happy to answer any questions.



North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

January 19, 2011

Dear Chairman Holmberg and Members of the Senate Appropriations Committee:

I am Dr. Emmet M. Kenney, Jr., a Child and Adolescent and General Psychiatrist. I am here today to speak on behalf of Prairie St. John's and the North Dakota Hospital Association, of which I am a member of the Governing Board. We are here to speak in strong support for Senate Bill 2012 and recommend your passage of this bill.

I wish to speak specifically to the mental health and substance abuse portions of this bill. Under the leadership of Executive Director Carol Olson, the Department of Human Services undertook Stakeholders' Meetings in both the eastern and western parts of the state beginning last winter. They carefully considered the input of providers and consumers of mental health and addictions treatment in making recommendations to Governor Dalrymple for his budget proposal. Governor Dalrymple's budget contains a realistic affirmation of where we are currently at in the State of North Dakota in the provision of psychiatric and addictions care and where we need to go. Highlights of this bill as it pertains to mental health and addictions:

1. Supports community-based treatment. Community-based treatment is less expensive and more accessible to North Dakota citizens than the alternative of simply funding treatment at the Jamestown State Hospital or various Human Service Centers. It is more respectful of patient choice, and leverages the available resources in communities beyond those currently provided by DHS HSCs.

2. It provides for services to be according to the patient's level of need. Therefore, expanded services such as residential treatment or crisis services could be offered as an alternative to the more expensive and more time constrictive hospital services that currently fill the gap when clinic level care alone is not appropriate for the patient populations.

3. Operates in fairness to providers already providing mandated care without payment, so they have an opportunity to partake in a contractual relationship for providing these services to North Dakota citizens.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

We also recommend appropriation of the "IMD Demonstration Pilot Project." This would make North Dakota one of five states leading in determining in a forward-looking demonstration project whether or not there are truly decreased expenses and better quality of outcomes for people with mental illness and addictions when they have funding in free-standing treatment facilities. This brings revenue into the State, helps offset some expenses already being incurred during the grant period, and may help facilitate access to further treatment for those in need, across the nation.

In summary, we strongly urge you to issue a "do pass" recommendation on this important legislation of Senate Bill 2012, with an amendment to include the IMD Demonstration Pilot Project. I am happy to address any questions that you may have.

Sincerely,

Emmet M. Kenney, Jr., M.D.

Senate Appropriations Committee
Testimony on Senate Bill 2012
Senator Ray Holmberg – Chairman
January 18, 2011

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Larry Bernhardt and I am the Executive Director of Catholic Charities North Dakota (CCND) and I am respectfully asking your committee to approve increased funding for corporate guardianship services for people with developmental disabilities.

CCND has been providing corporate guardianship services on behalf of people with developmental disabilities since 1987. Corporate guardianship is an integral part of the service system that is in place for individuals with developmental disabilities. It is a fundamental core service – just as we need residential and vocational services, we need guardianship services. The court appoints a guardian if the person is unable to make or communicate responsible decisions. Because a person's decision making skills are compromised, he or she is at risk of neglect, abuse and exploitation. Corporate guardianship services are essential if no one is available or appropriate to serve as guardian. Through the provision of guardianship services, we are able to intervene as necessary to ensure that our wards' basic needs are met, that they have an appropriate place to live, that they have access to ongoing medical care and that they are receiving necessary support services. It is our responsibility, as guardians, to support and assist each ward to be a fully participating member of the community and society.

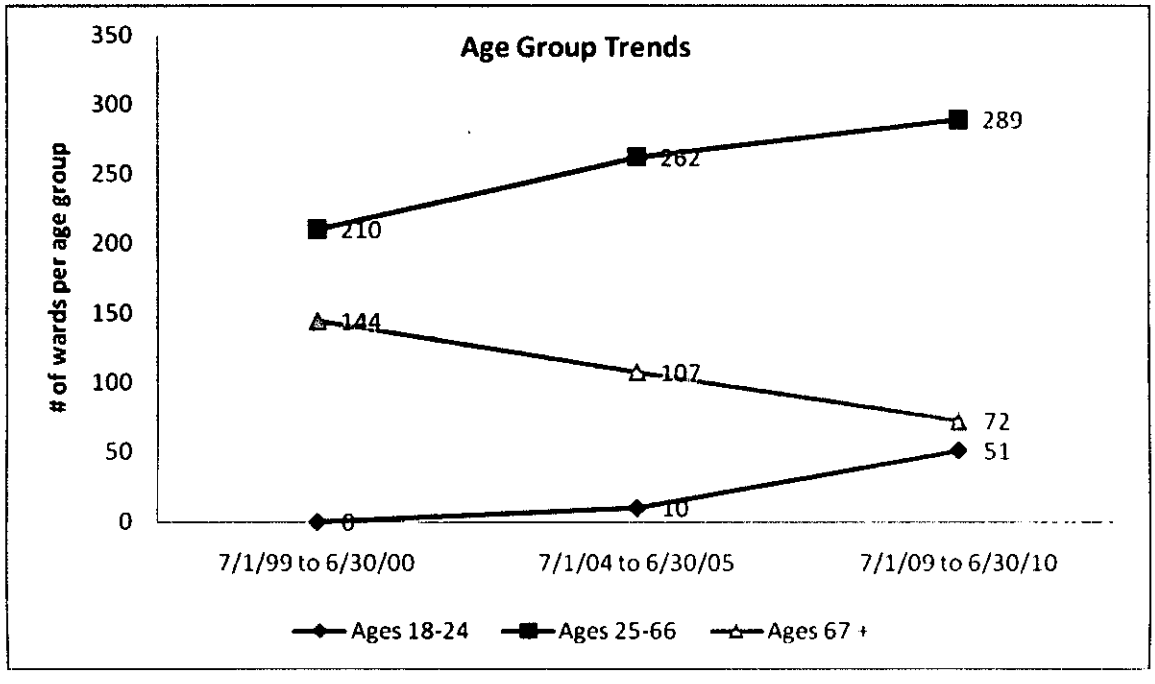
Corporate guardianship's line item within the DHS budget for next biennium will not meet the needs of our wards in three (3) key areas:

1) Due to the complex needs of our wards, the intensity of their service needs and accreditation standards, a decrease in the size of the caseloads of our guardianship workers is necessary;
2) The 2007 and 2009 legislative appropriation of $29,750 no longer adequately covers the legal costs related to the establishment of guardianships;
3) Because of a great number of referrals, it is highly possible that a waiting list for services will need to be established before the end of this biennium.

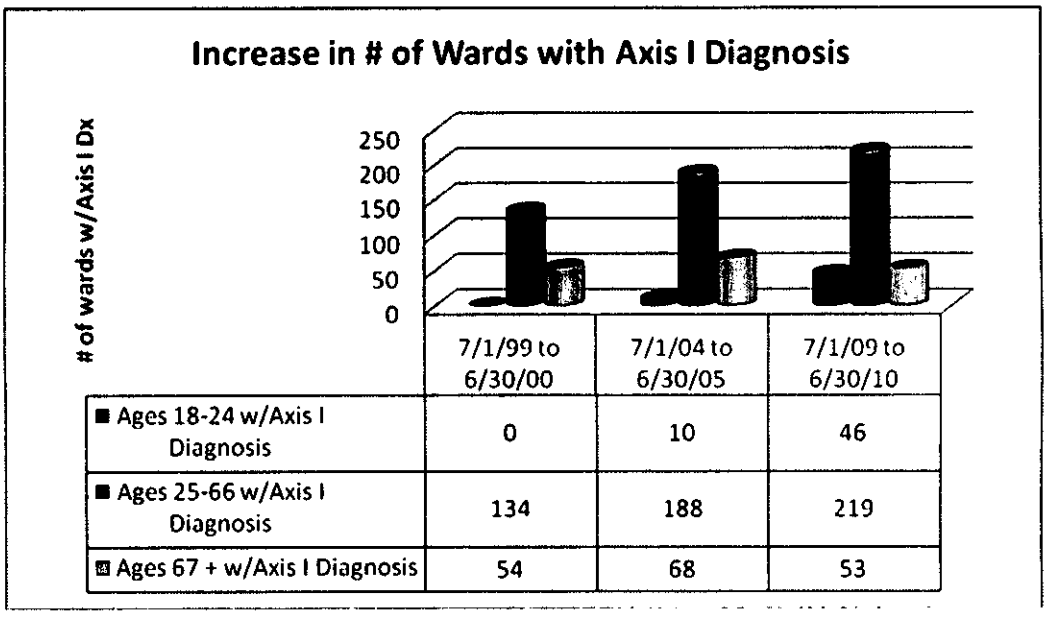
1) Increased service needs and caseload size:

Since 2002, our corporate guardianship program has seen an increase in the behavioral, psychiatric, chemical dependency, sexual health, legal and supervision needs of our wards. This places heavy demands on our guardianship workers.

- From 7/1/99 to 6/30/00, our guardianship program had no wards between the ages of 18 to 24. From 7/1/09 to 6/30/10, we served as guardian for 51 wards between the ages of 18 to 24.



- Wards in this age group typically have needs that are very time intensive because of psychiatric concerns, behavioral difficulties, alcohol/drug use, sexual health and legal issues. Because of complex needs, frequent team meetings are the norm as well as frequent face to face visits. Guardianship workers can expect numerous contacts with psychiatrists, psychologists, physicians, family members, attorneys, landlords and law enforcement.



(Axis I disorders are clinical mental health conditions that warrant clinical treatment such as anxiety, depression, or Bipolar disorder. These disorders usually disrupt a person's ability to function adequately and left untreated can lead to problems in work, school, family, etc.)

- During the past several years, there has been a significant increase in the number of family members who are upset that the courts have appointed a corporate guardian for their son, daughter or sibling (all ages not just the age group of 18 to 24). Disgruntled family members place a high demand on our guardianship workers in terms of time, effort and energy.
- Overall, the complexity of cases has changed a great deal over the past 23 years. Twenty years ago, the majority of our wards resided at the Developmental Center, nursing homes and group homes. During the past decade, the shift has been to Individualized Supported Living Arrangements (ISLA), Supported Living Arrangements (SLA), Transitional Community Living Facilities (TCLF) and Minimally Supervised Living Arrangements (MSLA) which translates to more independence and decreased supervision. The shift to increased independence results in more personal autonomy but also more exposure to sexual exploitation or abuse, financial exploitation and abuse, self neglect or

abuse and legal problems. Again, this places more demands on our guardianship workers' time.

- During the past decade our accreditation agency (Council on Accreditation) has dramatically increased our paperwork requirements to document accountability and the quality of our services.
- Medicaid changes, special needs trusts, tribal trusts and other complex financial activities have placed considerable responsibilities on our guardianship workers as they must spend numerous hours completing research before a decision can be made.

As guardians, it is our court appointed responsibility to assist our wards in being as independent and autonomous as possible while minimizing their risk of abuse, neglect and exploitation. Our ability to protect our vulnerable wards from harm is compromised because our staff to client ratio is too high. As of 7/1/09, our ratio was 1:40. The Council on Accreditation (our accrediting agency) has set this ratio at 1:20. We feel that a ratio of 1:34 would be much more realistic in terms of meeting our clients' needs and providing quality services. To meet the complex needs of our wards and to take into account the large geographical area that must be covered, we received approval in November 2009 from DHS to hire two (2) half-time guardianship workers utilizing roll up from our contract and an increase in the amount of the allowable guardianship fees through Medicaid for certain wards. This reduced our ratio to 1:36. We are very grateful to Brenda Weisz, JoAnne Hoesel, John Bole, Michael Marum and Curtis Volesky for authorizing this creative funding solution. We are extremely pleased that funding for the two half-time guardianship workers has been included in the Governor's budget for the next biennium. However, to achieve a caseload of 34 wards per full-time guardianship worker, supplementary funding to hire an additional full-time guardianship worker is requested.

2) Petitioning costs:

The 2007 and 2009 Legislature allocated $29,750 for petitioning costs for indigent people with developmental disabilities who are referred to our program. Petitioning costs

include the fees for the petitioning attorney, guardian ad litem attorney, court visitor and, on occasion, a fee for the proposed ward's doctor or psychologist. The actual amount spent on petitioning costs during the 2007-2009 biennium was $37,618.19. Eighteen (18) months into the 2009-2011 biennium, petitioning costs amount to $38,742.83 on behalf of 38 wards. At this rate, it is projected that petitioning costs may exceed $51,657 ($38,742.83 ÷ 18 months X 24 months) this biennium. There are two primary reasons for the increased petitioning costs: more guardianship cases are contested by the proposed ward or their family causing the attorneys and court visitors to spend more billable hours on those particular cases; and, in general, attorney and court visitor fees have increased for routine guardianship cases. To offset the increase in petitioning expenses, we are respectfully requesting that the appropriation for petitioning costs be increased from $29,750 to $51,657.

3) Need for additional openings:

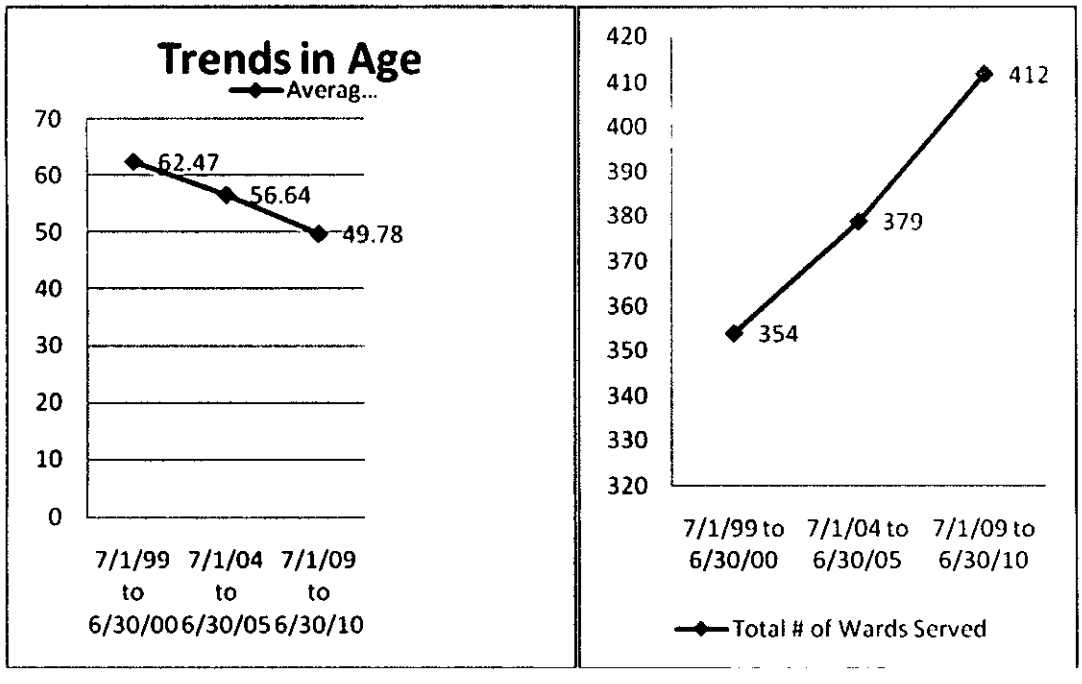
The 2007 Legislature approved funding for 35 additional openings for corporate guardianship services for people with developmental disabilities – a total of 414 wards. This eliminated a long waiting list of people needing our services. The following is a breakdown of admissions and terminations from 7/1/07 to 12/31/10.

Time Period	Admissions	Terminations	Net cases
7/1/07 to 6/30/08	24	18	6
7/1/08 to 6/30/09	25	17	8
7/1/09 to 6/30/10	24	18	6
7/1/10 to 12/31/10	17	8	9

The chart below illustrates the projected net growth of the number of wards served from 6/30/08 to 6/30/13.

Date	Net Number of Wards for Full Fiscal Year	Number of Active Cases on Final Day of Fiscal Year
6/30/08	6	380
6/30/09	8	388
6/30/10	6	394
6/30/11	16 (projected)	410 (projected)
6/30/12	10 (projected)	420 (projected)
6/30/13	10 (projected)	430 (projected)

From 9/1/10 to 12/31/10, an unprecedented number of 19 individuals with developmental disabilities were referred for corporate guardianship services, bringing our current referral total to 20 individuals. It is highly possible that our program will reach its capacity of 414 wards by the end of the current biennium which will result in a waiting list for services. Please note that if a person with developmental disabilities is in a life-threatening situation, we immediately accept that referral and provide guardianship services once the court makes that appointment. To insure corporate guardianship services are available for vulnerable adults who are in crisis and at risk of abuse or harm, we are requesting funding for fifteen (15) additional openings which increases our capacity to 429 wards.



In closing, I respectfully ask for your support of funding for corporate guardianship services as outlined in SB 2012 and the following increases:

1. One additional FTE to lower caseloads	**$141,814**
2. Increased rise in legal petitioning costs	**$ 21,907**
3. Fifteen (15) additional guardianship slots	**$ 67,342**
Total:	**$231,063**

With your help, the good and essential work of the corporate guardianship program can continue to provide persons with developmental disabilities the appropriate level of protection while fostering the highest degree of independence and self-growth possible. Thank you for the opportunity to stand before you today and I would be happy to try to answer any questions you may have.

Senate Appropriations Committee
Testimony on Senate Bill 2012
Senator Ray Holmberg – Chairman
January 19, 2011

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Larry Bernhardt and I am the Executive Director of Catholic Charities North Dakota (CCND) and I am respectfully asking your committee to provide increased funding for Special Needs Adoption above the line item in the DHS Budget in SB2012.

The AASK Program (Adults Adopting Special Kids) is a collaborative effort between Catholic Charities North Dakota and PATH ND, Inc. of North Dakota. We have been providing this Program since 2005 and collectively with the Department of Human Services we are responsible to provide the adoption services for children in the foster care system in North Dakota. These children have generally been in the custody of County Social Services or a Tribe prior to the termination of parental rights. Many times they have had multiple placements outside of their birth home. They may be older children, children placed along with a sibling for adoption, children with a mental, physical, emotional disability, or children of minority race which make them difficult to place. Often, many of these children meet several of these criteria. Parents adopting these children can be family members, grandparents, foster parents, or other parents wishing to start, add to, or complete their family. All of these parents choose to open their hearts and their homes to adopt these challenging children.

In Fiscal Year 2010, the AASK Program accomplished:

117 children from ND were placed for adoption, including

- 19 children from other states placed into ND homes
- 15 children from ND to be placed with families outside ND
- 27 sibling groups, involving 69 children placed for adoption

87 adoption assessments were completed by the AASK Program

104 children had their adoptions finalized

Special Needs Adoption line item within the DHS budget for next biennium is the same as was appropriated for the 2009-2011 biennium and this will be insufficient to meet the needs of those children with special needs for the 2011-2013 biennium. We are requesting additional funds in two (2) areas:

1) Funding for a 3% inflationary increase for each year of the biennium. This area of the budget did not receive the 3% inflationary increases as did other providers in other service areas.

2) Additional funding to allow for the increase of two additional staff for the Program. One of the positions would be of a caseworker, so that the caseload of the program could be spread out further to lower the current caseload among all of the workers. The second position would be of a supervisor, so that we could better support the increased complexity of the work and enhance the quality of the work.

In closing, I respectfully ask for your support of funding for Special Needs Adoption as outlined in SB 2012 and the following increases:

1. 3% inflation increase in each year of biennium	**$ 73,401**
2. Additional funding for two positions for biennium	**$ 314,453**
Total:	**$ 387,854**

With your help, the good and essential work of the Special Needs Adoption Program can continue to provide children and families in North Dakota a permanent home.

Thank you for the opportunity to stand before you today and I would be happy to try to answer any questions you may have.

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AASK ♡
Adults Adopting
SPECIAL KIDS

A collaborative program of Catholic Charities ND and PATH ND, Inc.

There are actually 9 adoption agencies - the 7 + named and PATH ND, Inc and a new agency -
All about You Adoption Agency -
my apologies forever.
LJ

Testimony
House Bill 2012 – Department of Human Services
Aging Services Budget
Senate Appropriations Committee
January 19, 2009

Chairman Holmberg and members of the committee, my name is Brian Arett. I am the Executive Director of Valley Senior Services and a representative of the 26 agencies that are members of the North Dakota Senior Service Providers (NDSSP) that provide Older American Act Services to the senior population of this state. I am here to testify in support of the budget for the Aging Services Division of the North Dakota Department of Human Services. In particular I am here to testify in support of the $300,000 increase in reimbursement to Older Americans Act Service Providers.

At the same time I am here to speak in support of this increase I am here to ask your committee to consider a request for an additional increase for Older Americans Act Service Providers. I make this request because of the significant challenges we face in providing for the growing numbers of seniors, particularly those ages 85 and older, throughout the state, and because of the services that we continue to provide with no reimbursement.

Older Americans Act services such as Home Delivered and Congregate Meals, Outreach, Health and Senior Companion services are an important part of the continuum of care that helps our seniors to remain in their homes as late in life as possible. They represent "a comprehensive and coordinated system of home and community-based services that allows older individuals to lead independent, meaningful, and dignified lives in their own homes and communities." (taken from Older American Act Services published by the North Dakota Department of Human Services – Aging Services Division; 2009.)

When we met with Governor Hoeven's office last fall to talk about our need for additional support for the services we provide for the elderly, our request once again, was to ask that the state fully fund the established reimbursement rate for the meals programs we operate. In addition we asked that the state fully fund the established reimbursement rate for Health Services provided to assist seniors to remain in their homes.

In FFY 2009 (the most recent year statistics are available) 1,198,725 Congregate and Home Delivered Meals and 139,688 units of Health Services were provided throughout the state. Of this number, 1,100,501 meals and 79,092 units of Health Services were reimbursed leaving 98,224 meals that were not reimbursed and 60,596 units of Health Services. The estimated combined cost to reimburse these units would have been $707,358 for one year or a total of $1,414,716 for a two year period of time.

The agency I work for, Valley Senior Services, provides services for seniors in the 6 counties in Region Five including meal sites in 33 communities. In 8 of these communities we contract with a local restaurant for meal services. Our agency has 24 full time and 60 part time employees with a total annual payroll of more than $1.5 million. We spend over $1 million annually on food purchased from wholesale vendors and restaurants.

In 2008 in our region, we provided 49,192 meals that we were not compensated for. In 2009 we provided 53,157 meals that were not compensated for. In 2010, following an increase in funding approved during the 2009 Legislative Assembly, that number dropped to 38,721 meals that were not compensated for. The additional local dollars we were required to generate to provide these uncompensated meals in 2010 were $135,524.

Last week one of the rural restaurants that we contract with for meals called to ask about getting an increase in the reimbursement rate. She expressed concern about being able to continue to provide meals at the $5.25/meal rate we are able to afford. I explained to her that we are working with the Legislature to hopefully increase the number of meals we are compensated for so that we will be in a position to increase the reimbursement rate for her restaurant.

Our request of your committee is to increase funding for Older Americans Act Providers for meals and health services by an additional $1.1 million so that we can be reimbursed at the established state rate for every meal and every unit of health service we provide.

The member agencies of the NDSSP are the organizations providing services to older people in the most rural parts of our state. Meal services are provided in 190 communities of all sizes and in all corners of the state. Many of the older residents of small towns throughout the state rely on these meal services as one of the few alternatives to institutional care available in their community.

The increase being requested in the DHS budget will help us to keep up with the inflationary increases we are experiencing. In particular, it will help us to maintain an adequate reimbursement rate for the many rural restaurants we work with.

If we are going to keep up with the growing costs for providing services and the growing need for services brought on by the ever increasing senior population we need to raise revenues from somewhere. Local resources have been stretched as thin as they can be. We look to the state as a natural partner in helping us to meet this need. The major benefit for the state comes from assisting seniors to stay at home in a less restrictive and much less expensive setting, saving dollars that would have to be spent on nursing home care if our services are not available.

Thank you for your time. I would be happy to answer any questions you might have.

North Dakota Senior Service Providers
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September 2010

Organizations that are members of North Dakota Senior Service Providers:

1. Williston/Region I Senior Services
2. Minot Commission on Aging
3. Kenmare Wheels and Meals
4. Tri County Meals and Services, Rugby
5. Souris Basin Transportation, Minot
6. Cavalier County Meals and Services, Langdon
7. Nutrition United, Rolla
8. Benson County Transportation, Maddock
9. Senior Meals and Services, Devils Lake
10. North Central Planning Council, Devils Lake
11. Walsh County Nutrition Program, Park River
12. Pembina County Meals and Services, Drayton
13. Greater Grand Forks Senior Citizens Association
14. Valley Senior Services, Fargo
15. Dickey County Senior Citizens, Ellendale
16. James River Senior Services, Jamestown
17. South Central Adult Services, Valley City
18. West River Transit, Bismarck
19. Mandan Golden Age Services
20. Burleigh County Senior Adults, Bismarck
21. Kidder Emmons Senior Services, Steele
22. Mercer McLean Counties Commission on Aging, Hazen
23. Elder Care, Dickinson
24. Southwest District Health Unit, Dickinson
25. Southwest Transit, Bowman
26. Legal Assistance of North Dakota, Bismarck

Providing Home Delivered and Congregate Meals, Outreach, Health Maintenance, and Legal Assistance Services for Older Adults in 198 North Dakota Communities

Testimony
Senate Bill 2012 – Department of Human Services
Aging Services Budget
Senate Appropriations Committee
January 19, 2011

Chairman Holmberg and members of the committee, my name is Pat Hansen. I am the Executive Director of South Central Adult Services and I am also president of the North Dakota Senior Service Providers that provide Older Americans Act Services to the senior population of this state.

Brian Arett's testimony explained the statewide situation regarding meals for seniors. I would like to provide you with information concerning my project. South Central Adult Services provides congregate and home delivered meals, outreach, and transportation to Region VI which includes the counties of Barnes, LaMoure, Foster, Logan, McIntosh, Griggs, Dickey, Stutsman, Wells and Sheridan. South Central provided 107,184 congregate meals, 75,359 home delivered meals, 13,038 billable units of outreach and 83,652 rides in 2010. **We provided 13,947 meals with no federal/state reimbursement.** At the $3.50 meal reimbursement rate for 2010 this is a shortfall of $48,815.

I am very appreciative of the increase we received during the last legislative session. We have to date been able to maintain the same level of service we were providing in 2008. We were able to keep all of our rural meal sites open. We do however need to receive reimbursement for **all** of the meals we provide. It is increasingly becoming more difficult to obtain the additional local funds we need to provide these non-reimbursed meals.

Today, in our region, 34% of all meals are provided to people age 85 and older, and 43% of all home delivered meal participants are age 85 and older. The meals are a necessity for these people. For those of you who are familiar with nursing home admission criteria, people who have deficits in two or more Activities of Daily Living (ADLs) are eligible for nursing home admission. In my

region alone we are serving 230 people who meet or exceed that criteria. If in-home services were not available and these people required nursing home placement it would cost in excess of $13 million dollars each year for their care, just for Region VI. Of those 230 people, 81 of them are already low-income and would likely be receiving Medicaid reimbursement for their care when they entered a nursing home.

Statewide statistics on active participants in 2010 indicate that there are a total of 991 people who meet the ADL criteria. Of the 991 people, 310 are already below poverty level and would likely qualify for Medicaid on admission. The increase in Medicaid funding for those individuals would exceed $18.5 million dollars per year.

I have a difficult time putting dollar values on the quality of life we provide for our elderly. I love my job, and it is not because of a great salary. It is because of the benefit I receive from serving some of our most precious assets, our seniors. Most of them worked to provide the quality of life we all have in North Dakota, and I think they deserve the best we can provide for them in their "golden" years. I would ask that you consider what your desire, or the desire of your parents is for the future. Do you want to continue to live in your own home, surrounded by members of your community? Or do you want to live in an institutional setting when a few relatively inexpensive services could keep you at home? We all know that nursing homes and assisted living facilities are necessary when we are unable to care for ourselves, but let's not hurry the process.

Thank you for allowing me to present this information. I have included attachments for your individual review. The first is a listing of the number of clients in each county with 2 or more ADLs. The second is an explanation of what the ADLs consist of. I would happy to answer any questions you may have.

Older Americans Act Clients served with 2 or more ADL's from 10/1/09 - 9/15/10

	County	Clients with 2 or more ADLs	Age 60-74	Age 75-84	Age 85+	Living Alone	Below Poverty	Male	Female
1	Adams	6	0	3	3	2	**1**	4	2
2	Barnes	62	11	20	31	39	**19**	19	43
3	Benson	11	3	2	6	7	**5**	2	9
4	Billings	1	0	0	1	0	**1**	0	1
5	Bottineau	6	1	1	4	0	**3**	2	4
6	Bowman	0	0	0	0	0	**0**	0	0
7	Burke	1	0	0	1	0	**0**	0	1
8	Burleigh	37	5	18	14	9	**9**	25	12
9	Cass	169	45	51	73	99	**54**	43	126
10	Cavalier	4	1	1	2	1	**0**	1	3
11	Dickey	10	2	5	3	5	**4**	2	8
12	Divide	1	0	1	0	1	**1**	0	1
13	Dunn	5	2	0	3	2	**1**	0	5
14	Eddy	6	1	2	3	3	**3**	1	5
15	Emmons	20	5	8	7	9	**10**	8	12
16	Foster	5	2	2	1	0	**0**	2	3
17	Golden Valley	2	0	1	1	1	**0**	1	1
18	Grand Forks	19	5	8	6	5	**4**	5	14
19	Grant	5	2	2	1	1	**1**	4	1
20	Griggs	9	1	4	4	4	**5**	2	7
21	Hettinger	1	1	0	0	1	**1**	0	1
22	Kidder	31	4	14	13	14	**13**	5	26
23	LaMoure	13	2	7	4	5	**3**	5	8
24	Logan	3	1	0	2	1	**2**	1	2
25	McHenry	3	1	0	2	1	**2**	0	3
26	McIntosh	9	3	1	5	0	**1**	4	5
27	McKenzie	5	4	0	1	1	**1**	2	3
28	McLean	40	8	10	22	24	**14**	14	26
29	Mercer	36	9	13	14	21	**14**	14	22
30	Morton	18	1	10	7	9	**5**	4	14
31	Mountrail	8	1	2	5	2	**5**	2	6
32	Nelson	2	0	1	1	1	**2**	0	2
33	Oliver	3	2	0	1	0	**1**	1	2
34	Pembina	37	7	15	15	16	**5**	13	24
35	Pierce	10	3	3	4	3	**3**	2	8
36	Ramsey	17	2	6	9	9	**5**	4	13
37	Ransom	34	2	16	16	24	**9**	9	25
38	Renville	1	1	0	0	1	**1**	0	1
39	Richland	9	5	1	3	4	**2**		9
40	Rolette	19	12	0	7	9	**7**	8	11
41	Sargent	28	8	10	10	19	**15**	7	21
42	Sheridan	0	0	0	0	0	**0**	0	0
43	Sioux	11	6	2	3	2	**1**	3	8
44	Slope	1	0	0	1	1	**0**	0	1
45	Stark	22	4	9	9	11	**11**	7	15
46	Steele	2	0	0	2	0	**0**	1	1
47	Stutsman	110	17	39	54	70	**47**	32	78
48	Towner	10	0	3	7	5	**1**	3	7
49	Traill	2	0	2	0	0	**0**	1	1
50	Walsh	59	10	27	22	25	**8**	19	40
51	Ward	46	9	20	17	24	**9**	12	34
52	Wells	9	2	3	4	7	**0**	1	8
53	Williams	13	7	3	3	1	**1**	2	11
	TOTALS	**991**	**218**	**346**	**427**	**499**	**310**	**297**	**694**

North Dakota Senior Service Providers

October 2010

Persons are eligible for nursing home admittance if they have 2 or more ADL's. The 310 low-income persons currently being served by Older Americans Act providers would most likely be Medicaid eligible at the beginning of their nursing home stay.

The low income 2 ADL' number of people (310) multiplied by the average most recent yearly nursing home cost of **$ 59,796** (reported at the May meeting of Legislative Interim Long Term Care Committee) comes to the sum of $ 18,536,760 per year of Medicaid Expenses - double it for the biennium = $37,073,520.

Even delaying by one month the nursing home admission of these 310 people would save more than the 1.4 million dollars that Title III providers are asking to be reimbursed for all the Title III services provided.

Activities of Daily Living (ADL)

Self-care activities performed daily without assistance, stand-by assistance, supervision or cues including:

- eating
- bathing
- walking
- dressing
- toileting
- transferring in and out of bed/chair

Instrumental Activities of Daily Living (IADL)

Independent living tasks that typically require mental/cognitive (memory, judgment, intellect) and/or physical ability such as:

- preparing meals
- medication management
- using the telephone
- doing light housework
- shopping for personal items
- managing money
- doing heavy housework
- transportation ability – this refers to the individual's ability to make use of available transportation

Testimony
SB 2012- Department of Human Services
Senate Appropriations Committee

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Shari Doe. I am the Director of Burleigh County Social Services here in Bismarck. I'm also the President of the ND Association of County Social Service Directors and I am here to speak in support of Senate Bill 2012.

Local county Social Service agencies are instrumental in carrying out the work of the Department of Human Services. In North Dakota's state supervised, county administered system, the Department depends on county social service agencies to provide services. Counties depend on the department for direction and resources to carry-out this work. I wish to speak to a few issues that are important to the counties and how those issues fit within SB 2012.

- The FMAP decrease has a significant increase on the Department's budget, $171.4 million, I believe. The FMAP decrease means that North Dakota has a growing economy and rising personal incomes. It seems counter intuitive then that at the same time the FMAP rates goes down, the number of Medicaid recipients are increasing. In Burleigh County, the number of Medicaid/SNAP recipients has increase over 25% in the past three years – the fastest growing Economic Assistance program we administer. Counties pay for the workers needed to determine Medicaid eligibility, and the non-federal share of our Medicaid reimbursed programs such as, Targeted Case Management for Child Welfare case management. Counties bill Medicaid for the full amount of the service. The state then turns around and bills the counties for the non-federal share. With the FMAP decrease, the amount counties are billed (the non-federal share) will increase proportionally to the Medicaid cost increases realized by the state.

- The federal Health Care Reform legislation as it currently stands calls for an expansion of the Medicaid Program to all individuals at 133% of poverty. And though this implementation is a couple of years away, we are beginning to look at how determining eligibility for all the newly eligible Medicaid recipients will affect counties. Currently, county Eligibility Workers determine client eligibility for Medicaid. The "word on the street" has been that North Dakota could expect up to 30,000 individuals newly eligible for Medicaid. With such a significant

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increase in Medicaid recipients, counties would have to add additional workers to meet the increased demand and additional space to house the workers. That is, unless the health insurance exchange takes over the determination of Medicaid eligibility. In that case, counties may actually be able to reduce the number of workers responsible for determining Medicaid eligibility because the health insurance exchange will take over that function. What happens in Washington D.C. and here the North Dakota Legislature will ultimately determine how we move ahead with the implementation of the Patient Protection and Affordable Care Act. However, when North Dakota does adopts legislation to meet federal requirements, consideration must be given to the role counties play in the administration of Medicaid benefits.

- Computer technology in the administration of programs is a key area in which counties depend on the Department of Human Services. A continuing need for county social service agencies has been for a comprehensive Eligibility Computer System to determine eligibility for all programs including: the Medicaid Program, the Supplemental Nutritional Assistance Program (SNAP formerly known as Food Stamps), Temporary Assistance to Needy Families Program (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care Payment Program and Child Care Assistance Program. At this time, county eligibility workers must enter data in four different aged computer systems (NATL, TECS, VISION, and CCWIPS) to determine eligibility for a single combined case. And though EW's are quite adept at making these systems work, having to work within four different computer systems is inefficient, difficult to learn and prone to error. The Eligibility System re-write did not make it into the Governor's budget. I understand, however, that the Industry, Business and Labor Committee is considering legislation on behalf of the Insurance Commissioner's office (HB 1126) regarding establishment of a Health Insurance Exchange in accordance with the Patient Protection and Affordable Care Act. An amendment has been offered for the Eligibility System re-write so that Medicaid and Healthy Steps (Children's Health Insurance Program) are able to interact with the Health Care Exchange. Although this is a round-about-way to address the aging and cumbersome Eligibility System, we very much support the state's efforts to move ahead with an Eligibility System re-write. In this day of continuous program changes, more complex policies and high quality performance standards, a computer system that allows workers to deliver timely and accurate benefits is essential.

- Another important computer system needing attention is Frame. Frame is the North Dakota's child welfare data management system. Frame was created by Information Technology Division in collaboration with the Department of Human Services and counties for foster care and child abuse neglect case management purposes. It combined two functioning systems (CCWHIPs and the Child Abuse and Neglect data-base system) so child welfare workers would have a less complicated system case documentation and the state would have a single source for data collection. Additionally, the system was designed to meet reporting and documentation requirements of the Children and Family Services Performance Improvement Plan. Frame is relatively new. It was rolled out as a pilot in Burleigh County in September 2009 and implemented state-wide shortly after that. We applaud the Department's efforts to improve the child welfare computer system, but enhancements to the system are necessary to make Frame the single source of documentation and data-collection as originally intended. The project was under-funded so critical programming had to be eliminated due to budget constraints. Enhancements to Frame will improve efficiency at the state, regional and county level. We strongly encourage additional resources be directed towards Frame enhancements.

- In the area of child welfare, counties are constantly in "putting out fires" mode. And though we all talk about the value of prevention services, the reality is that the "in your face" emergencies and the "deep end" families take up the majority of our resources. Services such as home visiting programs, parent resources centers, early intervention case management, intensive in-home services, family team/group decision making all significantly impact on a family's ability to provide safe, nurturing parenting. Family Preservation services such as safety and permanency funds, parent aides, and case management are often the critical difference between being able to keep a child at risk in the home, or taking custody away from a parent and placing the child in foster care. Early intervention with a family in stress is much more efficient and cost-effective than working with a family already in the system. The problem is that the child welfare workers are so busy with the "really bad" cases; we do not have the time or resources to do the prevention work we'd like. The Department of Children and Family Services is very committed to prevention as an overall strategy but that does not address the fact that some secondary prevention services are not available throughout the state. Burleigh County and Cass County

will be able to offer family team decision making services to every family at risk of losing custody of their child. This service is not available anywhere else. The Minot region has access to Family Group Decision-Making and the Bismarck Region does not. Grand Forks and Burleigh/Morton have access to Healthy Families, a home visiting program. We understand the Departments limitations in making these resources available to more North Dakota families, but we must invest more in prevention and intervention services. These children are our future.

In conclusion, all aspects of the human service budget, impact the citizens of our counties. As I stand up here and speak about computer systems and health care reform and lack of resources it's easy to forget that what we do is about improving the lives of people.

Chairman Holmberg and members of the Committee thank you for the opportunity to provide testimony on SB 2012 and I would be happy to address any questions you may have.

Center for Rural Health

RURAL HEALTH FACTS

Dementia Care Services Project Benefiting North Dakotans

December 2010

What is the North Dakota Dementia Care Project?

- This project, which spans January 2010 to June 2011, has a goal of informing people with dementia and their caregivers about dementia care issues which, in turn, may lead to increased family support, decreased depression, delays in nursing home placement, and reductions in unnecessary health service use.
- The project provides care consultations to persons with dementia and their caregivers. These consultations consist of assessing needs, identifying issues and concerns and resources, developing care plans, and referrals, providing education, and follow-up assistance.
- Created by the Dementia Care Services bill (North Dakota House Bill 1043), the project is being conducted by the Alzheimer's Association of Minnesota/ North Dakota and externally evaluated by the Center for Rural Health.

What has been the Project's effect on caregiving in North Dakota?

- From January to November 2010, 736 project contacts were made with 398 caregivers of 285 persons with dementia.
- Caregivers who had multiple contacts with project staff and services showed increases in completing important dementia care-related action steps (Figure 1).

Figure 1. Change in Completing Care-Related Action Steps

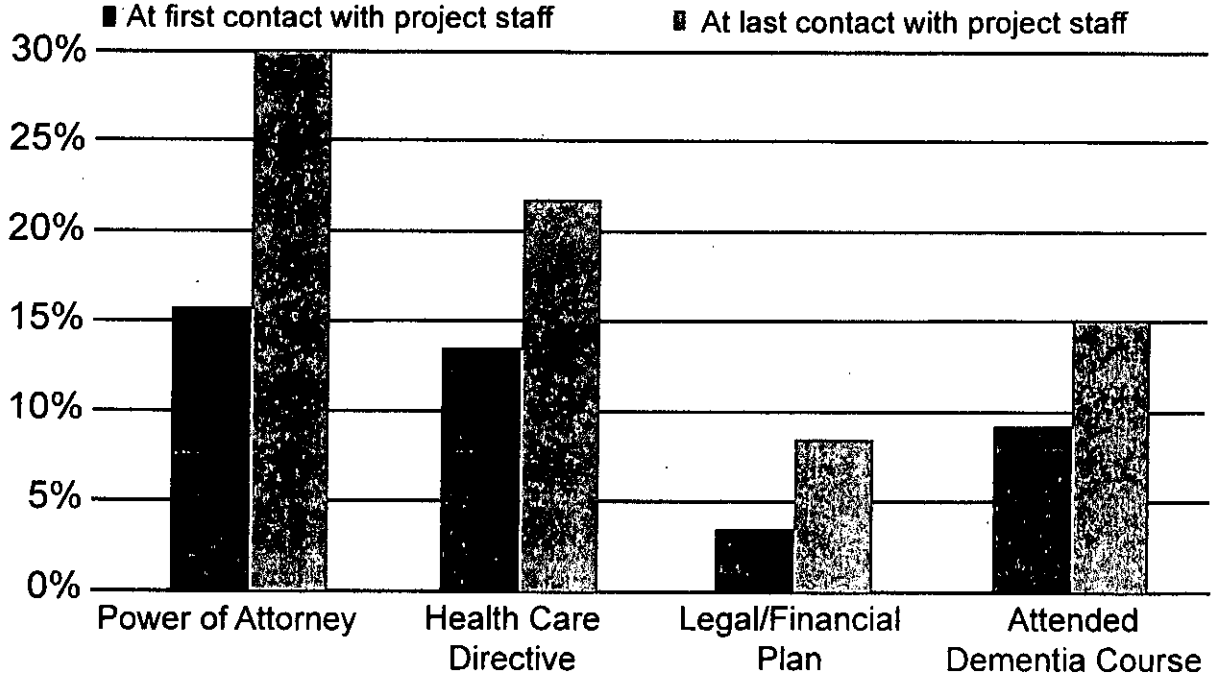
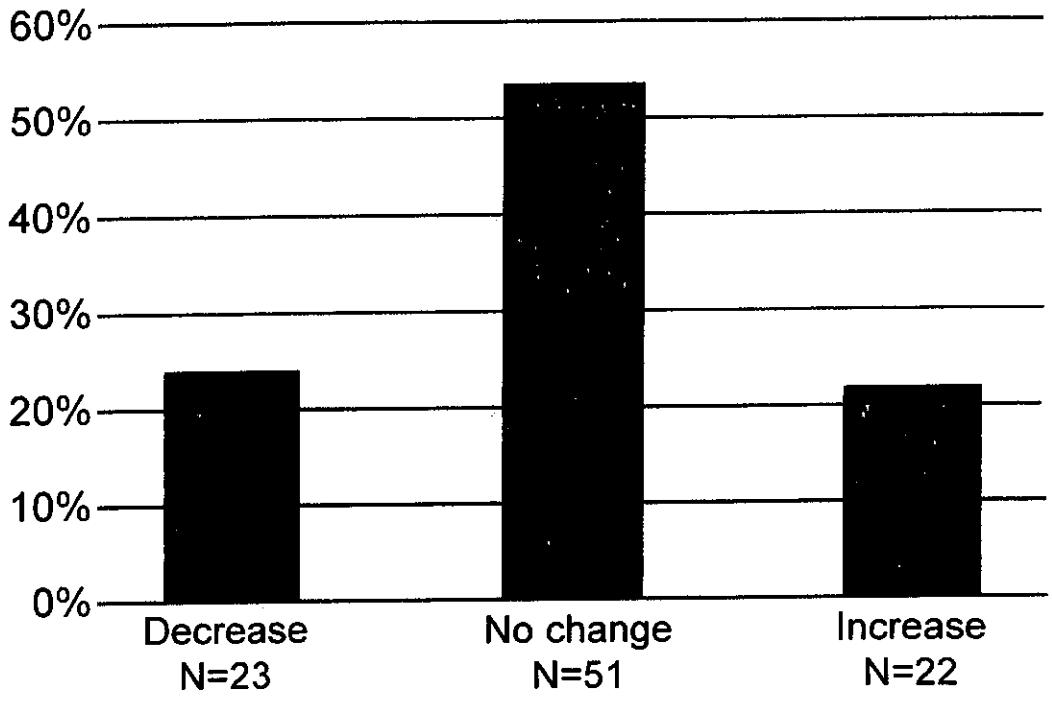


Figure 2. Change in Likelihood to Place Person with Dementia in LTC



- Nearly one in four caregivers who had multiple project contacts decreased their likelihood to place the person with dementia in a long term care facility (LTC; Figure 2).
- Persons with dementia who **showed a decrease** in likelihood to placement in LTC were all (100%) living in either their own home or assisted living, and 17% lived out in the country.
- Two out of three (66%) persons with dementia who **showed no decrease** in likelihood to placement in LTC lived in their own home or assisted living, and 11% lived out in the country
- The average amount of time before caregivers' change in LTC placement intention was noticed was two and one-half months.

Conclusion

- Preliminary results indicate the Dementia Care Services project is having positive impacts on the lives of persons with dementia and their caregivers, including enhanced support for caregivers and reduced intention for placement of persons with dementia in nursing homes.
- Important factors to consider when assessing care resources for persons with dementia include who the person lives with, (if they are independent or not), and if they live in a town (i.e., near a LTC facility) or out in the country.

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RURAL HEALTH FACTS

Dementia Care Services: Reaching Out to North Dakota

December 2010

What is the North Dakota Dementia Care Project?

- This project, which spans January 2010 to June 2011, has a goal of informing people with dementia and their caregivers about dementia care issues which, in turn, may lead to increased family support, decreased depression, delays in nursing home placement, and reductions in unnecessary health service use.
- The project provides care consultations to persons with dementia and their caregivers. These consultations consist of assessing needs, identifying issues and concerns and resources, developing care plans, and referrals, providing education, and follow-up assistance.
- The project was created by the Dementia Care Services bill (North Dakota House Bill 1043).
- Project funding is administered by the North Dakota Department of Human Services.
- The project is being conducted by the Alzheimer's Association of Minnesota/ North Dakota and externally evaluated by the Center for Rural Health, at The University of North Dakota School of Medicine and Health Sciences.

Who Benefited from the Project Services?

- From January to November 2010, 736 project contacts were made with 398 caregivers of 285 persons with dementia (Figure 1).

Figure 1. Number of Intake Forms Completed During January to November, 2010

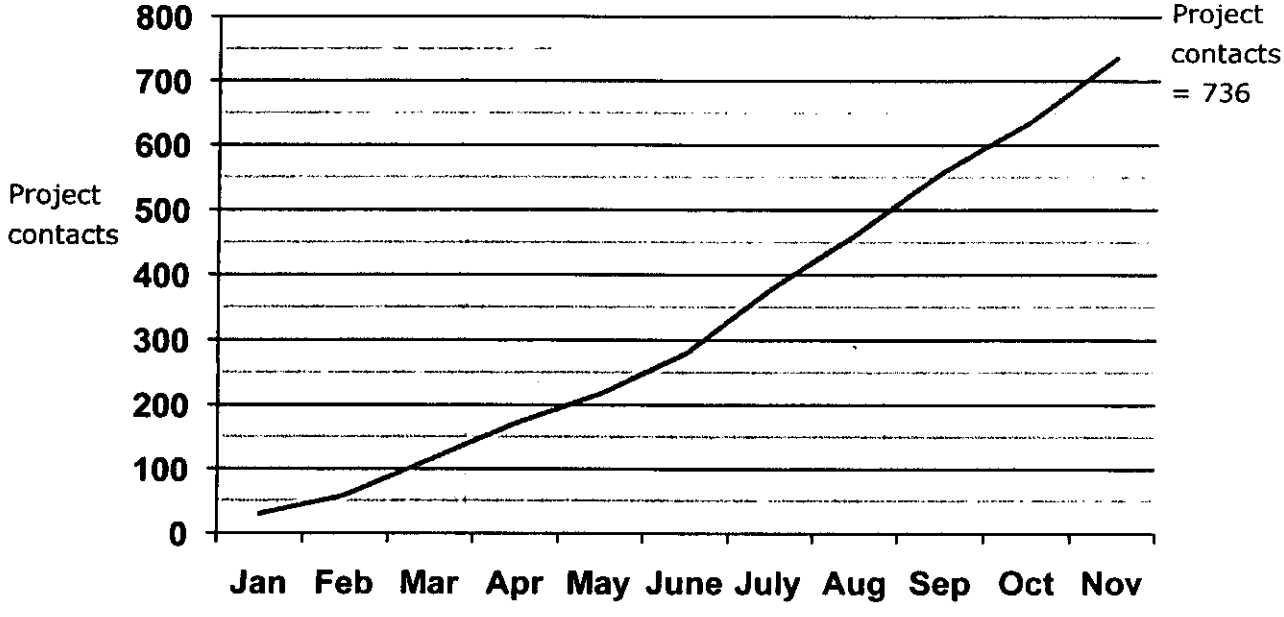
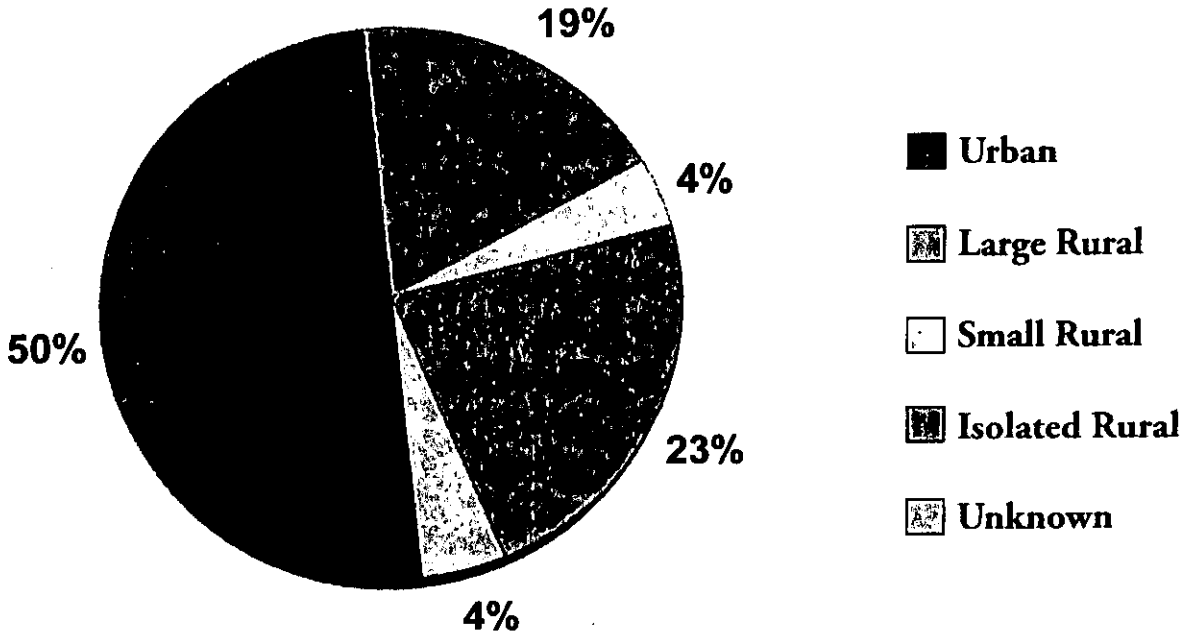


Figure 2. Rurality of Caregivers



Caregivers

- Among caregivers, 46% lived in rural areas within North Dakota (Figure 2).
- Services were provided in all eight regions of North Dakota.
- Caregivers who used project services were mostly female (78%) ranging in age from 23 to 93 years, with an average age of 62.8.
- The caregiver was often (40%) an adult child of the person with dementia.

Persons with Dementia

- Ages of the person with dementia ranged from 43 to 98 years, with an average age of 79.1.
- One in six persons with dementia was a military veteran.
- The majority (88%) of persons with dementia are living in a location other than a long term care facility.
- Six percent of the persons with dementia reported a secondary disease.

Conclusion

In its first 11 months of operation, the North Dakota Dementia Care Service Project has reached hundreds of North Dakotans with dementia and their caregivers. The beneficiaries of the project represent diverse population from urban, rural, and frontier areas around North Dakota. The project staff will continue to offer professional assistance to persons with dementia and their caregivers in the remaining seven months of the project.

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Center for Rural Health
The University of North Dakota School of Medicine & Health Sciences

alzheimer's association
the compassion to care, the leadership to conquer



Policy Brief

DECEMBER 2010

Dementia Care Services project: Supporting Caregivers in North Dakota

Kyle Muus, PhD, Boris Volkov, PhD, Marilyn G. Klug, PhD, Jan Mueller and Heidi Haley-Franklin

Bonnie's story

The diagnosis of Alzheimer's wasn't as shocking to hear as the word "severe." I had noticed signs and symptoms, but was still overwhelmed to hear a man give my mother a life sentence after spending forty minutes with her.

With Mom suffering from untreated depression most of her life, she has been a difficult person to get close to. I believed if she really wanted to be a different person, she would change and we could have a normal relationship. Even though Mom is still physically here, I grieved over the loss of the relationship I now knew we could never have.

Jodi Keller, Regional Care Consultant, helped me see things differently. I could choose to grieve over what would never be, or I could redefine our relationship. Her specific advice: "Make the most of the time you have left." Even though that put finality on Mom's condition, it changed my perspective. In the beginning I struggled to control my frustrations, but with Jodi's help I've learned a whole new level of patience. With this newly defined fortitude, our relationship is changing for the better. I will cherish the memories we are now creating. Ironically, these are the memories Alzheimer's disease will steal from Mom.

Jodi helped me separate the facts from fiction about Alzheimer's disease. She is knowledgeable about the stages of the disease, including a realistic picture of what is yet to come. Jodi is supportive of my approach to caring for Mom, but has also taught me some effective ways to ask family members for help without being overbearing. This has taught me another level of patience. I have to understand each sibling will have to redefine their relationship with Mom in their own time.

My perspective continues to change regarding Mom's care. Instead of keeping track of her medicine and worrying about what to make her for supper, I can focus on what her mind chooses to focus on. Jodi has been a true provider of encouragement and hope. She's told me several times, "Yes, this is difficult, but you are doing a great job. What you do really does make a difference to your Mom."

How Bonnie benefited from the Dementia Care Service project

- ***True support.*** *Jodi has the experience of talking to many people in my shoes. She shares those experiences so I can learn how to become a better caregiver. No medical staff, family member, or Web site can provide the insight one caregiver can give to another.*

North Dakota department of Human Services Contract #190-08067.

"Jodi [from the Dementia Care Services project] helped me separate the facts from fiction about Alzheimer's disease. She is knowledgeable about the stages of the disease, including a realistic picture of what is yet to come."

- ***Knowledge about the disease.*** *A reliable source of information was explained in terms 'simple caregivers' can understand. I didn't have to question where the information came from to accept it as truth, in contrast to mixed messages found by surfing the Web.*
- ***A sounding board.*** *When faced with a life-altering disease, having someone who really listens is what keeps me from being overwhelmed. This disease robs your family of 'life as you know it' and many of the thoughts and emotions that come with this can make you feel crazy.*

Alzheimer's disease and dementia

Every 70 seconds someone in America develops Alzheimer's disease. By 2050, it will be every 33 seconds.[1] Alzheimer's disease is the most common type of dementia, a syndrome that can be caused by a number of disorders that affect memory, thinking, behavior and the ability to perform everyday activities.[2]

- In 2000, there were 16,000 North Dakotans aged 65 and older with Alzheimer's disease
  - In 2010, there will be 18,000
  - In 2025, there will be 20,000[3]

People with Alzheimer's disease and other dementias are high users of health care, long-term care and hospice. Total annual costs to all payers for the care of people with Alzheimer's disease and other dementias will increase from $172 billion in 2010 to $1.08 trillion in 2050, which does not include the value of unpaid care provided by families and others, estimated to be $144 billion in 2009.

The challenge of providing care

As Bonnie's story shows, providing care to a person with dementia poses special challenges. As a result, many family and other unpaid caregivers experience high levels of emotional stress and depression. Caregiving also has a negative impact on the health, employment, income and financial security for affected families.[1]

Almost 11 million Americans provide unpaid care for a person with Alzheimer's disease or another dementia.

- In 2009, caregivers provided 12.5 billion hours of unpaid care. At $11.50 per hour, this is a contribution of nearly $144 billion[1]
- In 2009, 19,741 North Dakota caregivers spent about 22.1 million hours of unpaid care. The economic value of this care is estimated at $255 million[1]

North Dakota's Dementia Care Service project

In 2009, the North Dakota Legislature passed the Dementia Care Services bill (House Bill 1043) to provide resources, assistance, and support for the people of North Dakota. The Aging Services Division of the North Dakota Department of Human Services awarded the Alzheimer's Association of MN/ND the contract to do this work. The Alzheimer's Association of MN/ND is working with the Center for Rural Health to analyze and evaluate the program.

The project provides care consultations which can consist of assessments of needs, identifying issues and concerns, identifying available resources,

*"In 2000, there were **16,000** North Dakotans aged 65 and older with Alzheimer's disease. In **2010**, there will be **18,000**, in **2025**, there will be **20,000**[3]"*

developing a plan of care, referrals, providing support and education about dementia, and follow-up.

The project's goal is to inform people with dementia and their caregivers about dementia care issues which, in turn, may lead to decreased depression, increased family support, delays in nursing home placement, and reductions in redundant use of health services. The project began in January 2010 and will continue through June 30, 2011.

To what extent has the Dementia Care Services program been used?

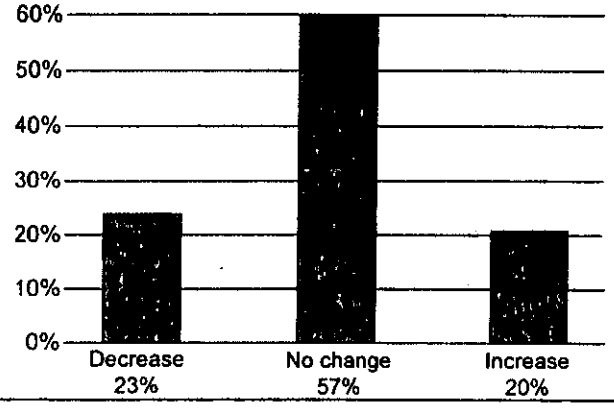
- From January through September 2010, 554 contacts were made to the Dementia Care Services project by 292 caregivers of 224 persons with dementia
- The Alzheimer's Association provided service delivery in every region of North Dakota
- 25% of services provided was to caregivers living in small or isolated rural areas

Who are the caregivers and persons with dementia the project has helped?

- Caregivers who used the project services were mostly female (80%) ranging in age from 28 to 89 years, with an average age of 64.1
- The caregiver was often (40%) an adult child of the person with dementia
- Ages of the person with dementia ranged from 48 to 98 years, with an average age of 78.7
- One in six persons with dementia was a military veteran
- The majority (54%) of persons with dementia were living in their home
- Among persons with dementia, 45% lived in rural counties of North Dakota
- Three-quarters of persons with dementia had a dementia-related diagnosis, and 17.5% reported having another disease in addition to having dementia

What has been the project's effect on caregiving in North Dakota?

Figure 1



As shown in Figure 1, caregivers who had one or more in-person visits with Dementia Care Services staff had the following changes in their intention to place their person with dementia in a nursing home.

The Figure includes only those caregivers who have had an in-person visit with project staff, change in placement likelihood is for the time period after initial encounter with project staff.

Figure 2

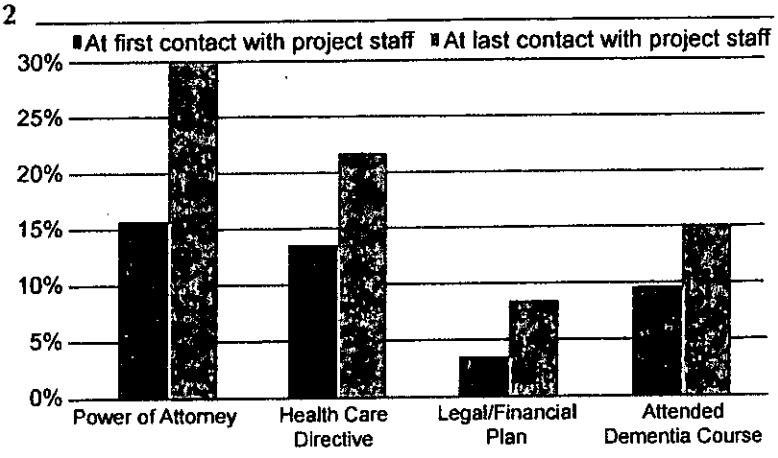


Figure 2 shows that caregivers who had multiple contacts with project staff and services showed increases in completing important dementia care-related action steps.

Conclusion

Preliminary results indicate the Dementia Care Services project is having positive impacts on the lives of persons with dementia and their caregivers, including enhanced support for caregivers and reduced intention for placement of persons with dementia in nursing homes.

As Alzheimer's disease is becoming more common, it is important to bolster efforts for finding a cure, develop new pharmaceutical treatments, and provide meaningful support to caregivers of persons with dementia through both the administration of proven, effective programs and the development of new and innovative approaches.

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[1]Alzheimer's Association. (2010). 2010 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia, Volume 6.*

[2]Alzheimer's Disease International. (2010). *World Alzheimer Report 2010: The Global Economic Impact of Dementia. London, UK: Alzheimer's Disease International.*

[3]Hebert, LE; Scherr, PA; Bienias, JL; et al. (2004). *State-specific projections through 2025 of Alzheimer's disease prevalence." Neurology, 62:1645.*

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Senate Appropriations
January 19, 2011
SB 2012 – Department of Human Services
Testimony from Teresa Larsen, Protection & Advocacy Project

AGING SERVICES

OMBUDSMAN PROGRAM

P&A supports additional staff for the long term care ombudsman program. The purpose of the program is to provide services to protect the health, safety, welfare, and rights of residents and advocate on behalf of all individuals living in nursing facilities, assisted living, swing beds, transitional care units, and basic care facilities.

Currently, the program has one full-time State Ombudsman to administer the program. 2.45 FTE's are spread amongst the eight regions to implement the services. These include:

Regions I and II:	.5 FTE	Regions III and IV:	.6 FTE
Regions V and VI:	1 FTE	Region VII:	.2 FTE
Region VIII:	.15 FTE		

As an example, with current staffing, the Bismarck/Mandan region has 8 hours/week of ombudsman services to cover more than forty facilities and approximately 1,500 residents. This is not adequate to meet the outlined responsibilities.

OAR 409, as submitted to the Governor by DHS, is for one additional FTE at a cost of $135,665 for the biennium. This will help in addressing the service gap but not close it.

GUARDIANSHIP SERVICES

P&A supports OAR 408, as prepared by DHS, for guardianship services. This would provide for necessary guardianships for those who do not have a developmental disability but who may have a mental illness, traumatic brain

injury, or other serious disability. Only $40,000 per biennium has been available for these services which is not addressing the need. No monies have been available for the costs of providing actual guardianship services. This OAR would provide funds of $80,000 for the establishment of guardianships plus an additional $24,000 to pay for professional guardianship services. These are needed when there is not an appropriate relative or other responsible person available to be the guardian.

Thank you for your consideration. I will be happy to answer your questions.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 19, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Nancy McKenzie, Director of the Human Service Centers (HSCs) for the Department of Human Services. I am here today to provide you an overview of the budget and program trends in the regional centers.

Human Service Centers

This area of the budget includes the eight (8) Regional Human Service Centers (HSCs), one in each of the geographical regions of the state.

- The HSCs are the network of public outpatient clinics that serve individuals who, because of illness, addiction, or disability are at risk of harm or institutional placement. The centers provide the community safety net for our most vulnerable citizens. Their mission is to provide services that are accessible at the most appropriate and cost-effective level of care.
- We place a high value on alignment across the regions, operating as one system that shares resources as needs and demands shift. Where possible, we implement consistent and systematic processes such as our common electronic medical record and data reporting.
- Services are provided within the clinic setting, rural outreach centers, client homes, or other community settings, and include 24-hour emergency services as well as follow-up services. Response to local community disasters/mental health tragedies are another service provided.

- Telemedicine services are being provided in several rural areas of the state to improve client access, and gradual expansion of this capability is allowing us more flexible use of our medical staff across the state.
- The HSCs are also responsible for program supervision and regulatory oversight of the Child Welfare services provided by county social services, and oversight of the Aging Services programs in their regions.

Caseload / Customer Base

Data regarding those served in State Fiscal Year 2010 include:

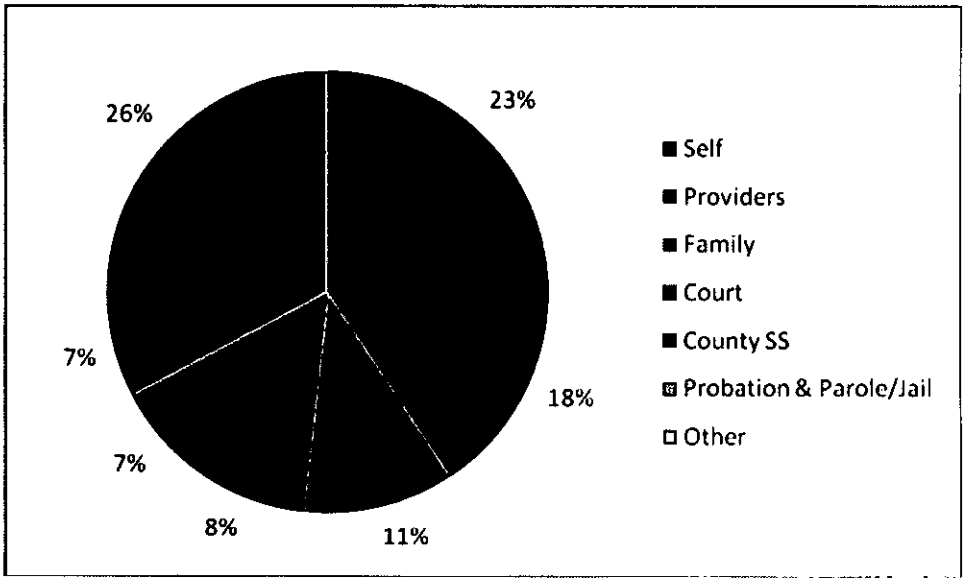
- 26,195 individuals were served excluding Vocational Rehabilitation (VR); this is an increase of 906 individuals served over the prior year (an increase of 3.5%), and represents 4% of North Dakota's residents.
- Approximately 25% of clients served were children; 75% were adults.
- During the same period, VR served 6,992 individuals, many of whom also received other HSC services. Older Blind programs served 1,074 individuals
- 39% of HSC clients qualified for no fee on the sliding fee scale; of those, 32% had no third party payment source. This compares to 43% and 33%, respectively, in 2008.

Program Trends / Major Program Changes

- Many of the clients served by the HSCs receive multiple services. This is not surprising as many have multiple diagnoses, a tendency to homelessness, and the need for services over time. We work to

wrap critical services around these individuals in the community, to support their stability and recovery, minimize symptoms, and decrease the potential for more costly hospitalization.

- Referral to HSC services came from the following in SFY 2010:



The primary difference seen when compared to referral sources reported during the last session, is a decrease in court referrals and an increase in the miscellaneous "other" category. This provides quicker intervention at the local level before formal commitment may be needed.

- Much work has been done in this interim period to assess local inpatient hospital needs through the Human Service Center contracts, and to plan with our partners in the private sector for needed bed capacity and funding. The budget section of my testimony further describes this part of the funding, which assists in meeting gaps in the current capacity.
- Community residential capacity for clients needing additional supports increased in the current biennium, due to funding supported by the Legislature in previous biennia. This enables us to

provide appropriate alternatives to hospitalization and to have available a more complete continuum of community services.

- An excellent example of effective community supports is the Cooper House "housing first" residence in Region V. This budget includes funding to assist with this community collaborative by providing contract funding to have two front-door staff on duty at all times to ensure client safety and effective operations.
    - The residence is now full, with 42 individuals who were chronically homeless or at risk of homelessness residing there.
    - When Cooper House opened in May of 2010, 4 of these individuals were SEHSC clients. Today, 20 are receiving needed services, and 6 more are in the process of engaging/considering treatment. The remainder either don't currently need services or are receiving them through the Veteran's Administration.
    - Fargo law enforcement reports indicate that admissions to the city detoxification facility decreased by nearly 600 for the period of January-November 2010. They believe the opening of Cooper House has contributed significantly to that reduction.
- This budget includes funding to allow for the important crisis care level in Minot, and to better meet demand in Bismarck by adding a few beds to their crisis capacity. Both will impact hospital admissions and give clients better local care.
- Further implementation of evidence-based practices in all of the regions continues. This results in more consistent implementation of services and better outcome tracking for those services.
- We speak often of the benefits to both client care and the budget when the right level of care is provided at the right time. Please

refer now to Attachment A for case-specific examples that demonstrate these benefits.

- Telemedicine need and growth is a continued focus across the state. We provide some services through a contract psychiatrist due to staff vacancies, and have also utilized our own psychiatrists to provide telemedicine services across regions. At this time, we are in the testing process of an application hosted by the Information Technology Department (ITD) that will allow even more connectivity (laptop-to-laptop; laptop-to-desktop), which then opens up new opportunities for rural clients to more easily access professional consultation when needed.
- The HSCs continue to work closely with the Department of Corrections & Rehabilitation, who refer a number of individuals with mental illness and/or substance abuse problems who are returning to the community. The joint Release & Integration project, which provides specific release planning with prison staff, Human Service Center staff, Probation & Parole staff and the inmate scheduled for release, has resulted in more smooth transition by ensuring that psychiatric appointments and medication needs are addressed prior to release.
- We have worked hard on internal staff development to assist in filling addiction counselor positions, and continue to have ongoing psychology and psychiatry vacancies. The recent designation of Southeast Human Service Center in Fargo as an approved internship site by the American Psychological Association is a very positive achievement. This will allow more psychology residents to consider that site, including those from the University of North Dakota.

Overview of Budget Changes – Human Service Centers Combined

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
HSCs / Institutions	146,717,139	164,732,358	18,015,219
General Funds	72,640,149	90,628,876	17,988,727
Federal Funds	67,159,214	66,150,835	(1,008,379)
Other Funds	6,917,776	7,952,647	1,034,871
Total	146,717,139	164,732,358	18,015,219

FTE	836.48	837.48	1.00

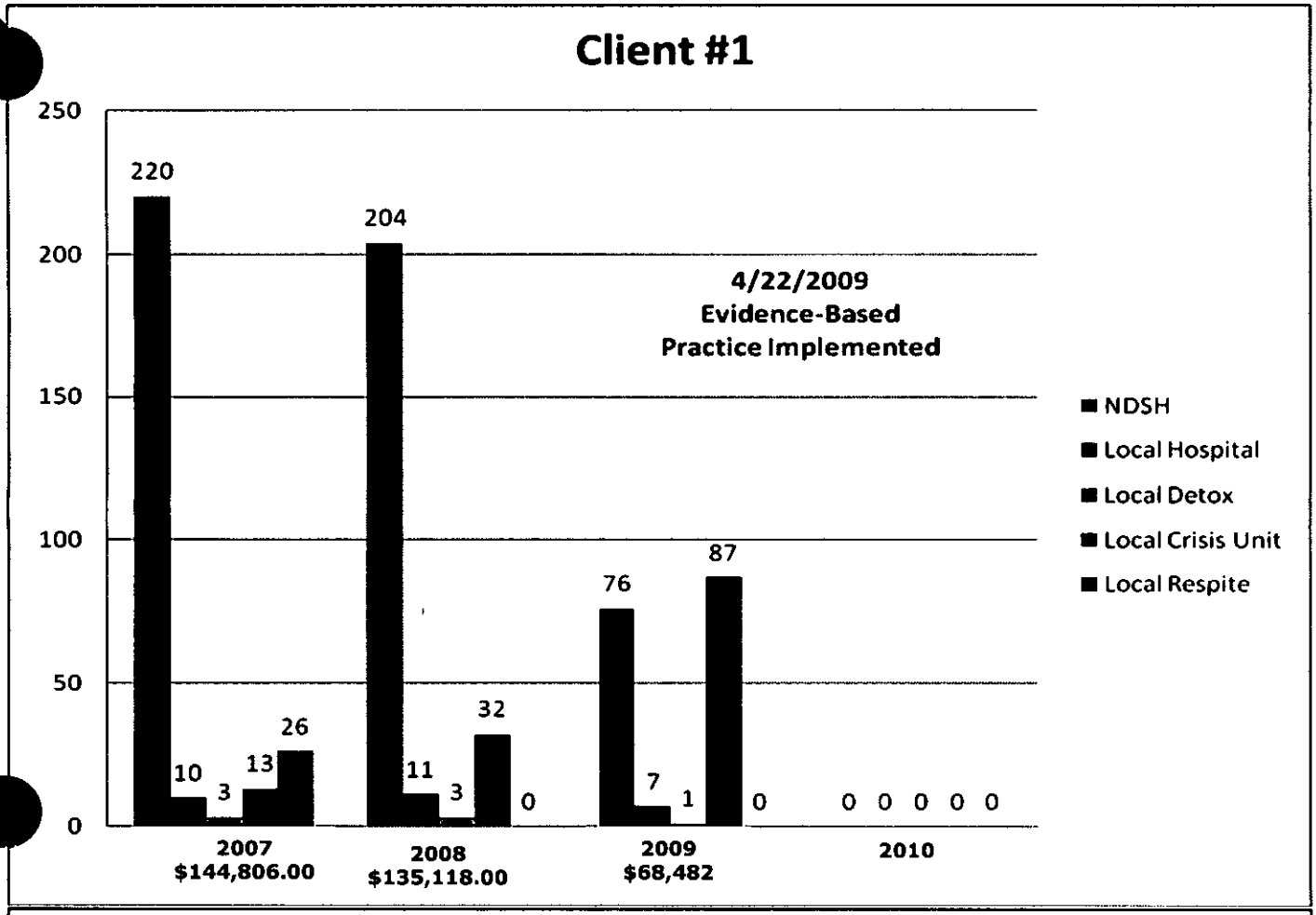
The major changes can be explained as follows:

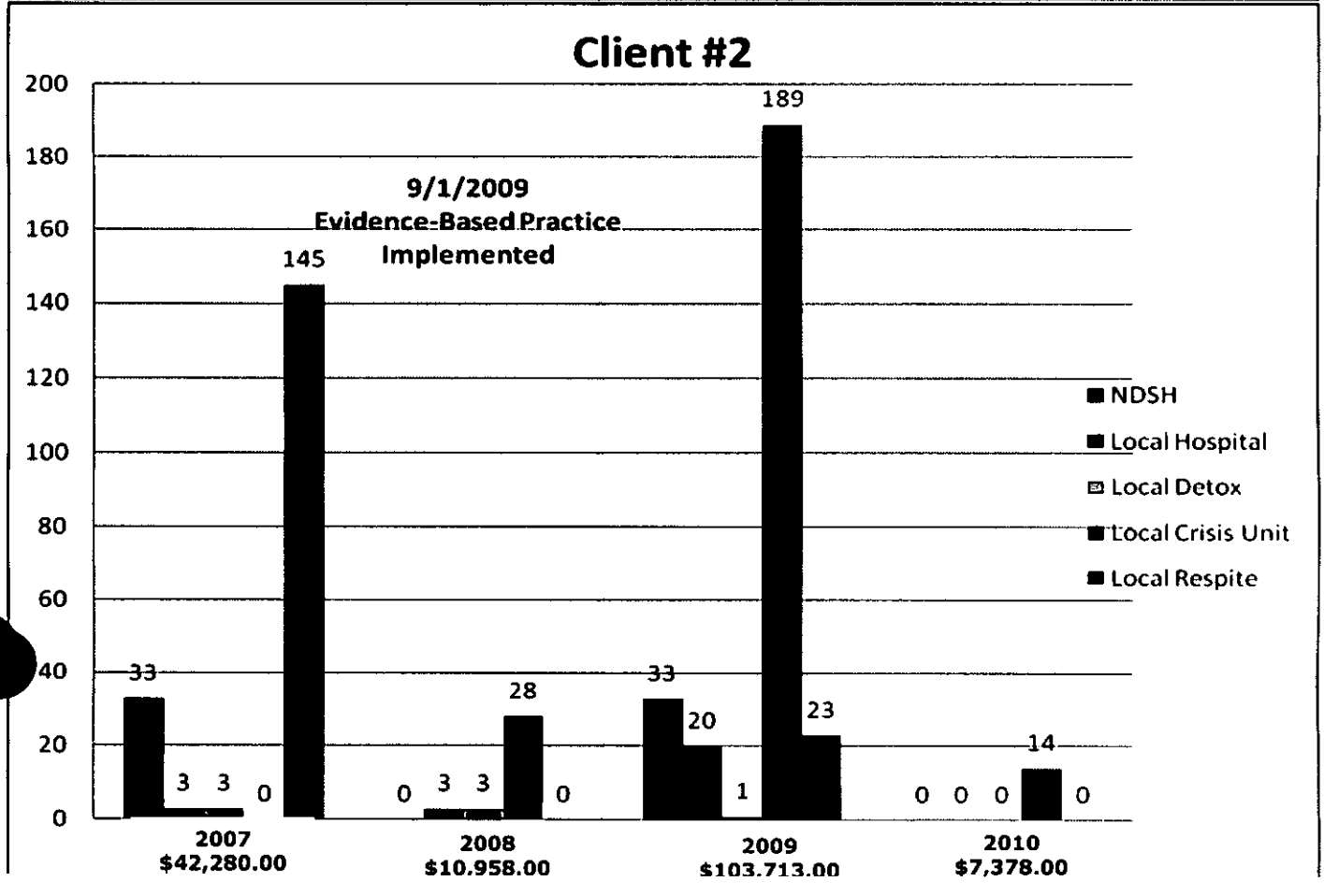
- $6 million in total funds of which $4.6 million is general fund needed to fund the Governor's salary package for state employees.
- $2.2 million in total funds of which $1.6 million is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $599,000 to cover an underfunding of salaries from the 2009 – 2011 budget, all general funds.
- A decrease of $500,000 to underfund the 2011 – 2013 pay plan, all general funds.
- An increase of 1 FTE for a Psychiatrist position at North Central, $411,000 total, $269,000 general fund.
- An increase of $1.0 million for added psychiatry positions at both NEHSC (by replacing two contracted part-time psychiatrists) and at BLHSC (instead of contracting for the service) by utilizing existing FTE.
- The remaining increase of $270,000 in the Salaries and Fringe Benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 837.48 FTEs in this area of the budget.

- $1.24 million increase, with $1.09 million in general fund to allow for a 3% inflationary increase for contracted providers each year of the biennium.
- An increase of $3.4 million (for a total of $4.26 million among Centers) to provide approximately 4,900 psychiatric inpatient hospital days to be paid at the Medicaid equivalent rate for those who are not eligible for Medicaid but are clients of the department. The department also plans to move forward with a centralized contract allowing for consistent contract terms statewide and allowing flexibility for amounts to be moved from region to region based upon need.
- Includes an additional $3.35 million to address the following residential capacity issues using general fund.
    - Includes $1.4 million for a 10 bed Crisis Unit for those who are Seriously Mentally Ill in the Minot region.
    - Includes $939,000 for a 15 bed Chemical Dependency Residential Unit in the Fargo region.
    - Provides for 4 additional Adult Crisis Beds in the Bismarck region at a cost of $309,000.
    - Provides for an additional 24/7 contracted staff at the Cooper House in the Fargo region to ensure safety at a cost of $498,000.
    - Includes $201,000 to continue the 8 bed short term residential services for alcohol and drug clients in the Fargo region.

This concludes my formal testimony I would be glad to answer any questions you may have. Thank you.

Attachment A





Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January 19th, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Alex C. Schweitzer, Superintendent of the North Dakota State Hospital and North Dakota Developmental Center (One Center) of the Department of Human Services. I am here today to provide you with an overview of the One Center for the Department of Human Services.

North Dakota State Hospital Programs:

The North Dakota State Hospital provides short-term inpatient and long-term residential psychiatric, chemical addiction, and forensic services for adults. Within this group of adult patients are offenders referred to the Tompkins Rehabilitation and Corrections Center by the Department of Corrections and Rehabilitation for residential addiction services.

The State Hospital also provides inpatient services for children and adolescents with serious emotional disorders and substance abuse problems. The Jamestown Public School System provides educational services to the child and adolescent population in a school located on the grounds of the State Hospital.

The above-mentioned patients are considered to be the traditional patient population of the Hospital.

The Hospital also provides inpatient evaluation and treatment services for sexually dangerous individuals. This group of patients are housed and treated in the secure services unit of the Hospital.

North Dakota State Hospital Census:

The State Hospital operates 307 beds.

The Hospital utilizes ninety (90) of these beds to provide addiction services to offenders in the Tompkins Rehabilitation and Corrections Center, comprised of 60 male and 30 female offenders.

The Hospital utilizes one hundred thirty-two (132) beds for inpatient and residential psychiatric services for the treatment of adults, children and adolescents with serious and persistent mental illness, serious emotional disorders and chemical addiction. Inpatient and residential services were highly occupied from 2006 through 2008, with occupancy often running between 95% - 100% and occasionally exceeding 100%. The major reasons for this high occupancy were the admission of first time patients, chronic patients awaiting referral to residential settings and the increased need for treatment of patients with complex medical and psychiatric issues.

The inpatient psychiatric service during the past two years (2009 – 2010) saw an increase in total admissions and a decrease in average daily census. Average occupancy was 86% during the past year and this better aligns with the ratio of staff to patient as the Hospital staffs patient units for 85% occupancy.

The decrease in occupancy can be attributed to increased community service options, treatment in local psychiatric inpatient facilities and discharge options for chronic patients.

The Tompkins Rehabilitation and Corrections Center and the Inpatient Psychiatric Service admissions and average daily census data is outlined in Attachments A (1) & (2) based on a calendar year.

The Hospital operates 76 beds in the sex offender unit, and at the end of 2010 we had occupancy of 59 patients. The Hospital also operates a Transitional Living Home on the campus for one sex offender in the late stages of their commitment to the program.

The census data on the sex offender population is outlined in Attachment B.

In summary, the Executive Budget recommendation for the North Dakota State Hospital is for a total capacity of 298 patients. The breakdown by program includes; 90 beds in the Tompkins Rehabilitation and Corrections Center, 76 beds in the Secure Services Unit (sex offender program) and 132 beds for inpatient psychiatric services.

Major Program Changes/Trends:

- The North Dakota State Hospital is providing more residential services for individuals with dual diagnosis, mental illness, chronic recidivistic alcoholics and individuals with intellectual disabilities that present with chronic medical and behavioral issues.

- After years of dramatic decline, because of the increased availability of community-based services, the State Hospital's patient census grew modestly after 2003. The growth was attributed to sex offenders, the Tompkins Program and first time admissions.

- The North Dakota State Hospital had pending waiting lists in the years 2006, 2007 and 2008. The Hospital adapted with the addition of more hospital beds. This moderated in 2009 and 2010 – frequently the Hospital was at 85% occupancy. The need for more inpatient beds was removed from the 2011 budget request and instead internal reorganization is meeting our patient needs.

- Individuals admitted to the North Dakota State Hospital have higher acuity levels than in the past.

- Secure Services had its first discharge in 2008 and we have discharged 16 individuals from the sex offender program to date. (Two returned to prison).

Overview of Budget Changes in Traditional Services:

Description	2009 – 2011 Budget	2011 – 2013 Budget	Increase/ Decrease
Capital Construction Carryover	1,179,625		(1,179,625)
Institutions	58,870,713	62,208,285	3,337,572
General Funds	40,114,197	42,061,882	1,947,685
Federal Funds	4,803,599	2,609,783	(2,193,816)
Other Funds	15,132,542	17,536,620	2,404,078
Total	60,050,338	62,208,285	2,157,947
FTE	380.96	381.45	.49

Budget Changes from Current Budget to Executive Budget:

The Overall Budget increase of $2,157,947 can be explained as follows:

- $2,558,189 in general fund needed to fund the Governor's salary package for state employees.

- $936,178 in total funds of which $882,686 in general fund and $53,492 in federal funds needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.

- An increase of $1,346,480 to cover an underfunding of salaries from the 2009 - 2011 budget.

- The 2011 - 2013 Executive Budget recommendation has a salary underfund of $796,986 for traditional services.

- The Executive Budget recommendation includes $222,970 to hire a pharmacist to provide telepharmacy services to the eight (8) regional human service centers.

- A decrease of $282,860 in temporary salaries as the 11 - 13 request splits the cost of patient employment between the traditional budget and secure services budget.

- The remaining decrease of $30,597 is a combination of increases and decreases needed to sustain the salary of the 381.45 FTE in this area of the budget.

- A increase in operating costs of $535,514, which includes; an increase in travel costs, educational supply costs, chemical supply costs, office supply costs, furniture replacement, insurance costs, a pharmacy bar code system for the pharmacy and increased stipend and professional development costs.

- The Executive Budget recommendation for major extraordinary repairs at the Hospital is for $733,650, which is a decrease of $2,267,367 from the current budget;

Major extraordinary repairs include; $220,000 for replacing the LaHaug sanitary sewer system, $50,000 for siding and windows for transitional living houses, $20,000 for overhauling chillers, $75,150 for asbestos and lead based paint abatement, $25,000 for the LaHaug fire alarm system upgrade, $15,000 for replacing the windows in the south end of the Chapel, $25,000 for roof repairs, $25,000 for new security lights, $25,000 for one unisex handicapped accessible bathroom in the Chapel, $30,000 for water supply repairs, $25,000 for coal handling equipment, $18,000 for boiler repairs,$33,500 for fuel oil pump, $27,000 for heating coils, $20,000 for handicapped accessible doors and $100,000 to upgrade the elevators in the LaHaug building.

- Other capital payments decreased by $437,729 as bond payments were paid off for the North Dakota State Hospital in 2010.

- Land and Buildings increase in the Executive Budget of $1,800,000 to include; $1,500,000 for Joint Commission accreditation items, the cost of replacing the emergency generator $1,300,000 and testing of fire/smoke dampers $200,000, and $300,000 for the rewiring and updating of electrical equipment in the New Horizons building.

- Equipment over $5,000 in the Executive Budget recommendation shows a decrease of $246,220.

- Capital Construction Carryover - Extraordinary Repairs also decreased by $1,179,625, which was a carryover of funds from the 2007 – 2009 biennium for capital projects in progress on July 1, 2009.

- The 2011 - 2013 Executive Budget recommendation contains an increase of .49 FTE. This includes the one (1) FTE for the telepharmacy position and a reduction of .51 FTE because of a transfer to secure services.

- The increase in General Fund is the result of the Executive Budget recommendation for the state employee's salary package and the one-time expense of capital projects.

- Federal Funds decrease by $2,193,816 because of the reduction in Federal Participation and fewer patients covered by Medicaid.

- Other Funds increase by $2,404,078 because of increased payments for Medicare Pharmacy Part D, Medicare Inpatient Part A and contract payments for Tompkins Rehabilitation Center patients.

Overview of Budget Changes in Secure Services:

Description	2009 – 2011 Budget	2011 – 2013 Budget	Increase/ Decrease
Institutions	10,480,123	11,264,915	784,792
General Funds	10,429,000	11,264,915	835,915
Federal Funds	17,824	-	(17,824)
Other Funds	33,299	-	(33,299)
Total	10,480,123	11,264,915	784,792
FTE	85.55	86.06	.51

Budget Changes from Current Budget to Executive Budget:

The Overall Budget increase of $784,792 can be explained as follows:

- The salary increase is $553,837 in general fund needed to fund the Governor's salary package for state employees.

- $282,242 in total funds of which $282,078 is general fund and $164 in federal funds needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.

- The 2011 – 2013 Executive Budget recommendation has a salary underfund of $900,000 for secure services.

- The 2011 – 2013 Executive Budget recommendation has an increase of $368,091 to cover underfunding from the 2009 – 2011 budget.

- An increase of $187,432 in temporary salaries as the 11 – 13 request splits the cost of patient employment between the traditional budget and secure services budget.

- The remaining increase of $183,727 is a combination of increases and decreases needed to sustain the salary of the 86.06 FTE in this area of the budget.

- Operating costs increase by $109,463, with the primary increases in educational supplies, health supplies, office supplies, flooring costs, estimated building repairs, added cost of psychological evaluations, stipends and professional development costs.

- Total FTEs increase by .51 because of the transfer of a RN II and Forensic Psychologist from the traditional services budget to the secure services budget.

- The increase in general fund in the Executive Budget recommendation for secure services is the result of Governor's salary package.

- Federal Funds decrease by $17,824, as we were unable to collect any federal dollars for the secure services unit.

- Other funds decrease of $33,299 is the result of patients not having private funds or third party payers for payment.

North Dakota Developmental Center Programs:

The North Dakota Developmental Center provides services for individuals with intellectual disabilities. The Center provides residential services, work and day activity services, medical services, clinical services and evaluation and consultation services.

Residential Services at the Developmental Center include:

- Secure Services Program – this unit is for individuals with intellectual disabilities who have sex offending behaviors and for other individuals from the campus that require a more secure living environment. These individuals require long-term care.

- Health Services Program – for individuals with intellectual disabilities who are totally dependent on staff to complete daily cares and have medical concerns that require nursing staff accessibility 24 hours per day. Also, in this area are a small number of individuals diagnosed with profound intellectual disability and dual sensory disabilities (vision and hearing). These individuals require long-term care.

- Behavioral Care Program – these individuals with intellectual disabilities present with psychiatric diagnoses and significant challenging behaviors. Some of these individuals may also have less severe medical needs.

- Youth Services Program - these young people between the ages of 16 - 25 have difficulty finding housing and services in the community. The Center provides short-term services to these individuals until a community placement can be found.

- Independent Supported Living Arrangement Program - the Developmental Center has three individuals with sexual health issues living in campus housing. The Center provides staffing to support these individuals in this independent living arrangement.

- Outreach Program – the Center provides outreach services for the community. The Consultation, Assistance, Resource, Evaluation and Service (CARES) team provides these services in order to prevent admissions, readmissions and also assist in transitioning people from the Developmental Center. In 2008 the CARES Team went statewide.

North Dakota Developmental Center (NDDC) Census:

See Attachment C, for the census data at the Center for the period of 1997 through 2010.

Major Program Changes/Trends:

- Census at the Developmental Center was steady for a number of years at an average of 143 individuals until the transition to community initiative started in 2005. The current budget request is based on 95 individuals. The goal is for 67 individuals to be residing at the Center by July of 2013.

- The Developmental Center transformation initiative is preparing the facility for a smaller population and the elements of this initiative include; decentralized dining, reorganized work and activity programming, the addition of transitional programs for adults and youth, preparing staff for transition, closing and reorganizing units, suites and buildings, and renting or selling underutilized buildings and land.

- The CARES function has been enhanced to support people in community settings and to prevent admissions and readmissions to the Center. The addition of the transitional programs, the enhancement of the CARES function and the addition of behavioral analysts are the primary drivers in managing admissions and readmissions. No additional dollars are requested for these enhancements.

- The Developmental Center has vacant space because of the transition of individuals from the Center to the community.

- The Developmental Center has higher acuity levels with the population that is remaining at the facility.

Overview of Budget Changes – North Dakota Developmental Center:

Description	2009 – 2011 Budget	2011 – 2103 Budget	Increase/ Decrease
Capital Construction Carryover	20,100		(20,100)
Institutions	54,082,240	51,809,247	(2,272,993)
General Funds	14,595,729	20,417,430	5,821,701
Federal Funds	35,363,271	27,823,460	(7,539,811)
Other Funds	4,143,340	3,568,357	(574,983)
Total	54,102,340	51,809,247	(2,293,093)
FTE	441.29	400.76	(40.53)

Budget Changes from Current Budget to Executive Budget:

The Overall Budget decrease of $2,293,093 can be explained as follows:

- The salary increase is $2,277,341 in total funds of which $1,060,331 is general fund, $1,217,009 in federal funds and $1 in other funds needed to fund the Governor's salary package for state employees.

- $700,042 in total funds of which $367,331 is general fund and $332,711 in federal funds needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.

- An increase of $201,159 to cover an underfunding of salaries from the 2009 – 2011 budget.

- The 2011 – 2013 Executive Budget recommendation has a salary underfund of $738,694 for the Developmental Center.

- Other salary changes include; a decrease of $323,601 because of retirements and a decrease of $3,536,968 as a result of reduced client population.

- The remaining decrease of $162,509 is a combination of increases and decreases needed to sustain the salary of the 400.76 FTE in this area of the budget.

- Operating Fees and Services increase $433,134 due to increased provider assessment costs.

- Other Operating costs decrease by $413,034 due to reduced resident population, with decreases in flex training costs, supply costs, professional fees, and medical, dental and optical costs.

- The Executive Budget recommendation for extraordinary repairs at the Center is for $579,469, which is a decrease of $133,206 from the current budget. Extraordinary repairs include; $199,100 for sprinkler system upgrade for the residential buildings, $203,747 for flooring, $50,000 for replacement of piping for the steam distribution system, $10,000 for campus concrete projects, $25,000 for door and hardware replacement, $50,000 for repairs to the chill water piping system, $18,000 for pool patio covers and $23,622 for ceiling upgrades in the food service area.

- Equipment over $5,000 in the Executive Budget recommendation is a decrease of $75,000 from the current budget because of reduced population.

- Decrease of $501,657 for the final bond payment made in 2010.

- Capital Construction Carryover - Extraordinary Repairs also decreased by $20,100, which was a result of carryover funds from the 2007 – 2009 biennium for capital projects in progress on July 1, 2009.

- The net decrease of 40.53 FTEs at the Developmental Center because of reduced resident population.

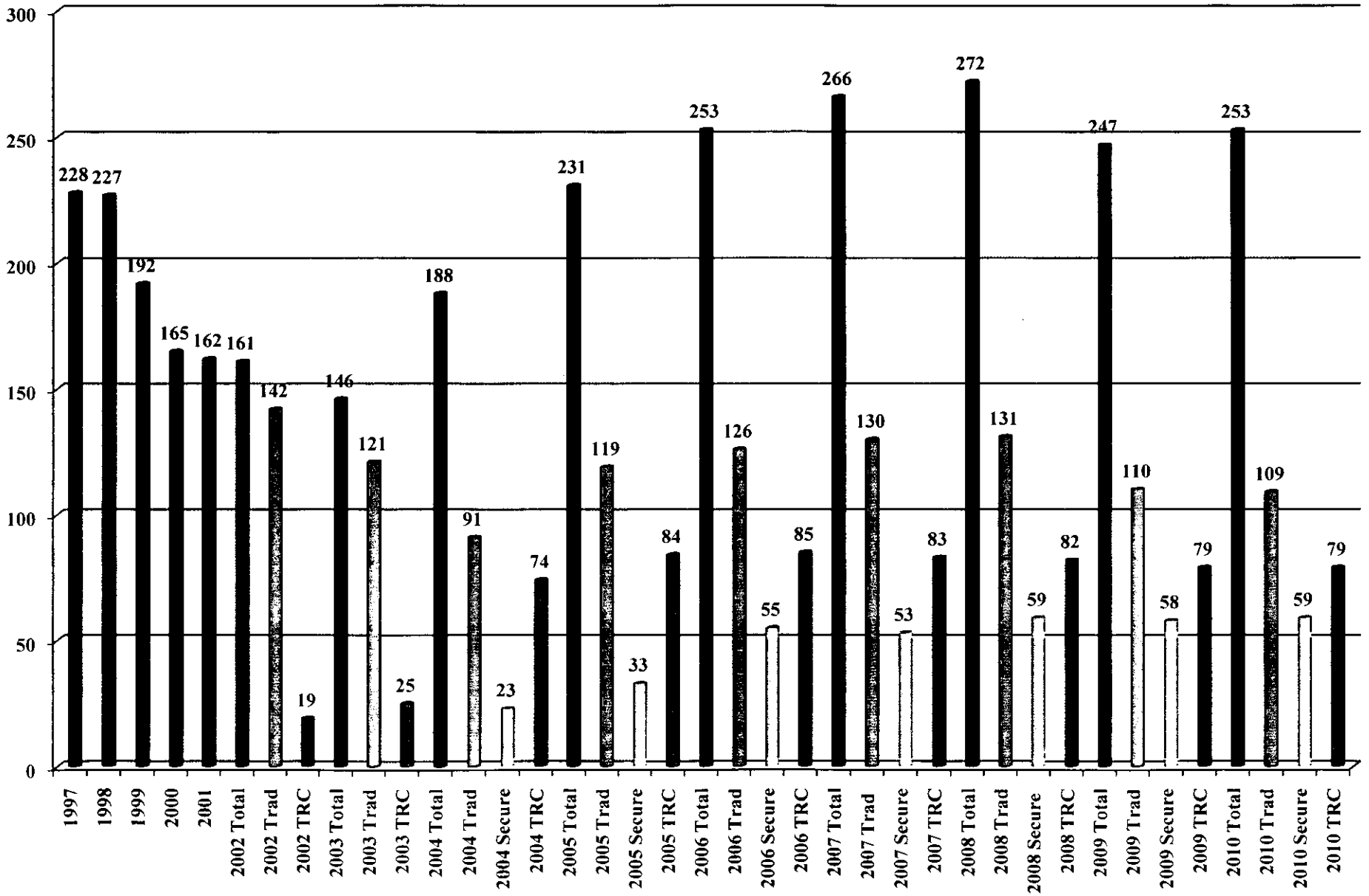
- The increase in General Fund is for the Executive Budget recommendation for the state employee's salary package and to cover the reduction in the federal match.

- The Federal Funds decrease is because of the reduction in the federal match and decrease in resident population.

- The Other Funds decrease because of a reduction in recipient liability and Medicare Part D payments because of the decrease in resident population at the Center.

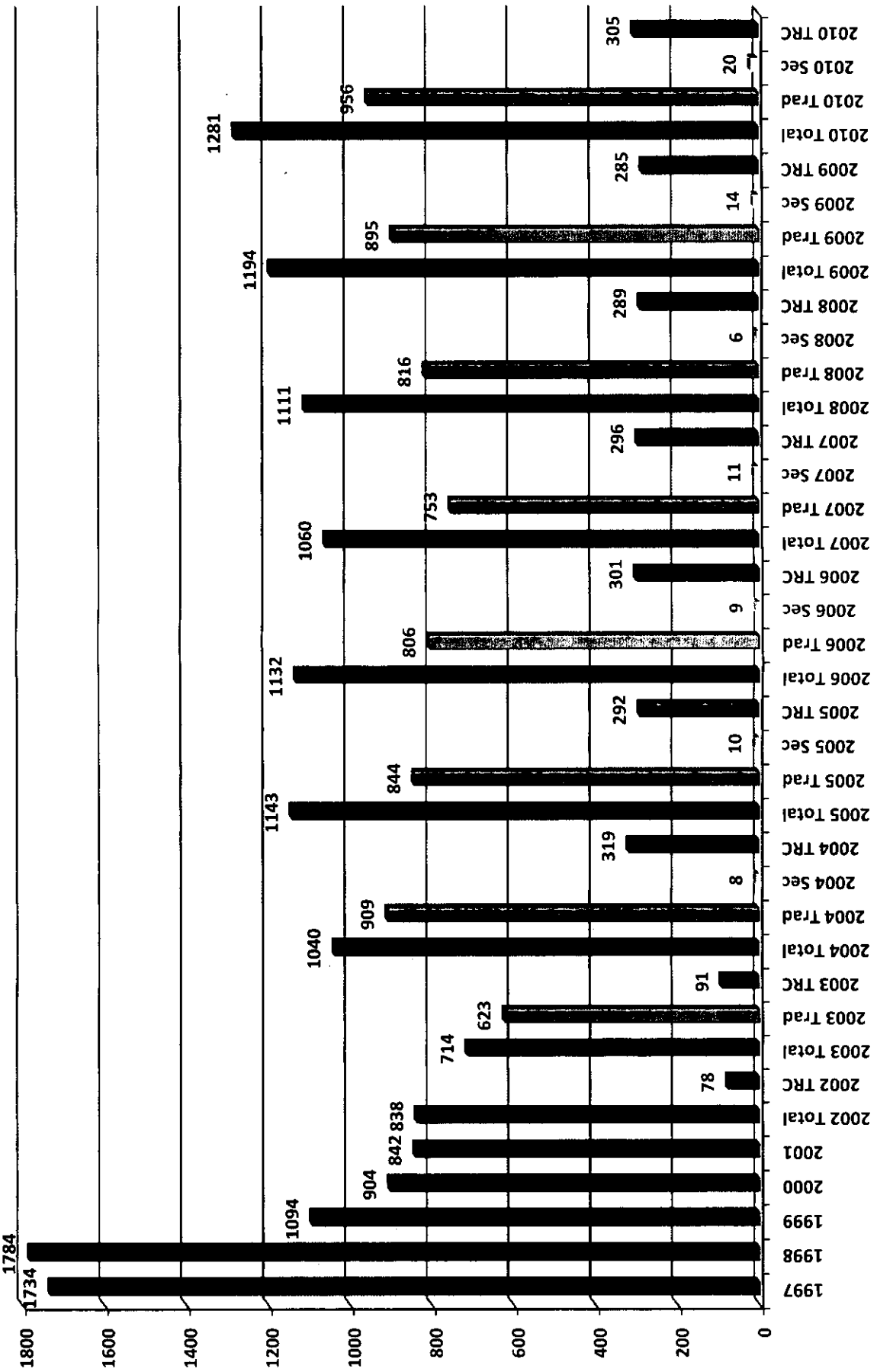
Thank you. I would be happy to answer any questions about the budget request for the North Dakota State Hospital and North Dakota Developmental Center (One Center).

NDSH AVERAGE DAILY POPULATION

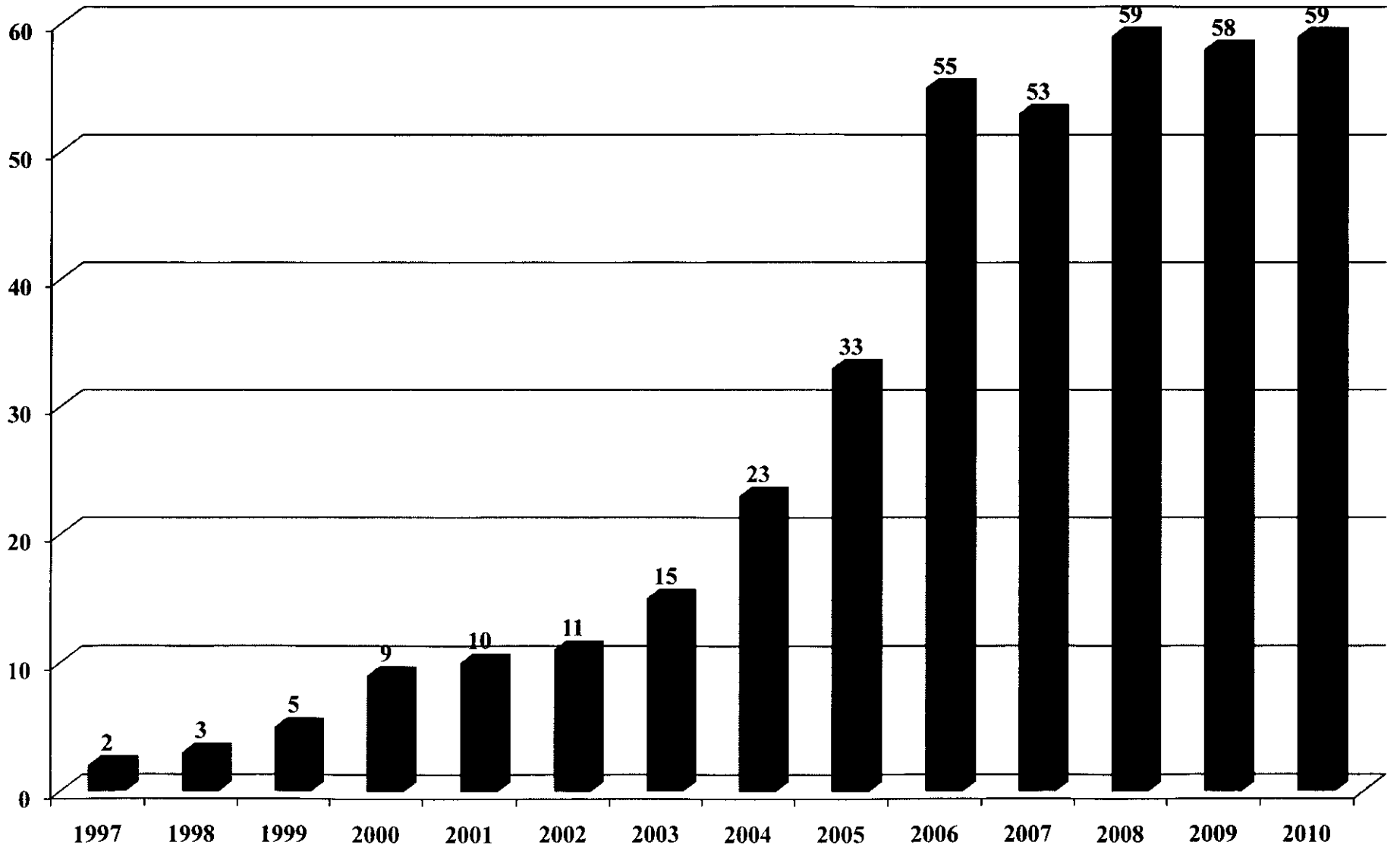


Attachment A (1)

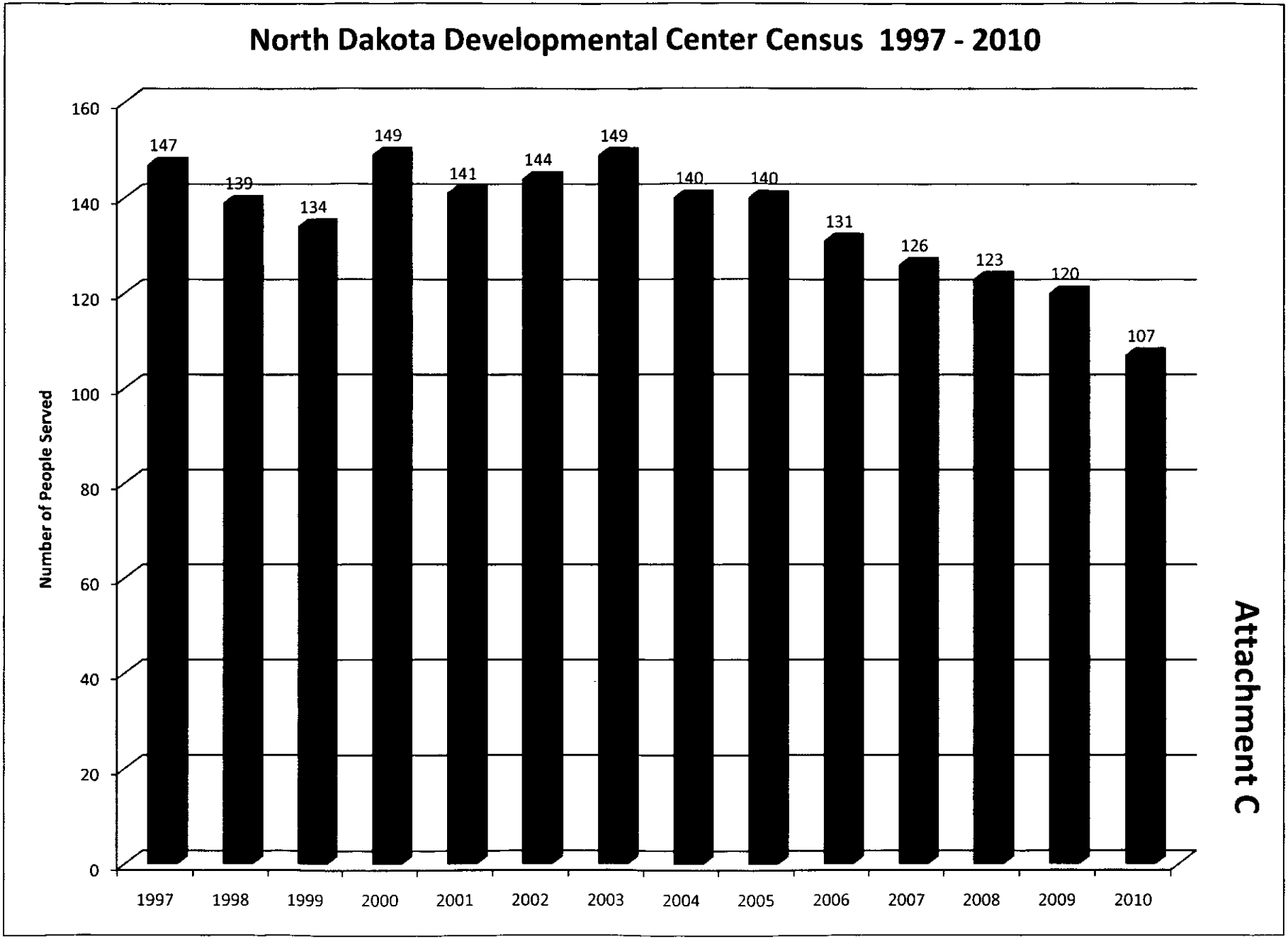
Attachment A (2)



NDSH SEX OFFENDER PROGRAM CENSUS
1997 - 2010



Attachment B



Attachment C

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
January 19, 2010

Chairman Holmberg, members of the Senate Appropriations Committee, thank you for the opportunity to provide commentary on Senate Bill 2012 – Department of Human Services' budget request for the 2011-2013 biennium.

My name is Dianne Sheppard. I am Executive Director for The Arc, Upper Valley in Grand Forks and an official spokesperson for The Arc of North Dakota. Our mission is to ensure that children and adults with an intellectual disability have the supports, benefits, and services they need, and are accepted, respected and fully included in their communities.

The North Dakota Department of Human Services' budget is a good budget as it relates to programs and services for people with an intellectual disability. We would like to see it adopted as presented along with other critical items that were identified as an OAR, but failed to be included in the budget or were not fully funded.

<u>Please consider the following</u>:

1. The North Dakota legislative effort to increase staff wages and benefits for DD providers is commendable and should be continued.

   This biennium, DD community service providers are budgeted to receive an equity increase of 3% each year of the biennium. We are asking you to approve these increases.

   In addition, we are asking you to approve a $1.46 per hour market adjustment for all DD community service provider staff.

This increase will address the wage disparity between DD community service provider staff and what the state provides for staff working in state operated programs. It will also help reduce community staff turnover, currently at 33% annually, which is unacceptably high at 1,200 to 1,500 staff leaving each year. The goal is to reduce staff over to 20% or less.

Many workers find that they can earn higher hourly wages, and receive better benefits, in far less demanding jobs. As a result, people with disabilities experience continuous turnover of staff or they find themselves unable to get workers at all. Unable to obtain adequate assistance, people with disabilities find their health and safety at risk.

A well-trained, adequately compensated workforce is essential to providing the necessary supports and services to our constituents, who constitute a very vulnerable population. Higher wages reduce employment turnover and is correlated with an increase in the quality of services.

We realize this is a big request; however, it is needed to turn the tide on staff turnover and eliminate the gap between wages paid to private employees and wages paid to public employees in the state.

2. **Critical Needs Funding**

We are asking you to approve the continued funding for the critical needs of individuals who are medically fragile and/or behaviorally challenged at $4.2 million and a 3% increase each year of the biennium.

This funding is needed so people can get the support they need to stay in their community and avoid being admitted to the Developmental Center.

3. Developmental Center Budget

We ask that you approve the Developmental Center 2011/2013 budget request funded for 95 residents, which is the current goal of the Transition to the Community Task Force.

The decrease in FTE's and some decrease in budget should only be approved if the quality of care for those individuals remaining at the institution can be guaranteed and not negatively impacted.

Any cost savings from downsizing the institution should be reallocated to community programs and services.

4. Restore OAR 407 Downsizing the Developmental Center

Institutions: We are asking you for a commitment to steadily reduce reliance on and ultimately close the North Dakota Developmental Center at Grafton.

Most professionals, family members and persons with an intellectual disability believe that large group settings are no longer acceptable living arrangements because of the difficulty of personalizing services. Virtually every credible research study supports the assertion that people are well served in small community settings, including those with behavior issues, or people with complex medical needs.

As such, institutional placement cannot be justified on the programmatic needs of the people who are forced to reside in an institution in order to receive services. The long-term future of services to persons with an intellectual disability in North Dakota is in community settings.

The **Transition to the Community Task Force**, chaired by Alex Schweitzer, Superintendent of the Developmental Center, has put together a transition goal for July 1, 2013 for a maximum of 67 people residing at the Center. This is a reasonable goal and should be supported with a

budget that will meet that goal. **Restoring OAR 407** will help meet that goal. Without those funds, transitions to the community will happen at a slower pace and make the goal of 67 residents at the institution by the target date difficult to reach.

These funds also address the need for dual funding during the transition process. The resident per diems for those residents remaining at the Center during the downsizing process will increase due to fixed costs being spread over fewer residents. Conversely, as people move to the community the related costs will also increase.

General Funds: $2,712,968
Federal Funds: $3,382,849
Total Funds: $6,095,817

The closure of a state institution can generate savings for state government over time because it:

1) Eliminates the high fixed cost of operating a state-owned facility, originally built for many more residents than live there at the time of closure;

2) Shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI);

3) Increases the likelihood that individuals will engage in productive employment in a local community because they now live closer to employment markets;

4) Utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expense, specialized services provided in the institution; and,

5) By renting/leasing a residence, the expensive institutional capital construction and remodeling costs necessary for most institutions to remain open and certified for receipt of federal reimbursement are avoided.

5. **Restore OAR 408 – Guardianship Program**

We ask that you approve additional funding for the Guardianship Program so they can pay for corporate guardianship services as well as a Guardianship Handbook.

General Funds: $65,275

6. **Children's Health Insurance Program (CHIP)**

The Arc supports the protection and expansion of CHIP as a dedicated program for insuring currently uninsured children to include dental and mental health benefits.

We ask that you approve an increase in CHIP at 250% of poverty rather than the proposed 160% of poverty.

Conclusion:

North Dakota has a healthy budget surplus, and this would be the ideal time to invest in our community service delivery system. People are confined to the Developmental Center in Grafton in part because of the lack of appropriate resources in the community. When the state has the resources to provide those services in the community and fails to commit the money, it is difficult to conclude that the state has a real commitment to community services and the least restrictive environment as required by state and federal law.

Attached is *Closing the North Dakota Developmental Center: Issues, Implications, Guidelines* where you will find 10 key issues addressed on the closure of the Developmental Center at Grafton.

I would be happy to answer any questions you may have.

Thank you.

Dianne Sheppard
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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

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March 7, 2006

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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

PURPOSE AND FOCUS OF THE PAPER

This paper has been prepared at the request of the Arc-Upper Valley Board of Directors. It is intended to stimulate discussion and further study by the Arc and other interested parties in North Dakota on the possible closure of the North Dakota Developmental Center at Grafton (hereafter "Grafton").

The primary focus of the paper is to identify and discuss 10 key issues, expressed as questions, associated with the potential closure of Grafton, North Dakota's remaining mental retardation and developmental disabilities (MR/DD) institution. The implications of closing Grafton are considered in light of other states' experiences in closing state-operated MR/DD institutions and in light of relevant research. The paper addresses the following ten questions:

1. How did state-operated institutions for persons with mental retardation and developmental disabilities evolve nationally?
2. What are residential and community services trends in North Dakota today and in two groups of "comparison states"?
3. How many states have closed state MR/DD institutions and how many are planning to do so in the near future?
4. What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?
5. How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?
6. How do parents of individuals relocated from state institutions to community settings respond to this process of change?
7. How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

8. Should the State of North Dakota anticipate a need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

9. What are some of the alternate uses to which a closed Grafton facility might be put?

10. What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

Question #1: How did state-operated institutions for persons with mental retardation and developmental disabilities (MR/DD) evolve nationally?

The first state-operated MR/DD institutions were opened in the Northeastern U.S. in the 1850s. They were developed to provide a temporary residential placement for individuals who, after a relatively brief period of education and training in these facilities, returned to community life. Early success at several schools led to the opening of additional state-operated MR/DD institutions across the U.S. (Braddock & Parish, 2003). The first state MR/DD institution in North Dakota was opened as the State Institute for Feeble-Minded in Grafton in 1904. In addition, the San Haven facility, opened originally as a tuberculosis hospital in 1922, was converted to MR/DD use in 1973, and closed in 1987 (Braddock & Hemp, 2004).

As the country industrialized and urbanized, state institution populations expanded much faster than facilities' capacities to provide appropriate training and educational services. By 1930, more than 100,000 persons with mental retardation were institutionalized across the U.S., and most residents received minimal custodial care. This trend toward custodial care and "warehousing" of persons with mental retardation increased after the Second World War and throughout the 1950s. Media exposés about deficient conditions were commonplace (Blatt & Kaplan, 1974).

In 1967, the nation's institutional census peaked at 195,000 residents in 240 state mental retardation facilities. Since 1968, the number of individuals with mental retardation served in state institutions has declined every year and, on average, four percent annually for 37 consecutive years. In 2004, the residential census of the nation's state institutions was 41,214 persons. If present trends continue, there will be fewer than 20,000 residents in state institutions in 10 years (2016). Costs for residential care, however, are climbing rapidly. Based on previous trends, in 10 years they are projected to reach an average of approximately $193,000 for each resident per annum ($530/day), in constant 2004 dollars. The per diem cost in the Grafton facility in 2004 was $392/day and $143,000 annually (Braddock, Hemp, Rizzolo, Coulter, Haffer, & Thompson, 2005).

Current trends promoting community services in the mental retardation field evolved out of the parent movement in the 1950s and 1960s. At that time, parents began insisting upon both a higher quality of institutional care and greater opportunities for community living. Federal legislation was enacted in 1963 (Pub. L. 88-156 and Pub. L. 88-164) that authorized the establishment of an initial, but incomplete, network of community centers and services across the country (Braddock, 1987). Segregating individuals with MR/DD in large, often remote institutions and providing substandard care became prominent civil rights issues in the 1970s and 1980s. Class action lawsuits (e.g., *Wyatt v. Stickney* in Alabama, *Ricci v. Okin* in Massachusetts, *New York State Arc v. Carey, Association for Retarded Citizens of North Dakota v. Olson*) were filed and such litigation continues in Federal District Courts throughout the U.S. (Braddock, 1998). By 1980, however, many states had begun implementing community services initiatives involving the development and funding of

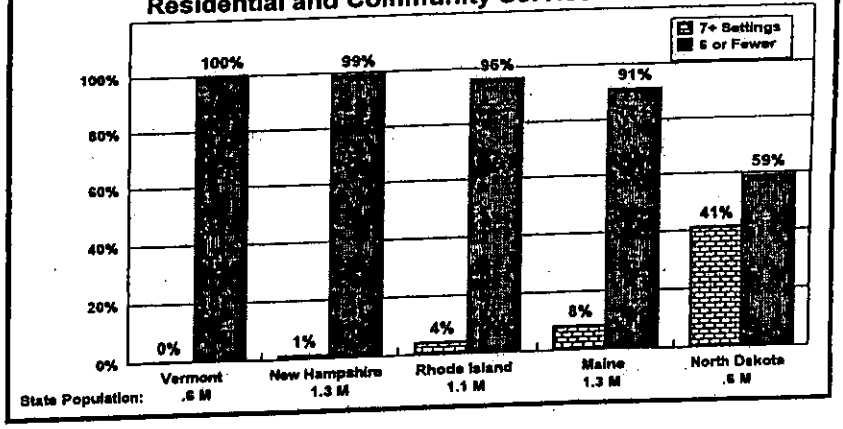
small group homes, supervised apartments, in-home family support programs, and supported employment.

Question #2: What are residential and community services trends in North Dakota today and in two groups of "comparison states"?

Today, institutional settings are being replaced by smaller, more individualized community placements and family support services. There are now more than 140,000 supervised living settings in the U.S. for six or fewer residents with MR/DD (Prouty, Smith, & Lakin, 2005). The total residential population of these small living environments was approximately 335,000 and this figure represented 68% of all out-of-home residential placements in 2004. In contrast, 86% of all persons with mental retardation in out-of-home residential placements nationally were living in large, 16 beds or more, publicly and privately-operated institutions in 1977 (Braddock et al., 2005).

North Dakota, however, significantly lags the dominant national trend in this regard. The State ranked 39th in 2004 in the percentage of persons with MR/DD living in smaller (six person or fewer), family-scale out-of-home environments, and 44th in the proportion of its total spending allocated to six-person or fewer settings. ***Figure 1*** compares North Dakota to four New England states with roughly the same state general population as North Dakota (Braddock et al., 2005).

Figure 1
Percentage of Total State Spending for 6-Person or Fewer Residential and Community Services: FY 2004



Another analytically useful comparison group of states includes South Dakota (.8 million population), Wyoming (.5 million), Montana (.9 million), and Idaho (1.4 million). Each of these "mountain west/plains states," like North Dakota, has one remaining institution. The 2004 MR/DD institutional censuses were 90 (MT), 92 (WY), 94 (ID) and 176 (SD), compared to 146 in North Dakota. Although South Dakota's census in 2004 was larger than North Dakota's, all four of these states had lower institutional utilization per capita rates (per 100,000 of the state general population).

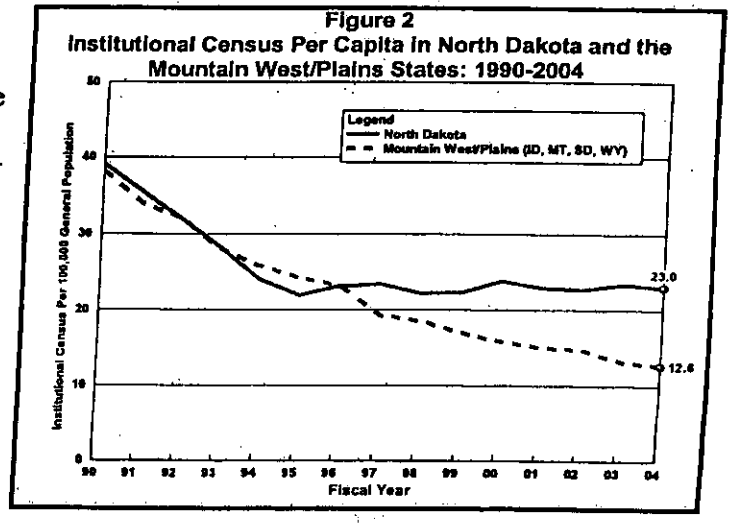


Figure 2 illustrates how the MR/DD institutional utilization per capita (of the state general population) for the four mountain west/plains comparison states began diverging from North Dakota in 1996. In 2004, North Dakota's institutional utilization exceeded the aggregate of the four comparison states by 83% (23.0 vs. 12.6). Moreover, South Dakota, Wyoming, Montana, and Idaho each committed a considerably larger share of total MR/DD spending to six-person or fewer residential and community services (70-77%) compared to only 59% in North Dakota. North Dakota's utilization rate for state-operated institutional care has been stable for the past 12 years, through 2006.

Question #3: How many states have closed state MR/DD institutions and how many are planning to do so in the near future?

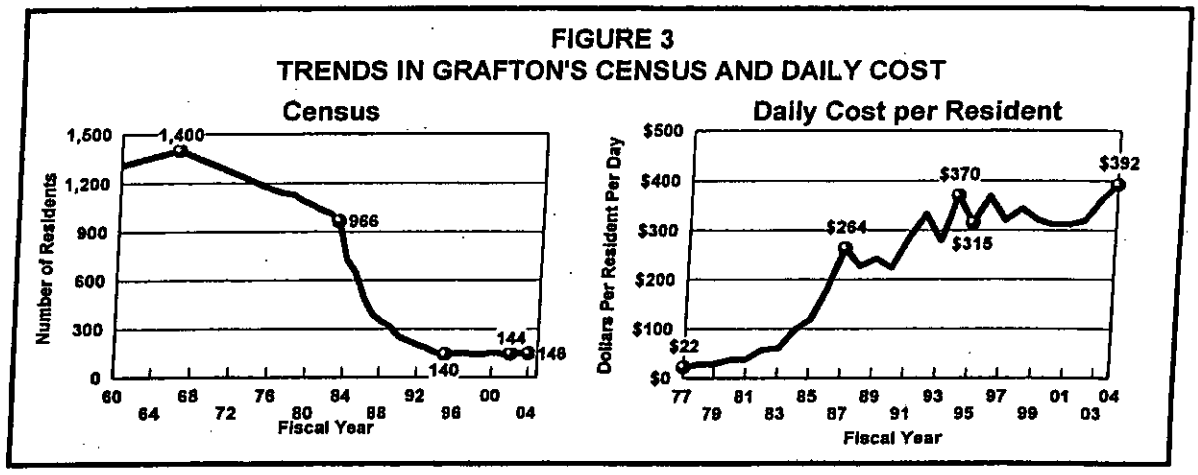
Since 1970, on a national basis, 39 states have closed, or are planning to close, 139 state-operated MR/DD institutions (***Appendix I***). This is more than one-half the 240

institutions that existed in 1970. (The average institutional census in 1970 was about 800 persons, compared to an average of 206 residents for the 200 facilities open in 2004.)

Sixty of the 139 completed and in-progress closures have occurred in the past 10 years. In January 1991, New Hampshire closed the Laconia State School and became the first contemporary American state to operate an institution-free service delivery system. The District of Columbia, Vermont, Rhode Island, New Mexico, West Virginia, Hawaii, and Maine became institution-free from 1991 to 1999. Michigan has closed 12 state institutions and in 2004, its only remaining facility, Mt. Pleasant, had a census of 162 persons. Minnesota has only one "institutional" program for persons with MR/DD. This is an intensive behavioral treatment program for seven consumers, located in a state psychiatric hospital.

Providing community-based services for persons with MR/DD and their families has gained considerable public support in recent years. Between 1977 and 2004, the annual growth of total community spending in the United States averaged 10% per year, after adjusting for inflation. Total state institution spending, however, actually declined 1% annually during 1977-04, and the average annual census of residents in institutions dropped by five percent per year.

The census of Grafton and San Haven in North Dakota (***Figure 3***) declined by an average of two percent per year from 1966 to 1983, one-half of the U.S. institutional rate over that period. Following the implementation of the consent decree in *Association for Retarded Citizens of North Dakota v. Olson* (1982), the North Dakota institutional census dropped by 15% per year from 1983 to 1995, from 966 to 140 persons. San Haven closed in 1987. In the past 12 years, through early 2006, there has been essentially no further decline in Grafton's institutional population. In fact, it has increased slightly since 1995.



Question #4: What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?

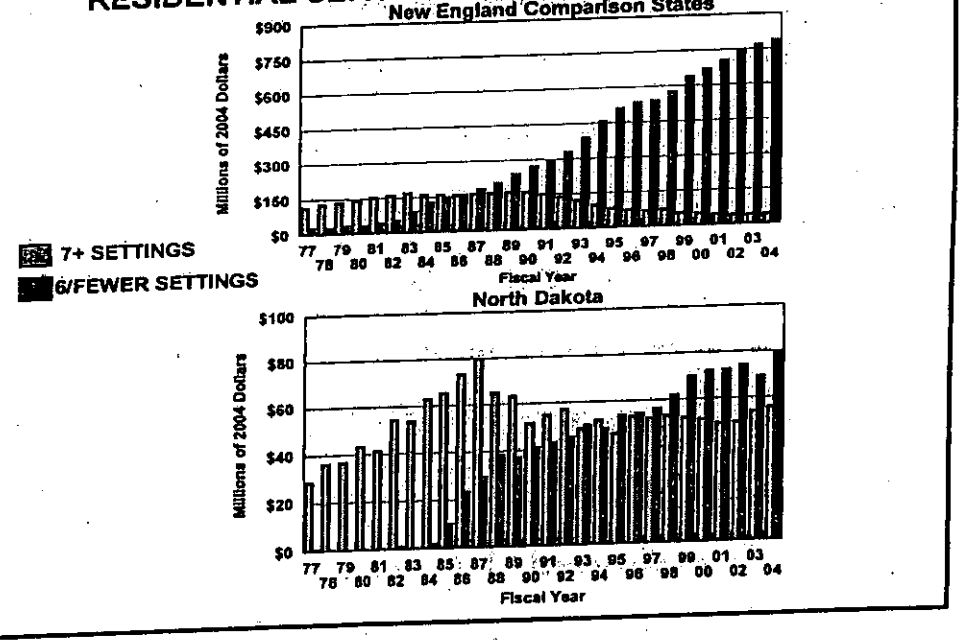
If present trends continue, an average of $193,000 per year, or $530 per day in constant 2004 dollars, is expected to be spent in the year 2016 for each institutional resident in the United States. From 1977 to 2004, average per diems grew nearly nine-fold, from $45/day to $400/day, and in 2004 per diems exceeded $500/day in 15 states, $400/day in 21 states, and $300/day in 35 states (Braddock et al., 2005).

Since 1995, the cost for each Grafton resident has advanced from $315 to $392 per day (***Figure 3***). The average cost of care in North Dakota's institution is now over $143,000 per year for each resident. Absent a decision to close Grafton, and given the stability of the Grafton census, the Grafton per diem for fiscal year 2016 in constant 2004 dollars may well surpass $600/day for approximately 146 residents. This amounts to $219,000 per year per resident, or $32.0 million per annum for the Grafton facility in 10 years.

An equally significant fiscal consequence of continuing to commit increasingly larger sums of money to institutional operations lies in the fact that, given current spending trends for Grafton, fewer "new" funds would be available to initiate additional or higher quality community services for consumers and families in the State. However, the New England

states of Maine, New Hampshire, Rhode Island and Vermont have all closed their remaining state MR/DD institutions, reallocated institutional funding, and greatly expanded their community services for thousands more individuals with MR/DD and their families (***Figure 4***). In contrast, North Dakota has continued to dedicate funding to persons in Grafton and to larger group living arrangements for seven or more persons. The New England states' decisions to close their MR/DD institutions lead to the development of a range of community housing and supported work options that subsequently received widespread political support (e.g., Covert, Macintosh & Shumway, 1994).

FIGURE 4
SPENDING FOR SIX PERSON OR FEWER RESIDENTIAL SERVICES: 1997-2004 (ADJUSTED)



Question #5: How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?

Larson and Lakin (1989) of the University of Minnesota published a comprehensive review of research on changes in adaptive behavior associated with residents moving from state mental retardation institutions to smaller community living arrangements. Over 50

studies published between 1976 and 1988 were initially identified. After screening them according to six quality standards, 18 studies were subsequently analyzed. Results of the analysis indicated that institutions were "consistently less effective than community-based settings in promoting growth, particularly among individuals diagnosed as severely or profoundly retarded" (p. 330). The 18 studies reviewed involved 1,358 participants. The studies were conducted in 13 different states from all regions of the country. The authors concluded:

> ...it must be recognized that based on a substantial and remarkably consistent body of research, placing people from institutions into small, community-based facilities is a predictable way of increasing their capacity to adapt to the community and culture (p. 331).

In California, Brown, Fullerton, Conroy, & Hayden (2001) evaluated the well-being of more than 2,000 individuals with developmental disabilities who left state-operated California developmental centers from 1993 to 2001. The researchers assessed each individual at the state institution prior to the move, and, during 1994-2001, visited all 2,170 relocated individuals in their new homes in the community.

Data collected included measures of independence, behavioral challenges, choice-making, friendships, integration, person-centered planning, health, service intensity, earnings, and both consumer and family satisfaction. Brown et al. (2001) found that those relocated, compared to their lives in an institution in 1994, experienced improvement in "integrative activities," individualized treatment," "progress toward individual goals," "opportunities for choice-making," "reduced challenging behavior," and "perceived quality of life." Families were reported to be "unexpectedly and overwhelmingly happy with community living, even those who formerly opposed the change" (p. 3).

Brown et al. (2001) acknowledged that individuals relocated lost some of those gains between 2000 and 2001, stating that a plausible explanation was that "low salaries and high turnover rates translate into poorly motivated and poorly trained staff" in the community, an issue confirmed by family members who stressed the "poor quality and the short tenure of direct care staff" (p. 50). The State of California spent only 55% of the previous institutional cost per person, compared to community spending levels in New Hampshire, Pennsylvania, and Connecticut ranging from 80% to 86% of their states' institutional costs (Brown et al., 2001; Conroy, 1996).

Many people with levels of impairment once believed to be manageable only in institutional settings now live satisfactorily in community settings. This includes individuals with health problems (Gaylord, Abery, Cady, Simunds, & Palsbo, 2005; Hayden, Kim, & DePaepe, 2005; Larson, Anderson, & Doljanac, in press) and with challenging behaviors (Hanson, Wiesler, & Lakin, 2002; Kim, Larson, & Lakin, 2001; Stancliffe, Hayden, Larson, & Lakin, 2002). Undeniably, anecdotal reports of instances in which community placements did not work out are occasionally cited by proponents of continuing institutionalization of persons with MR/DD. However, the institutionalization of persons who have committed no wrong against society can only be justified by demonstrating clear benefits accruing to these persons from living in an institution. *Research literature noted above clearly indicates that state institutions do not provide a superior level of care for people with mental retardation.*

Question #6: How do parents of individuals relocated from state institutions to community settings respond to this process of change?

Families often initially oppose the transfer of their relatives from institutions to community settings, but after transfer occurs, the great majority of parents become strong

supporters of community placement (Heller, Bond, & Braddock, 1988). Since the late 1970s several studies have addressed the reactions of parents of institutionalized persons to the community placement of their relative with mental retardation. The studies demonstrated that, after community placement, parents consistently reported lower levels of satisfaction with the earlier institutional placement and higher levels of satisfaction with community placement (Brown et al., 2001; Larson & Lakin, 1991).

Initial family dissatisfaction with closure often bears little relationship to family attitudes toward closure a year later. The relative's medical status and the family's worry over "transfer trauma" have often both played significant roles initially upon the announcement of the closure, but not in determining longer-term parent reactions. The primary variables affecting both parent satisfaction with closure and parent stress levels is the family's current appraisal of the quality of the new community placement. Frequent staff consultation with the family members during the closure process was related to higher parent satisfaction with closure one year later (Heller et al., 1988).

Given that some families might resist institutional closure and the relocation of their relative, it is important to assure families that increased consumer health and adjustment problems are now uncommon during and following institutional closures. This is due to implementing the relocation process with sensitivity to the consumer's needs and preferences and involving families directly in the process. The literature on family reaction to institutional closure and relocation may be summed up as follows:

> ...the clearest message in these studies is that the overwhelming majority of parents become satisfied with community settings once their son or daughter has moved from the institution, despite general predisposition to the contrary (Larson & Lakin, 1991, p. 36).

Question #7: How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

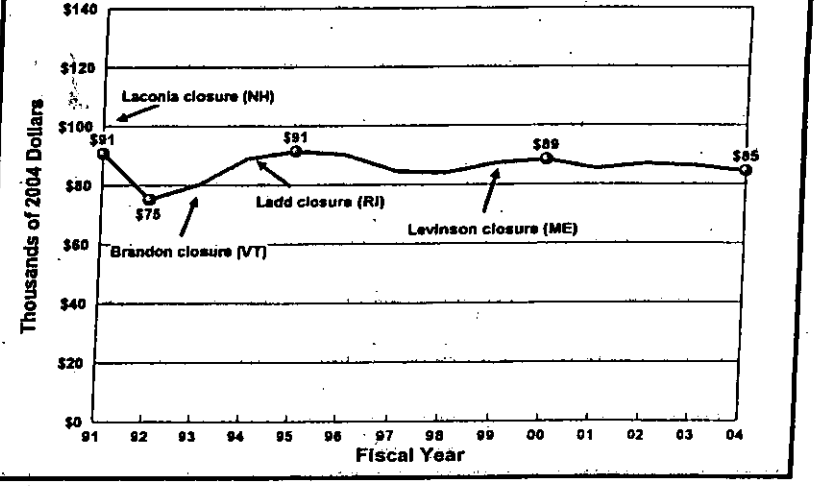
The closure of a state institution can generate savings for state government over time because it: 1) eliminates the high fixed cost of operating a state-owned facility, usually built for many more residents than live there at the time of closure; 2) shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI) and, in some cases, to local government sources; 3) increases the likelihood that individuals will engage in productive employment in a local community because they now live there; 4) utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expensive, specialized services provided in the institution; and, 5) by renting/leasing residences it avoids the expensive institutional capital construction and remodeling costs necessary for most older institutions to remain open and certified for receipt of federal reimbursement (Braddock, 1991a, 1991b).

In a relevant study of closure costs and savings, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) retained the services of an independent consulting firm to study the cost implications of its decision to close multiple mental retardation institutions. The study, authored by the Grant-Thornton accounting firm, concluded that the average post-closure per diem operating costs for each client "were approximately 9% lower than the pre-closure costs" (New York OMRDD, 1990). The study found that closure had little effect on state employee levels. Conversion of a state school campus to an alternate use such as a prison or juvenile facility provided substantial new employment opportunities and absorbed much of the economic impact of the state institution closure.

Another perspective on pre- and post-closure costs is afforded by the four New England states (Maine, New Hampshire, Rhode Island, and Vermont). These states, upon the closures of their last remaining institutions during 1991-99, became "institution-free"--like North Dakota would with the closure of Grafton. New Hampshire closed Laconia in 1991, Vermont closed Brandon in 1993, Rhode Island closed Ladd in 1994, and Maine closed Levinson in 1999 (Braddock et al., 2005).

An analysis of pre- and post-closure costs per residential recipient across 1991-2004 was completed. From the dates of the first closure (Laconia in 1991) through 2004, in inflation-adjusted terms, annual spending per statewide residential recipient in the four New England states declined from $91,000 to $85,000 (***Figure 5***). In addition, the number of aggregate MR/DD recipients served in the four states increased by 44% from 1991 to 2004. The number of recipients post-closure increased by 76% in New Hampshire, 50% in Rhode Island, 41% in Vermont and 30% in Maine.

FIGURE 5
AVERAGE ANNUAL RESIDENTIAL SERVICES SPENDING FOR MR/DD RECIPIENTS IN FOUR NEW ENGLAND STATES CLOSING THEIR ONLY MR/DD INSTITUTIONS, 1991-04



Question #8: Should the State of North Dakota anticipate a short-term need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

Without specific knowledge as to how a closure process might be implemented in North Dakota, including the nature of the phase-down of the physical plant and the duration

of the closure's implementation, it is difficult to provide an accurate estimate of "dual" costs associated with the closure. However, the state should anticipate some temporary dual costs. Assuming closure takes three years to implement (i.e., 2007-09), and that approximately 50 residents move to the community each of the three years, "dual" costs were estimated to be $3.1 million in the first year, $5.7 million in the second year, and $1.9 million in the third year. These estimates, totaling $10.7 million for the three year implementation period are based on the following two additional assumptions:

- The annual cost per relocated consumer in the new community settings in FY 2007 was assumed to be equivalent to the projected per diem cost at Grafton in FY 2007. This assumption permitted community direct support staff wages in 2007, the first year of closure implementation, to be comparable with Grafton's wages. Community direct support staff wage costs for FYs 2008 and 2009 were projected to increase at the average annual rate of increase in Grafton's per diem rates during FYs 1977-04 (2.6% per year on an inflation-adjusted basis).[1]
- Consumer per diems for those residents remaining at Grafton during the closure process will increase significantly in the second and third years, due to fixed costs being spread over fewer residents. We estimated the increased Grafton per diem rates based on the average increases in per diems in the New England comparison states to be 17% in year one, 51% in year two and 57% in year three.

However, as noted in the previous discussion for ***Question 7***, average inflation-adjusted statewide costs per resident receiving services in the consolidated four New England comparison states actually declined from 1995 to 2004. This was due to the fact that additional community recipients with lower average support needs were able to be served as well. North Dakota may experience a similar trend in average overall community costs in the long-term as well.

[1] Some studies, however, have indicated that community costs for individuals with MRDD who had comparable needs were only 55-86% of those in institutions (Brown et al., 2002; Conroy, 1996). These lower community cost estimates were not used to generate the community per diem estimates in favor of emphasizing the conservative assumption of equalizing FY 2007 direct support staff wages in community settings with Grafton's projected FY 2007 staffing costs.

Question #9: What are some of the alternate uses to which a closed Grafton facility might be put?

Alternate uses possible for the Grafton physical plant depend upon the facility's proximity to projected population growth areas, the adaptability of the facility to alternate public or private use (e.g., prison, factory, state or industrial warehouse, etc.), and other factors. ***Table 1*** presents a summary of the various alternate uses for 130 developmental disabilities institutional closures in the U.S. See ***Appendix I*** for additional detail on each of the facilities that closed.

TABLE 1: ALTERNATE USES FOR INSTITUTIONAL CLOSURES IN THE U.S.

Alternate Use	Number[1]	Alternate Use	Number[1]
Corrections (including federal corrections)	22	New MR facilities	2
DD or other state/local administrative offices	15	Unoccupied (asbestos)	2
Alternate use not yet known	9	Private institutions	2
Universities/junior colleges	9	Historic preservation	1
Property vacant	9	Housing	1
Various community uses	6	Public health infirmary	1
Community DD programs	5	Retirement program	1
To be sold (including realty, public auction)	5	Reverting to U.S. Department of Defense	1
Commercial uses	4	Veterans' medical center	1
MI facilities	4	Water survey office	1
Demolished	3	Women's prison	1
Juvenile facilities	3	Undetermined	29

[1]Total is 137--7 institutions had two alternate uses

The four New England closures demonstrate the range of possible alternate uses displayed in ***Table 1***. The Laconia State School in New Hampshire was quickly reopened in 1991 as the Lakes Region Adult Correctional Facility. The town of Laconia (population 16,411) is 30 miles from Concord (population, 40,687). Brandon Center in Vermont, closed in 1993, is near Rutland (population 17,292) which is 85 miles from Colonie, New York (population 79,258). The closed facility is currently under development as a manufacturing site, with both private and state ownership.

The Ladd Center in Rhode Island, closed in 1994, was located in Exeter (population

6,045), 13 miles from Warwick (population 85,808) and was also proximal to Providence, a large city. A $6.4 million state fire academy and new state police headquarters is being developed on the Ladd Center site. The Elizabeth Levinson Center in Maine closed as a state institution in 1999 and now operates as a state-run short-term residential and health program for medically fragile children. Levinson, in Bangor (population 31,473) is 129 miles from Portland (population 64,249). Like North Dakota, the institutions in New Hampshire and Vermont were located in small towns, somewhat distant from a larger city. Grafton, a town of 4,516, is located 38 miles from Grand Forks.

Question #10: What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

In 1983, Illinois successfully relocated the 820 residents of the Dixon State School within a single calendar year. More than 90% of the parents were satisfied with the closure process and outcomes. Resident friendship patterns were kept intact by moving small groups of individuals together and by closing down one residential unit at a time (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986).

Guidelines based on state experiences in MR/DD institutional closures are summarized in ***Appendix II.*** They are presented from five perspectives: 1) general guidelines; 2) the individuals with developmental disabilities who are being relocated; 3) their families; 4) the community programs receiving residents from the closing facility; and 5) the staff of the closing facility. The guidelines were revised from Braddock et al. (1983) and Heller, et al. (1986).

CONCLUSION

In three previous analyses of the structure, financing and quality assurance of residential and community services in North Dakota, Braddock & Hemp (2004, 2000) and Braddock, Hemp, & Rizzolo (2002) suggested service and funding priorities for the State. For example, it was noted that North Dakota had fared better than most states fiscally in the recent national economic downturn during 2003-2005, and North Dakota was one of 10 states with the strongest financial outlook for fiscal year 2005. Priority needs for MR/DD services identified in the most recent North Dakota study included: 1) continuing the expansion of the Medicaid Home and Community-Based Services (HCBS) Waiver; 2) reducing reliance on Intermediate Care Facility/Mental Retardation (ICF/MR) programs for 16+ person public and private institutional facilities; 3) increasing family support, supported employment and supported living; and, 4) enhancing direct support staff wages and benefits (Braddock & Hemp, 2004, p. 50).

Nationwide, there are over nine times more individuals with mental retardation and developmental disabilities living in supervised out-of-home community settings than in state-operated institutions. The number of families and persons with disabilities benefiting from community services and supports nationally is growing as well. State-operated institutions are being closed in many states across the country and few families prefer such programs. Thus, given the trends outlined in this paper, the long-term future of services to persons with mental retardation and developmental disabilities in North Dakota is in community settings.

It therefore seems appropriate for North Dakotans to seriously consider expanding community residential services and support programs for people with MR/DD and their families, and subsequently closing the North Dakota Developmental Center at Grafton.

However, if Grafton is slated for closure, the implementation of that closure needs to be planned and executed in a manner sensitive to the needs of Grafton's consumers and their families and considerate of the employees of the facility as well. As previously noted, suggested guidelines specifically addressing closure implementation issues are presented in ***Appendix II.***

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APPENDIX I
COMPLETED AND IN-PROGRESS CLOSURES OF STATE-OPERATED 16+ INSTITUTIONS IN THE U.S. (139 CLOSURES IN 39 STATES)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Alabama	Brewer-Bayside	1964	MR Facility	67	2003	Corrections
	Glenn Ireland	1966	MR Facility	20	1996	To be sold
	Tarwater	1975	MR Facility	74	2003	Corrections
	Wallace	1970	MR Facility	80	2003	Corrections
Alaska	Harborview	1964	MR Facility	45	1997	Community Programs
Arizona	Phoenix	1974	MR Facility	46	1988	Commercial
	Tucson	1972	MR Facility	13	1997	Outreach Offices
California	Agnews	1855/1966	MI Facility	411	2007	Undetermined
	Camarillo	1935	MR Facility	497	1998	University
	DeWitt	1942/1947	Army Hospital	819	1972	Placer County Recreation
	Modesto Unit	1943/1946	Army Hospital	1,394	1969	Modesto Co. Comm. College
	Napa	1875/1967	Asylum for MR/MI	30	2001	MI Use Only
	Stockton	1852	Asylum for MI	414	1996	University
Colorado	Pueblo	1935	MI/MR Facility	163	1989	Pueblo Regional Center
Connecticut	John Dempsey Center	1964	MR Facility		1998	Administrative Offices
	Mansfield	1908/1917	Epileptic Colony	146	1993	Corrections/U. of Connecticut
	New Haven	1964	MR Facility	56	1994	Job Corps
	Seaside	1961	MR Facility		1996	Administrative/Storage
	Waterbury	1963/1972	Convent	40	1989	Administrative Offices
DC	Forest Haven	1925	MR Facility	1,000	1991	Private Rehab/PH Infirmary
Florida	Community of Landmark	1965	MR Facility	256	2005	Revert to Dade County social programs
	Gulf Coast Center	1960	MR Facility	306	2010	Undetermined
	Orlando	1929/1959	TB Hospital	1,000	1984	Demolished, land to school, county
	Tallahassee	1928/1967	TB Hospital	350	1983	Unoccupied: asbestos
Georgia	Bainbridge	1967	WW II Air Force School	129	2001	Corrections
	Brook Run	1969	MR Facility	364	1997	Undetermined
	Georgia Regional-Augusta			438	2004	Undetermined
	Gracewood School/Hospital			93	2004	Undetermined
	Rivers' Crossing	1969	MR Facility	37	1994	Undetermined
Hawaii	Kula Hospital (privatized)	1964			1999	
	Waimano	1921	MR Facility	96	1999	Art Center for PWD
Illinois	Adler	1967	MI/MR Facility	16	1982	Water Survey Offices
	Bowen	1965	MR Facility	105	1982	Corrections
	Dixon	1918	MR Facility	820	1987	Corrections/New MR Facility
	Galesburg	1950/1969	Army Hospital	350	1985	Head Start/Community Programs
	Lincoln	1877	MR Facility	153	2004	Vacant*
	Meyer	1966/1970	MI Facility	53	1993	Women's Prison
	Singer	1966	MI Facility	45	2004	Undetermined
Indiana	Central State	1848	MI/MR Facility	83	1994	Undetermined
	Ft. Wayne	1879	MR Facility	120	2007	To be demolished
	Muscatatuck	1920	MR Facility	287	2005	Undetermined
	New Castle	1907	Epileptic Village	200	1998	Corrections
	Northern Indiana	1943	MR Facility	53	1998	Undetermined
Kansas	Norton	1926/1963	TB Hospital	60	1988	Corrections
	Winfield	1888	MR Facility	250	1998	Undetermined
Kentucky	Frankfort	1860	MR Facility	650	1972	Demolition
	Outwood	1922/1962	TB Hospital	80	1983	Demolition/New Campus
Maine	Aroostook	1972			1995	
	Levinson	1971			1999	
	Pineland	1908	MR Facility	265	1996	Undetermined
Marytand	Victor Cullen	1908/1974	TB Hospital	79	1991	Private Juvenile Facility
	Great Oaks	1970	MR Regional Center	273	1997	Private Senior Retire. Community
	Henryton	1928/1962	TB Hospital	312	1985	Undetermined
	Highland Health	1870/1972	General Hospital	88	1989	Sold to Johns Hopkins University
Massachusetts	Belchertown	1922	MR Facility	297	1992	Vacant
	John T. Berry	1900/1963	TB Sanitarium	101	1995	Undetermined
	Paul A. Dever	1940/1946	P.O.W. Camp	294	2001	Undetermined
	Fernald	1848	MR Facility	274	2007	Undetermined
Michigan	Alpine	1937/1959	TB Hospital	200	1981	Notsego County Offices
	Caro	1914			1998	
	Coldwater	1874/1939	Orphanage	113	1987	Corrections
	Fort Custer	1942/1956	Army Hospital	1,000	1972	Back to U.S. Dept. of Defense
	Hillcrest	1905/1961	TB Hospital	350	1982	Demolition
	Macomb-Oakland	1967/1970	CDA	100	1989	Reverted to Community Dev.
	Muskegon	1969	MR Facility	157	1992	Vacant
	Newberry	1896/1941	MI Facility	39	1992	Vacant
	Northville	1952/1972	MI/MR Facility	160	1983	Revert to MI Use
	Oakdale	1895	MR Facility	100	1991	Vacant/County Negotiating
	Plymouth	1960	MR Facility	837	1984	County/State Offices
	Southgate	1977	MR Facility	55	2002	Undetermined

APPENDIX I (CONTINUED)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Minnesota	Brainerd	1958			1999	
	Faribault	1879	MR Facility	501	1998	Portion used by Corrections
	Fergus Falls	1888/1969	Asylum for MI	38	2000	Regional MH Center
	Moose Lake	1938/1970	Psychiatric Hosp	34	1993	Corrections
	Owatonna	1895/1947	Orphanage	250	1970	Abuse
	Rochester	1879/1972	MI Facility	150	1982	Federal Corrections
	St. Peter	1968			1996	
	Willmar	1973			1996	
Missouri	Bellefontaine	1924	MR Facility	341	2005	Undetermined
Montana	Eastmont	1969/1979	Residential School	29	2003	Nursing Facility
New Hampshire	Laconia	1903	MR Facility	4	1991	Corrections
New Jersey	Edison	1975/1981	Corrections	70	1988	Sold at public auction
	Johnstone	1955	MR Facility	239	1992	Corrections
	North Princeton	1898/1975	Epileptic Colony	512	1998	Undetermined
New Mexico	Fort Stanton	1864	Army Apache Outpost/TB H	145	1995	Skilled Nursing/Respite
	Los Lunas	1929	MR Facility	252	1997	Community Based Program MR/DD
	Villa Solano	1964/1967	Missile Base	82	1982	Housing
New York	J.N. Adam	1912/1967	TB Hospital	180	1993	Undetermined
	Bronx	1977	MR Facility	217	1992	Plans Not Final
	Craig	1896/1935	Epilepsy Hospital	120	1988	Corrections
	Gouverneur	1962	MR Facility	N/A	1978	Leased site
	O.D. Heck	1972	MR Facility	274	1999	Administrative Offices; non-profit use
	Letchworth	1911	MR Facility	704	1996	Undetermined
	Long Island	1965	MR Facility	682	1993	Undetermined
	Manhattan	1919/1972	Warehouse	197	1991	OMRDD Office
	Newark	1878	Custodial Asylum	325	1991	Community College
	Rome	1825/1894	County Poorhouse	638	1989	Corrections
	Sampson	1860/1961	Naval Base	695	1971	Office of Mental Health
	Staten Island	1942/1952	Army Hospital	692	1987	OMRDD & Community College
	Sunmount	1922/1965	TB Hospital	503	2004	OMRDD Specialty Units
	Syracuse	1851/1972	MR Facility	409	1997	Undetermined
	Valatie	1971	MR Facility	N/A	1974	Private Holdings and ICFs/MR
	Westchester	1932/1979	MI Facility	195	1988	Office of MH
	Wilton	1960	MR Facility	370	1995	Sold to private industry
North Dakota	San Haven	1922/1973	TB Hospital	86	1987	Vacant
Ohio	Apple Creek	1931	MR Facility	178	2006	Undetermined
	Broadview	1930/1967	TB Hospital	178	1992	City Administration Building/Retirement
	Cleveland	1855/1963	MI Facility	149	1988	Vacant/Negot. with City of Cleveland
	Orient	1898	MR Facility	800	1984	Corrections
	Springview	1910/1975	TB Hospital	86	2005	Undetermined
Oklahoma	Hissom	1967	MR Facility	451	1994	Corrections/Educational
Oregon	Columbia Park	1929/1963	TB Hospital	304	1977	College
	Eastern Oregon	1929/1963	TB Hospital	240	1984	Corrections/Opened New MR Facility
	Fairview	1907	MR Facility	327	2000	Light commercial/housing
Pennsylvania	Altoona	1975	MR Facility	90	2005	Undetermined
	Cresson	1912/1964	TB Hospital	155	1982	Corrections
	Embreeville	1880/1972	County Poorhouse	152	1998	Undetermined
	Hollidaysburg	1974	MR Facility	60	1976	Revert to MI Use
	Laurelton	1920	MR Facility	192	1998	Undetermined
	Marcy Center	1915/1974	TB Hospital	152	1982	Vacant
	Pennhurst Center	1908	MR Facility	179	1988	Veterans' Medical Center
	Philadelphia	1983	MI/MR Facility	60	1989	Vacant
	Western	1962		133	1999	
	Woodhaven	1974	MR Facility	N/A	1985	Became private institution
Rhode Island	Dix Building	1945/1982	WPA	80	1989	Corrections
	Ladd Center	1907	MR Facility	292	1994	Undetermined
South Carolina	Clyde Street	1973	Home for unwed mothers	20	1985	Administrative Offices
	Live Oak	1967	Nursing home	50	1999	To be sold
South Dakota	Custer	1984	TB Hospital	76	1996	Boot camp for delinquent boys
Tennessee	Winston	1979			1998	
Texas	Forth Worth	1976	MR Facility	339	1995	Undetermined
	Travis	1934	MR Facility	585	1997	Undetermined
Vermont	Brandon	1915	MR Facility	26	1993	For Sale, Local Realty
Washington	Interlake School	1948/1967	Geriatric MI	123	1995	Other State Agency
West Virginia	Colin Anderson	1920s	MR Facility	85	1998	Possible Juvenile Corrections
	Greenbrier	1901/1974	Women's College	58	1994	Community College
	Spencer	1893	MI/MR Facility	150	1989	Vacant/Possible Corrections
	Weston	1864/1985	MI/MR Facility	99	1988	Revert to MI Use
Wisconsin	Northern Wisconsin Ctr.	1897	MR Facility	173	2005	Intensive Treatment/Dental

*Four 10-bed "grouphomes" to be built on the Lincoln, Illinois site, to be named "Lincoln Estates."

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

APPENDIX II
SUGGESTED PRELIMINARY GUIDELINES FOR INSTITUTIONAL CLOSURES

Institutional closure affects "sending" facility staff (staff at the institution that is closing), the "receiving" community staff and their agencies, and, of course, the individuals with disabilities and their families who are most affected. These guidelines were primarily adapted from closures at the Dixon and Galesburg Centers in Illinois (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986)

There are five sections in the Guidelines:

I. General Guidelines
II. Individuals Moving from the Institution
III. Families and Guardians
IV. Community Programs
V. Personnel of the Closing Facility

I. GENERAL GUIDELINES

1. Evaluate the Closure Systematically and Longitudinally

Develop a plan to evaluate (study) the closure of Grafton, first from the standpoints of the residents and their families but also from the standpoint of the impacted staff and the local community in which Grafton is situated. Use this evaluative information to help increase the likelihood of positive long-term impacts on consumers, employees, and communities. Announce the study at the same time the closure is announced. It should continue for at least two years after the last resident is moved to the community.

2. Seek Out Knowledge From Other States' Experiences with Institutional Closure

Many states have a great deal of experience with closing institutions for people with MR/DD. Seek out that experience if you choose to close Grafton.

II. GUIDELINES FOR INDIVIDUALS MOVING FROM THE INSTITUTION

1. Minimize Resident Transfer Trauma by Implementing an "Anticipatory Coping Strategy"

- Close Down Institutional Cottages or Units One at a Time;
- Keep Resident Groups and Friends Intact;
- Minimize Internal Transfer of Residents and Staff in the Closing Facility;

- Conduct Preparatory Programs for Consumers. This should include site visits to the new residential settings, as desired by the individuals, and in respect to any support needed based on their level of functioning; and,
- Involve Consumers Personally in Choosing Their Roommate(s) and Their New Community Home and Support Network.

2. Transfer Staff with Those Moving From the Institution

Determine whether institutional staff can be employed at community programs with individuals with developmental disabilities who know them and who are relocating to those programs.

3. Adopt a Relocation Assessment Process with an Appeal Mechanism

- Level One: Identification of an Alternative Plan

  The sending facility and state agency staff recommend a receiving program in the community for each resident based on service and support needs, preferences of the individual and/or the legally responsible persons, and availability of community resources.

- Level Two: Development of an Individual Services Plan

  A service plan is developed by the receiving program staff in collaboration with the sending facility staff. Minimizing internal transfers at the sending facility will improve the quality of information transmitted, as staff most familiar with the individuals moving would be available to provide the necessary input into the plans. The community agency staff has the final discretion in writing the plan.

- Level Three: Conference with Legally Responsible Person

  Prior to relocation, a meeting is offered at the community program with the legally responsible family member or guardian, if desired, to review with the community program staff the individual service plan. Closing facility staff may also participate in the meeting.

- Level Four: Appeal Process Available to Legally Responsible Person

  The legally responsible parent or guardian can object to the transfer plan if he or she believes it does not meet the individual's habilitation, support or medical needs. An appeal process is a necessary "relief mechanism."

III. FAMILY AND GUARDIAN GUIDELINES

1. Consultation with Closing Facility's Parents' Association

If a closure is decided upon, the state agency should promptly request permission to address the facility's parents' association. Meetings should be held, as necessary, to explain the closure process and to deal with problems that might arise during the relocation process. It is wise to acknowledge upfront to parents at both the sending facility, and to the community programs, that the relocations may temporarily disrupt routines at the institution and the community programs and in the lives of the individuals being relocated and their families. Every attempt to minimize this disruption should be made.

The state agency representative should convey to parents her or his willingness to work out solutions. It is also important for community program parents to be engaged to help provide a receptive environment for the relocated individuals and their families.

2. Involve Parents Who Have Been Through the Process

Parents involved in a successful institutional closure from a nearby state with such experience may be invited to the initial closure discussions with state agency representatives and with the closing facility parents' association. This can help reduce family anxiety and build support for the positive opportunities that a well-planned relocation can bring to their relatives.

3. Family/Guardian Notification

Individualized notification of families and guardians can serve to reduce anxiety and build support for individuals' planned relocations. Immediately upon the announcement of closure or phase-down, notification letters are sent to family members or guardians providing the following information.

- A rationale for the closure;
- The approximate time-frame;
- Anticipated positive aspects of the change;
- Types of community programs that will be available;
- Family and guardian options for alternative community programs;
- Reaffirmation of the state's commitment to serve the individual throughout relocation;
- Description of the four-level relocation assessment process--what will happen next; and,

- Name and phone number of a contact person designated by the state agency.

Follow-up is continued through telephone contact reiterating essential information that was in the letter of notification and soliciting family or guardian participation in the individual's relocation to the community program.

4. Encourage Family Involvement

The following six steps can be employed to involve the families meaningfully in the process:

- Hold Informational Sessions at the Sending Facility

Invite families to informational sessions at the sending (closing) facility. Representatives of the receiving community programs should also make presentations about their programs for the families.

- Open House at Community Programs

Most community agencies operate a range of residential, day, work, and other support services. Invite families to an open-house at each receiving agency so that they have access to the appropriate information about the programs their family member is likely to be involved in.

- Parents at the Receiving Community Agencies. Contact families at the sending institution to offer assistance, inviting them for individualized or small group visits.

- Set Up a Family Buddy System at the Community Agency

This system connects community agency families with the new families before, during and after the relocation.

- Family and Guardians Should be Present During the Actual Relocation if Desired

- The Community Agency Should Contact Families and Guardians to Inform Them When the Relocation is Scheduled and Invite Them to be Present. (The community agency parent buddy should also be present if possible.)

IV. COMMUNITY PROGRAMS RECEIVING RESIDENTS FROM THE CLOSING FACILITY

1. Develop Consistent Entry Criteria

Develop systematic criteria for accepting residents at each receiving program and communicate these clearly with sending facilities and family/guardians. Encourage pre-placement visits to the receiving programs by staff, consumers with disabilities, and families to enable them to evaluate the program's appropriateness.

2. Provide Staff Training

Prepare incumbent staff and personally orient new staff to the consumers who will be moving in. Often the persons coming from closing facilities are lower functioning, medically fragile, or have challenging behaviors. Without sufficient training, staff may lack the specific knowledge and skills to properly support some of the individuals moving.

3. Involve Receiving Programs in Planning

Once closure has been scheduled, involve receiving program representatives early in the planning process and keep them involved and well-informed.

4. Establish Mental Health Back-Up Supports

Mental health back-up supports to community residences should take the form of a troubleshooting group of trained and experienced professionals drawn from the state facility and community agencies. A "behavioral unit" at one of the community programs or at a state mental health center could function as a temporary placement until appropriate, permanent back-up programs are established in the community and/or state mental health center.

5. Develop Public Relations and Education Programs for Communities

Community providers and state agency personnel can enlist community support by attending meetings with persons and groups in the receiving communities. These meetings could be held at churches, schools, or informally with immediate neighbors, to educate and reassure.

6. Establish Relationships with Local Resources

Some new community residences may need to establish relationships with such local resources as the fire department, health providers, and public safety offices. Specific recommendations for local resources include the following topics:

- Testing, counseling and behavioral support for community mental health providers;
- Updated treatment and medication training for physicians and hospitals on topics such as challenging behavior, seizures, and motor problems;

- Dental monitoring and treatment techniques for neighborhood dentists; and,
- General orientation to developmental disabilities for firemen, police, recreation facilities.

7. Provide Financial Incentives for Community Residential Development

Community placements will be greatly facilitated by financial incentives for community programs. The Medicaid Home and Community-Based Services (HCBS) Waiver has been used successfully in most states.

8. Facilitate Development of Needed Support Services in the Community

Closure affords the opportunity for the development of necessary community services "infrastructure." For example, expanded supported living and supported employment programs for individuals moving from the institution will be needed.

V. PERSONNEL GUIDELINES

1. Plan Ahead Beginning Early in the Process

Develop a plan for future staffing patterns as individuals are relocated, conduct surveys of employee desires for transfer, and determine clear personnel policies early in the closure process. Do not promise employees what cannot be delivered.

2. Terminate One Unit at a Time and Minimize Internal Transfers

Close down one unit, wing, ward, or cottage at a time when possible and determine the schedule ahead of time, not during implementation. Closing down one component at a time keeps groups of individuals with developmental disabilities and familiar staff together, and can also result in increased administrative efficiency and cost savings.

3. Minimize Employee "Bumping"

"Bumping" (whereby staff working elsewhere in a state agency have more seniority and can replace less senior employees) should be avoided or at least minimized during the closure process. Bumping destroys program continuity in the closing facility at precisely the moment individuals being relocated need it most, with a deleterious effect on individuals who have developed interdependent relationships with staff over a long period of time.

4. Establish Employee Counseling Service

Establish an employee counseling and job placement service at the closing facility as soon as the closure is announced and becomes evident to staff. This service

would include individual counseling, workshop training, job relocation and transfer planning, job fairs, resume writing, and retirement planning.

5. Conduct Early and Continuing Briefings for Staff

Have a representative of the state agency or the state's personnel department present comprehensive briefings to facility staff when closure is announced. The briefings should announce the initiation of the employee counseling service, and fully discuss employee rights, benefits, and realistic expectations concerning layoffs, employee transfers, and retirement.

6. Develop an Open Door Policy

Develop clear lines of communication between management and all levels of staff at the closing facility.

7. Establish Liaison with Other Departments and Facilities

Establish positive working relationships with the other major employers in the closing facility's community, and in neighboring municipalities.

8. Adopt as Many Staff Incentives as Possible

Consider using one or more of the following incentives for staff in the closing facility:

- Early Retirement Inducements
- Staff Retraining

  In particular, develop staff retraining programs for community-based services employment.

- Extended Health Coverage

  Temporarily extend health insurance benefits for laid-off workers and their families throughout the first year if the workers remain unemployed.

- Adopt a Priority Interviewing Policy at Community Agencies

  Implement a priority for community agencies to interview staff from the closing facility, but give the community agency complete latitude to judge an employee's potential for working at the agency.

- Payment of Moving Expenses

Consider paying a pre-designated sum of money for moving expenses for employees transferring to MR/DD community agencies or to other MR/DD-related employment in North Dakota that is beyond 30 miles from Grafton.

9. Develop/Distribute Newsletter

Develop a periodic newsletter, perhaps monthly, and distribute it to staff at the closing facility and at the community agencies receiving individuals from the closing institution. A newsletter is useful in dispelling rumors and improving communication between the supervisory staff at the closing facility and employees affected by the closure. Rumors breed anxiety in staff and this can be transmitted to individuals who are undergoing the relocation to community agencies. The newsletters should include time tables, administrative policies including changes in policy, information about employees receiving new positions, job search information, and where to obtain counseling or other services.

10. Use a Participatory Management Approach

Involve top management and employee unions (if applicable) in the initial and ongoing planning for the closure. Make it clear to them that they cannot change the fact that closure is going to happen, but that they can and should influence and help make the decisions about the best way to carry out the closure and implement the relocation process.

Testimony
Senate Bill 2012
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
January 17, 2011

Chairman Holmberg and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of ND Federation of Families for Children's Mental Health (NDFFCMH). NDFFCMH is a parent run advocacy organization that focuses on the needs of children and youth with emotional, behavioral and mental disorders and their families, from birth through transition to adulthood.

NDFFCMH Supports increasing the net income eligibility from 160% to 250% of the poverty line for the state children's health insurance program. Expanding the net income eligibility allows more children to access mental health care. For many children, mental health care is a key component of the array of services needed for healthy childhood development.

Mental disorders affect about one in five American children and one in ten experience serious emotional disturbances that severely impair their functioning, according to the Surgeon General's comprehensive report on mental health. **Moreover, low income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems.**

Sadly, over two-thirds of children struggling with mental health disorders do not receive mental health care. The President's New Freedom Commission on Mental Health found that without early and effective identification and intervention, childhood mental disorders can lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood.

Untreated mental illness may also increase a child's risk of coming into contact with the juvenile justice system, and children with mental disorders are at a much higher risk for suicide.

NDFFCMH supports the proposed Children and Family Services budget. However, the department should look at increase funding in the areas of prevention. In particular, we would like to see more focus on parent education.

Transition age youth with mental health disorders are not unique in experiencing difficulties as they transition to adulthood, they are more likely than their peers to experience poor outcomes, including areas of employment and education. Left without access to necessary services and supports, successful transitions to adulthood cannot be realized.

NDFFCMH supports the Division of Mental Health and Substance Abuse exploration of expanding the Transition to Independence Program as are outlined in OAR 413 Enhancement of Transitional Youth.

NDFFCMH supports the proposed Vocational Rehabilitation budget. Youth with mental health disorders need better employment outcomes. There is no other form of treatment that has a better impact on mental health than employment. We support Vocational Rehabilitation in not only helping youth get jobs but in the efforts that are being done for them to maintain employment.

NDFFCMH would also like to support the DHS in continuing to support the wraparound process as it is a successful planning process used in both in CFS and the Partnership Program. We support the ongoing efforts in serving children with mental health and their families.

Thank you for your time.

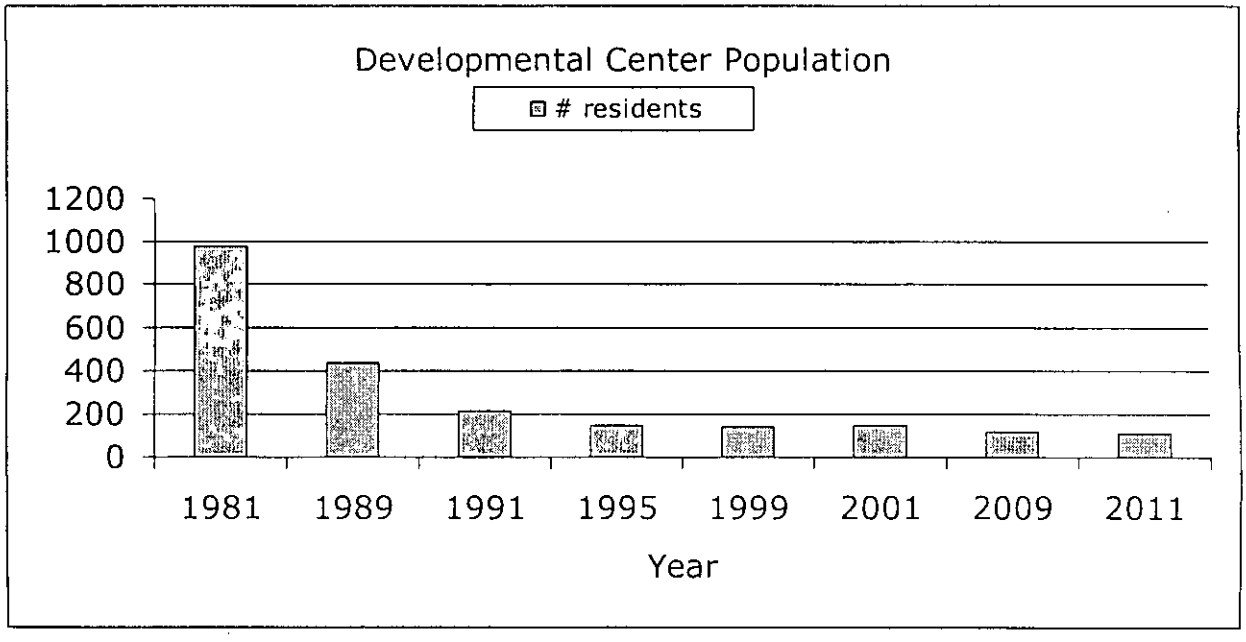
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Senate Appropriations
SB 2012 – Department of Human Services
January 18, 2011
Testimony of Teresa Larsen, Protection & Advocacy Project

Developmental Center

The Arc's law suit with the State of North Dakota ended in 1995 at which time the population at the Developmental Center was 144 residents. Sixteen years later, 107 individuals with developmental disabilities remain at the institution. Despite the mandate of the Olmstead decision, the financial assistance of Money Follows the Person, and the target goals set by the Transition to the Community Task Force, we have discharged a net of just over two individuals per year for the last sixteen years. A significant portion of this net decrease is due to deaths.



The 12th anniversary of the U.S. Supreme Court's Olmstead decision will arrive in June. The Olmstead decision stands for the proposition that it is unlawful discrimination for a state to unnecessarily place a person with a disability in an institution.

At the Developmental Center, this means a resident must have placement in a less restrictive setting: 1) when the State's treatment professionals determine a community placement is appropriate; 2) the individual resident does not oppose community placement; and 3) the State can reasonably accommodate that placement, taking into account the resources available to the State and the needs of others.

The least restrictive setting is "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." [U.S. Dept. of Justice regulation]

It is of particular note that the United States District Court that initially decided the Olmstead case determined that the State could "provide services to plaintiffs in the community at considerably less cost than is required to maintain them in an institution." In general, this is also true in North Dakota where the average per diem at the Developmental Center is over $500/day, closing in on $200,000/year.

The Developmental Center Transition to the Community Task Force has been in place since 2005. It established target populations beginning in 2006, with the first one being to reach a population of 127 residents by July 1, 2007. This target was achieved. The intermediate goal set by the Task Force was to reach 97 by July 1, 2009. This was revised to 115. The actual population of the Developmental Center on that date was 123. The long term goal of the Task Force was to be at 67 residents by July 1, 2011. This has been revised to 95 and, reportedly, the Developmental Center is on track to reach that goal. The current population is 107. The Task Force has now set its population goal of 67 residents for July 1, 2013.

There have been some barriers to de-institutionalization and the developmental disabilities service providers, along with other Task Force members have been working together to address these. A Centralized

Project Development Team has been assembled to encourage creative ways to address community capacity issues.

Transition funds, to assist with moving residents to the community while down-sizing the institution, have been made available in the DHS' budget as follows: 05-07 biennium - $50,000; 07-09 biennium - $2.5 million ($1.6 million Federal and $900,000 General); 09-11 biennium - $0.

DHS submitted an OAR (# 407) to the Governor for transition funds for the 11-13 biennium in the amount of $6,095,817 ($3,382,849 Federal and $2,712,968 General). This will reportedly provide for 28 ICF/MR beds, phasing in 4 beds each quarter. DHS has indicated that it cannot approach the goal of 67 by July 1, 2013 without these monies.

There are currently twenty-five individuals on the Residential Decision-making Profile list, compiled by Developmental Center staff. With few exceptions, these are individuals who have been determined by State professionals to be appropriate for community placement and who want to move. The State of North Dakota has the resources to make this happen.

As of June 2009, at least eight states and the District of Columbia had closed all state operated residential facilities with sixteen or more residents who have intellectual or developmental disabilities. Those states are Alaska, Hawaii, Maine, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia. The first of these states, New Hampshire, closed its facilities in 1991.

There is no need to continue to have individuals with developmental disabilities move into the Developmental Center. At $500/day, North Dakota can provide the needed resources and support in the community for individuals to remain near their families and friends in small home settings. This is their right.

Thank you. I am happy to answer questions.

TESTIMONY
Senate Bill 2012 - Department of Human Services
Senate Appropriations – Chairman Ray Holmberg
January 19, 2011

Chairman Holmberg and members of the Senate Appropriations Committee, my name is Susan Rae Helgeland. I am Executive Director of Mental Health America of ND (MHAND). Our non-profit organization is 59 years old in ND and 102 years old nationally. Our Mission is to promote mental health through advocacy, education, understanding and access to quality care for all individuals.

An average of one individual dies by suicide every four days in ND. Suicide is the fourth leading cause of death in ND preceded by cancer, heart disease and accidental deaths. People are dying because they cannot get the help they need due to the stigma that still surrounds mental illness and the barriers to access behavioral (mental illness and substance use) health services.

I have been involved in advocacy since 1964 when, as a senior in Social Work at UND, I visited the ND State Hospital. I saw nearly 2000 people segregated in the state hospital and "zoned out" in what, at that time, were the drugs of choice, Haldol and Thorazine. Men and women were dressed in a type of pajamas and house dresses as my mother used to call them. I was shocked to see that individuals, through no fault of their own, were warehoused in this way. I was so shocked that it has motivated me to be an advocate for the last 47 years.

Deinstitutionalization happened in the 70's. It happened without a comprehensive transition plan for individuals to be able to be successful and live independently in the community after leaving the various state hospitals. There were no community- based or support services in place. Now we have, in my words, reverse deinstitutionalization, such as prison. For example more that 65% of people in the ND Corrections system have, or are experiencing behavioral health symptoms.

Current research findings indicate that 90% of people with behavioral health issues can participate in recovery. Yet only one in four actually access treatment because of the stigma that is still as significant now as it has been in the past. The 90% recovery rate was not true in 1964. Today increased research on the brain has resulted in the development of effective medications and therapeutic strategies for more successful treatment of behavioral health issues. The national and state public policy behavioral health care changes have not kept pace with the advances made in diagnosis and treatment plans.

In ND we are critically short of behavioral health services including in-patient care. Community based out-patient and support services are under-funded when compared to people with intellectual disabilities, nursing home services and, of course, all other medical illness like diabetes, arthritis, heart disease, etc. Governor Dalrymple has included funding to help meet the current needs of people with behavioral health issues in his budget. MHAND applauds and

supports the Governor's Budget and the Department of Human Services budget as it relates to specific line items for behavioral health issues:

- **$3.4 million to hospitals for uncompensated care when serving Department of Human Services mental health clients;**
- **$1.4 million from the general fund for additional beds in a crisis stabilization unit for people with mental illness;**
- **$939,159 from the general fund for contract services for chemical dependency residential services. Included are services for social detox and crisis mental health;**
- **$309,128 to expand the residential adult crisis bed capacity.**

Resolana: Voice of the People, a documentary recently produced by MHAND, is about personal testimonies by real rural ND behavioral health consumers and behavioral health providers telling their stories. Every one of the eight who were interviewed for the documentary talked about the weeks and sometimes months of waiting in order to even see a provider. After a diagnosis is made, the individuals interviewed said there are very little to no case management services to help support recovery in the community and to help the individual stay out of the hospital or jail.

MHAND supports the OAR request for the MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT which is within the Affordable Care Act. Sen. Olympia Snowe (R-ME) introduced the measure and along with

Sen. Conrad led the effort to get it passed. Psychiatric care delivered in general hospitals and freestanding psychiatric hospitals is an integral component of community-based care for people with mental illnesses. With a 30% decline in inpatient psychiatric beds over the past two decades, it is hard to find beds for individuals needing mental health care services. Individuals with mental health needs are diverted to emergency rooms or travel long distances to receive care.

In a June 1, 2009, Government Accountability Office report (GAO-09-347) on hospital emergency departments, it was reported that difficulties in transferring, admitting, or discharging psychiatric patients from the emergency department were a factor contributing to emergency department overcrowding.

Medicaid is vital for people with mental disorders, funding more than 50% of state and local spending on mental health services. Community-based psychiatric hospitals could help relieve this access problem; however, due to a Medicaid provision called the Institution for Mental Disease exclusion, patients receiving care in these hospitals are not covered for their care if the patients are between the ages of 21-64.

The Medicaid Emergency Psychiatric Demonstration Project will expand the number of emergency inpatient psychiatric care beds available in communities by establishing a three-year, $75 million demonstration project. Among other things the demonstration will allow states to cover patients in non-governmental

freestanding psychiatric hospitals and receive Federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms and improve the efficiency and cost-effectiveness of inpatient psychiatric care.

Key immediate issues are:

1. Three-year demonstration/Medicaid dollars became available 10/1/10.
2. States must contribute their $1.4 million match dollars to the $1.4 million Federal match.
3. States may apply to the HHS Secretary for approval on a competitive basis.
4. The Centers for Medicare and Medicaid Services is developing a Request for Proposal, which may be made available in the Federal Register by April 2011, demonstration projects chosen by summer, and money provided to demonstrations in October 2011.

National organizations endorsing the demonstration project are:
American Academy of Child and Adolescent Psychiatry * American Association for Geriatric Psychiatry * American Association for Marriage and Family Therapy * American Association of Pastoral Counselors *American College of Emergency Physicians * American Counseling Association * American Group Psychotherapy Association * American Hospital Association * American Mental Health Counselors Association * American Psychiatric Association * American Psychiatric Nurses Association * Anxiety Disorders Association of America * Association for Ambulatory Behavioral Healthcare * Association for Behavioral Health and Wellness * Child Welfare League of America * Children and Adults with Attention-Deficit/Hyperactivity Disorder * Clinical Social Work Association * Eating Disorders Coalition * Emergency Nurses Association* Federation of American Hospitals * National Alliance on Mental Illness* National Association for Children's Behavioral Health * National Association of County Behavioral Health and Developmental Disability Directors * National Association of Psychiatric Health Systems *National Association of Rural Mental Health * National Association National Association of Rural Mental Health * National Association of Anorexia Nervosa and Associated Disorders * National Coalition of Mental Health Professionals and Consumers, Inc.* National Foundation for Mental Health* Therapeutic Communities of America.

MHAND supports funding to address the Federal Medical Assistance Percentage (FMAP) reimbursement change.

Thank you for the opportunity to testify today. I will be happy to answer any questions.

Testimony delivered to the Senate Appropriations Committee in support of SB 2012, Jan 19,2010 – by Lynn Fundingsland, Executive Director, Fargo Housing and Redevelopment Authority.

Mr. Chairman and members of the committee, thank you for the opportunity to speak with you today.

I am here to request your support for an adjustment to the budget for the SEHSC. In May of last year the Cooper House supportive housing for the homeless facility was opened in Fargo. The project was built in response to Fargo's 10-year plan to end homelessness. One of the plans recommendations was that permanent housing with support services be provided to assist individuals experiencing chronic homelessness.

The last census of the homeless in Fargo counted 347 homeless persons, 160 of whom were categorized as chronic or long term homeless. This means they have been homeless for over a year or, have experienced homelessness at least 4 times in the past 3 years. Cooper House follows the "housing first" model, which advocates getting people into stable housing first and then working with them on those issues that contributed to their homelessness to begin with. Up to 80% of this population exhibit mental health or substance abuse issues (usually alcoholism) or a combination of both. Many of them have been on the streets and in transitional shelters for several years. One Cooper resident had lived this way since 1969.

If you can imagine, it's a difficult life. It's difficult dealing with the elements and the frequent hunger and the stigma and too, having to be mixed in with others who may have unpredictable and sometimes aggressive behaviors. Sometimes the aggressiveness is adopted as a defense mechanism and a means of protection. So, now we have put 42 of these folks under one roof and they are living in close proximity. There are always a few people in the group that can be pretty tough to work with. They can exhibit some very borderline behaviors and at times they can be frightening or even dangerous.

The project is very successful in a couple of important ways though. As you can see from the hand-out brochure, it's been shown to be more cost effective to house these folks than to provide essential services to them on the street like we have historically. Typical services used are overnight shelters, detox, police intervention, emergency room services, the court system and rehabilitation programs. The study inventoried the services that had actually been used in the year prior

to being housed - by the first 29 tenants of Cooper House. We found about a 35% reduction in costs to the community. If this information is extrapolated to the 42 people we now house, the savings approaches 45%, since we are saving more in services without a commensurate increase in the cost of operating the facility - even accounting for the addition of another staff. Strictly in terms of economics, the housing first model has proven to be a very effective way to work with this population.

On the humanitarian side it works too. People are getting healthy, they are dealing with their addiction issues, they are getting job training and jobs and, they are regaining some dignity and self esteem. Last August one of our tenants celebrated his 100th day of sobriety –in August of the year before he had been admitted to detox 16 times.

In the current 2009-2011 budget, the SEHSC is budgeted for one contracted staff on duty at Cooper 24 hrs. a day. This person provides front door security, admits tenants and guests and keeps track of who is in the building. He also performs searches as needed, monitors the security cameras that are throughout the building and, interacts with tenants.

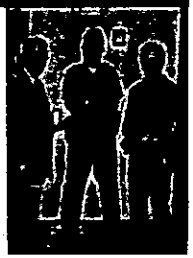
Since we need to always maintain security at the front door, the on duty staff currently need to call in an off duty supervisor or the police or an ambulance to assist with situations that develop elsewhere in the building and require intervention. Examples are an altercation between tenants, or someone has fallen down or is passed out or obviously needs medical or other assistance, or a smoke alarm has gone off in an apartment. A responder may get there anywhere from 5 to 30 minutes later and, this occurs several times in a typical week.

A lot can happen in that period of time waiting for help – especially if there is an altercation going on or, the (lone) staff is being confronted or threatened by a belligerent and inebriated tenant or guest.

In the SEHSC section of the proposed DHS budget for the 2011-2013 biennium, there is an increase in the grants line, a part of which is there to cover the contract cost of a second 24-hour staff at Cooper House – primarily for the safety of staff and others. We ask that the request for a budget adjustment for this purpose be honored by this committee and, by the greater legislative body.

Thank you for your time and consideration and I will be pleased to answer any questions you may have.

Legal & Law Enforcement



Data provided by the Fargo Police Department and the Municipal Court tell us that the average per person per month costs associated with arrests, citations, warrants, incarcerations, and court appearances ran about **$198** prior to Cooper House opening.

In the first three months of operation the average monthly per person cost was **reduced by 51% to $97**.

The average monthly cost associated with **arrests, citations, and warrants** for individuals in the Study Group went **down 82%** from **$45 per person to $8**.

REAL PEOPLE, REAL LIVES: In August of 2009 one future tenant visited Detox 16 times. In August 2010, after moving into Cooper House, that same individual celebrated his 100th day of sobriety.

Emergency Shelter & Detox

The cost of emergency shelter and detox services, as reported by the Gladys Ray Shelter, New Life Center, and both CENTRE, Inc. and ACS detox facilities, for our study group prior to moving in at Cooper House ran **$408** per person in a typical month.

The snapshot of the first three months at Cooper House indicates that these costs have gone down significantly to about **$300**. The cost of 24/7 desk staff is included in the "After" number.

The average number of times this group used **detox services** each month **dropped from 53 times to 8.** The average monthly **cost of detox services** for individuals in this group was **reduced** from **$210** to **$29**, an **86% reduction.**

Cooper House Apartments
414 11th Street North, Fargo, ND

Developed by Beyond Shelter, Inc. (BSI) in partnership with the Fargo Housing & Redevelopment Authority (FHRA), with funding from WNC & Associates, City of Fargo HOME and CDBG programs, Otto Bremer Foundation, FHRA, and BSI.

Operated by the Fargo Housing & Redevelopment Authority; with assistance from the City of Fargo, Southeast Human Services Center, Dacotah Foundation, ND Coalition for Homeless People Continuum of Care, Family HealthCare Center, Sanford Health, and the Great Plains Food Bank.

Beyond Shelter, Inc. · Fargo Housing & Redevelopment Authority · Fargo · north dakota department of human services · Family HealthCare Center · Dacotah Foundation · MDCHP · Great Plains Food Bank · Sanford Health

REAL PEOPLE, REAL LIVES

One new Cooper House tenant had been homeless since 1969.

Cooper House has provided the first Fargo home to one man who has lived in Fargo since the late 1970s. Bunking with friends or sleeping on the streets, he has worked all of these years and sent money to his family but never had a home of his own.

For more information contact:
Lynn Fundingsland
Executive Director, FHRA
701-478-2552



Initial Impact Report
August 2010

A snapshot of the ***Impact*** *of* ***Housing*** *North Dakota's* ***Chronically Homeless*** *population*

COOPER HOUSE
Permanent Supportive Housing

for People coming out of homelessness

Background



Cooper House opened in Fargo, ND in May of 2010. The 42 apartments are rented to individuals coming out of homeless shelters or from the streets. Preferences are given for those experiencing chronic or long term homelessness, veterans, and people with disabilities.

Cooper House has a front desk which is staffed 24/7 by Dacotah Foundation through a contract with Southeast Human Services Center. The front desk is the key to Cooper House's success and integration into the community. They check tenants and all guests in and out of the building, monitor the extensive system of security cameras inside and out, interact with tenants daily, do wellness checks, and deal with any situations that arise.

Cooper House employs the "Housing First" model. Meaning, give people a home first and then offer a variety of services to help them improve their lives.

This Study

This study is meant to be an early snapshot of the impact of housing North Dakota's chronically homeless population. The data for this study was collected with the consent of the first 29 tenants (the Study Group) who moved into Cooper House. Area service providers, shelters, police, court system, and healthcare providers all cooperated in providing the number of contacts with each of these individuals for the 12 months prior to Cooper House opening, and the subsequent 3 months. The data was consolidated then an average per person per month cost was calculated. The average monthly per person cost was used to calculate the group average. This study will be done again at the end of 2010 and after the first full year of operations.

Please note that not all of the services accessed are accounted for here so the cost of working with these individuals on the street is understated. For example only two emergency shelters reported for this study. Meals from community based organizations are not accounted for. Court costs reported only include an $80 filing fee for each case and do not consider the time and cost of all of the court personnel involved with a court visit. Also, applicants for Cooper House who had outstanding warrants were required to clear them (schedule court date) prior to being accepted in the building which forced court dates that would have otherwise been avoided thus increasing the "After" costs.

Similarly, clinic visits increased as many of the new tenants were sent to primary care physicians to deal with ailments which had gone untreated while they were homeless. Again these costs get front loaded and as people live there longer and their health stabilizes clinic visits are expected to go down.

The overall **societal cost of housing** this **chronically homeless** population is shown to be **considerably less** than the **cost of continued homelessness.**

Snapshot on the Impact of Housing the Chronically Homeless

before and after opening Cooper House

(Average Monthly Usage of Services for Study Group)

	BEFORE	AFTER	CHANGE
Healthcare & Medical Costs	**$43,355**	**$28,943**	**down 33%**
ER Visits	*14*	*11*	
Ambulance Calls	*8*	*6*	
Clinic Visits/Wellness Visits	*11*	*52*	
State Hospital Days	*12*	*0*	
Legal &Law Enforcement Costs	**$5,745**	**$2,824**	**down 51%**
Arrests/Citations/Warrants	*11*	*2*	
Days of Incarceration	*37*	*22*	
Court Appearances	*4*	*3*	
Detox Costs	**$6,101**	**$840**	**down 86%**
Detox Visits	*53*	*8*	
Emergency Shelter Costs	**$5,756**	**$0**	**down 100%**
Emergency Shelter nights	*207*	*0*	
Cooper Desk Staff Cost	**$0**	**$7,868**	**up 100%**
Total Average Cost per Month for Study Group	**$60,597**	**$40,474**	**DOWN 34%**

Medical & Healthcare



Based on information from Sanford Health, Essentia Health, the Family HealthCare Center, the VA, and the ND State Hospital, the average monthly cost of medical expenses per individual in this group in the one year period prior to opening was **$1,495.**

After moving in to Cooper House the average monthly cost per person of medical expenses has been **$998**, a **33% cost reduction.**

The after move-in cost of medical expenses includes the cost of a part time RN who has an office at Cooper House. This position is expected to further reduce clinic and ER visits.

Testimony-Senate Bill 2012
Senate Appropriations Committee-Senator Holmberg, Chairman
January 19, 2011

Chairman Holmberg and members of the Appropriations Committee:
My name is Kim Osowski. I'm the Director of Programming for the Stadter Center in Grand Forks.

Thank you for the opportunity to testify before you today in support of the Psychiatric Demonstration Project (OAR) Optional Adjustment Request for inclusion into SB 2012. The OAR is $1.4 million state and 1.4 million federal.

As you have heard, many North Dakotans suffer with very serious untreated or undertreated mental illness.

Psychiatric care delivered in hospitals (both general and freestanding psychiatric) is an essential component of community-based care for persons with mental illnesses. Right now, it can be difficult to find beds for individuals needing immediate mental health care services.

Community-based psychiatric hospitals could help relieve this access problem; however, due to the Medicaid provision called the Institution for Mental Disease exclusion, patients receiving care in these hospitals are not covered for their care if the patients are between the ages of 21-64.

North Dakotans would benefit if that changed and with the passage of the federal MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT, we have the opportunity. This project would expand the number of emergency inpatient psychiatric beds available in communities by establishing a three-year demonstration project, and would allow North Dakota to cover patients in non-governmental freestanding psychiatric hospitals and receive Federal Medicaid matching payments to demonstrate that covering patients in these hospitals will

1-improve timely access to emergency psychiatric care
2-reduce the burden on emergency rooms
3-improve the efficiency and cost-effectiveness of inpatient psychiatric care

Please help us collaborate between our public and private agencies to become one of those states.

After passing the OAR, a Psychiatric Demonstration Project proposal would be prepared for submission by a coalition of providers to support the Department of Human Services for the demonstration project.

Please Approve the Psychiatric Demonstration Project OAR for inclusion into SB 2015. Thank you.

Early Intervention as Prevention
Educating Medical Providers

NEDA

STAR Program
States for Treatment Access and Research

Eating Disorder Prevalence:

NationalEatingDisorders.org

- In the United States, a total of 24 million pe
nervosa, bulimia nervosa, and binge eating disorder (This estimated figure was created by utilizing current US Census numbers and statistics from the National Institute of Mental Health's (NIMH) guide, *Eating Disorders: Facts About Eating Disorders and the Search for Solutions)*
- The incidence of bulimia in 10-39 year old women TRIPLED between 1988 and 1993 (Hoek, H.W., & van Hoeken, D., 2003).
- Anorexia is the 3rd most common chronic illness among adolescents (South Carolina Department of Mental Health, 2006).
- 1 For females between fifteen to twenty-four years old who suffer from anorexia nervosa, the mortality rate associated with the illness is twelve times higher than the death rate of ALL other causes of death (Sullivan, 1995).

Eating Disorder Treatment:

- 2 Only one-third of people with anorexia in the community receive mental health care (Hoek, H.W., & van Hoeken, D., 2003).
- 3 Only 6% of people with bulimia receive mental health care (Hoek, H.W., & van Hoeken, D., 2003).
- 4 Many eating disorder patients are treated by their primary care physician for their illness for some time prior to the referral for a more intensive intervention (Bravender, Robertson, Woods, Gordon & Forman, 1999).
- 5 Focus groups being conducted at treatment facilities continue to find that the overwhelming consistency is that the family doctor did not take it seriously or said things like, "Oh all girls that age are on diets".

Impact of Current Treatment:

- 35% of "normal dieters" progress to pathological dieting. Of those, 20-25% progress to partial or full-syndrome eating disorders (Shisslak & Crago, 1995).
- Eating disorders are often not recognized until the individuals' physical health is compromised, and the illness is entrenched, at which point irreversible damage may already have been inflicted.
- Individuals with eating disorders suffer from a lowering of body temperature to 95 degrees or lower, heart rates in the 30's, dangerously low blood pressure, stomachs and intestinal problems, brittle bones which are prone to fractures, cognitive deterioration, and diminished brain size (Jahraus, 2003).
- Post-managed care eating disorder hospital admissions have been shown to be, on average, characterized by more severe physical symptoms, such as lower heart rates (Bravender, Robertson, Woods, Gordon & Forman, 1999).

Support for Increased Education for Medical Providers:

- Studies have demonstrated a link between early intervention and treatment outcome (Bravender, Robertson, Woods, Gordon & Forman, 1999).
- With treatment of full syndrome eating disorders costing upwards of $30, 000 month, early recognition is cost-effective, as it may prevent the develop of full-syndrome

disorders and chronic conditions (South Carolina Department of Mental Health, 2006).

- Early eating disorder symptom recognition, as well as awareness of early warning signs for the development of eating disorders, among medical providers can lead to early intervention, and hence possibly, prevention.

References:

Bravender, T., Robertson, L., Woods, E.R., Gordon, C.M. & Forman, S. (1999) Is there an increased clinical severity of patients with eating disorders under managed care? *Journal of Adolescent Health, 24,* 422-426.

Crowther, J.H., Wolf, E.M., & Sherwood, N. (1992). Epidemiology of bulimia nervosa. In M. Crowther, D.L. Tennenbaum. S.E. Hobfoll, & M.A.P. Stephens (Eds.). The Etiology of Bulimia Nervosa: The Individual and Familial Context (pp. 1-26) Washington, D.C.: Taylor & Francis.

Fairburn, C.G., Hay, P.J., & Welch, S.L. (1993). Binge eating and bulimia nervosa: Distribution and determinants. In C.G. Fairburn & G.T. Wilson, (Eds.), Binge Eating: Nature, Assessment, and Treatment (pp. 123-143). New York: Guilford.

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Shisslak, C.M., Crago, M., & Estes, L.S. (1995). The spectrum of eating disturbances. International Journal of Eating Disorders, 18 (3), 209-219.

South Carolina Department of Mental Health. (2006) Retrieved June 22, 2009, from: http://www.state.sc.us/dmh/anorexia/statistics.htm.

Sullivan, P. (1995). American Journal of Psychiatry, 152 (7), 1073-1074.

Supportive partners regarding initiatives concerning mental health and eating disorders:

1) North Dakota Students Against Destructive Decisions (NDSADD)

2) Mental Health America of North Dakota (MHA)

3) North Dakota Family and Community Leaders of America (FCCLA)

4) Dr. Lisa Borden-King, Field Director, Center for the Applied Study of Cognition and Learning Sciences (CASCLS), Minot State University

5) Dr. Terry Eckmann, Associate Professor and Past President for the North Dakota Alliance for Physical Activity, Recreation and Dance (NDAPHERD).

6) Bismarck City Human Relations Committee

7) Kelly Fisher, Licensed Registered Dietician (LDR), Medcenter One

8) Karli Ghering, Clinical Psychologist, Archway Mental Health

9) The National Eating Disorders Association (NEDA)

10) North Dakota Mental Health Planning Council (NDMHPC)

11) MentorConnect Organization, the first global eating disorders mentoring community.

12) CollegeResponse Program, Screening for Mental Health (SMH)

13) Jeanne Blake, Creator of WordsCanWork Productions

14) Dr. Wonderlich and Dr. Mitchell of the Eating Disorder Institute of Fargo.

15) Families of victims of eating disorders.

Testimony for the Senate Appropriations Committee
Senator Ray Holmberg, Chairman

SB 2012- As it relates to Dental Medical Assistance Reimbursement

Chairman Holmberg and members of the Committee, my name is Joe Cichy. I am the Executive Director of the North Dakota Dental Association (NDDA). I present this testimony in support of SB 2012 with regard to the Governor's dental Medicaid budget proposal.

The 2000 Surgeon General's report "Oral Health Care in American" noted that dental decay is the most common chronic childhood disease and that low income children suffer twice as much tooth decay as more affluent children. By and large, the segment of North Dakota's population for which Medicaid services are provided does not engage itself in this legislative process. Children, the primary beneficiary of dental Medicaid services in North Dakota, are not equipped to voice their needs. The NDDA is here to speak for them. The NDDA supports that state's efforts during the past session in its increased funding of dental services to low income families and supports the budget for 2011-13 which reflects the increased utilization that occurred as a result of last session's increase.

The Center for Medicare and Medicaid Services (CMS) 2008 NATIONAL DENTAL SUMMARY points out:

"...a State must adhere to certain federal requirements. ... for most individuals under the age of 21, dental services are mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service as defined in section 1905(r) of the Social Security Act."

Such statutory requirements are intended to ensure all eligible Medicaid beneficiaries under 21 are both informed of **and have access to** dental services. How are we doing? Based upon the analysis by the department, North Dakota is improving in this area. We commend the legislature for recognizing the need to improve dental access for North Dakota's low-income families – especially children.

The CMS 2008 Summary further reports that dental Medicaid program improvements can be expected to yield significant savings in treatment costs on an individual level since on average, ongoing treatment costs to maintain oral health, per individual, will decrease over time. Further substantial savings will be seen since care provided in dental office settings reduces the frequency of emergency room visits by Medicaid enrollees where treatment is primary palliative and recurring rather than definitive and corrective. This is particularly likely for very young children with catastrophic treatment needs that often require costly hospital services in addition to significant dental treatment. These costs can account for approximately 30% of typical Medicaid dental program expenditures.

Engaging the capacity of private-sector dentists with adequate Medicaid funding will maximize the use of taxpayer dollars in providing dental care to the state's low-income population.

Next month, dentists in communities across North Dakota will be working to improve access for North Dakota's less fortunate population through Give Kids a Smile projects, an American Dental Association (ADA) nationwide event where dentists volunteer care for children. Since 2000, North Dakota dentists have also given time and resources through the Donated Dental Services Program, providing over one million dollars of free dentistry for disabled and elderly North Dakotans. On September 30th, North Dakota pediatric Dentists will provide a full day of free dental care to the children on the Spirit Lake Reservation. Dentists in many communities voluntarily provide yearly dental screening for Head Start kids. Through these projects and more, dentists demonstrate their generosity on a daily basis.

The governor's budget is an extremely important step in continuing to improve access to dental care to North Dakota's less fortunate.

We ask you to support the governor's budget regarding dental Medicaid.

Thank you,

Joe Cichy
Executive Director
North Dakota Dental Association

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The governor's budget is an extremely important step in continuing to improve access to dental care to North Dakota's less fortunate.

We ask you to support the governor's budget regarding dental Medicaid.

Thank you,

Joe Cichy
Executive Director
North Dakota Dental Association

Department of Human Services O[redacted] for the 2011-2013 Biennium

as of December 9, 2010

Cabinet Priority	IBARS OAR #	Cabinet Category	Description	FTE	General	Federal	Other	Total
01	101	Optional 3% Savings Plan	Optional 3% Savings Plan		(26,964,940)	(34,055,516)	-	(61,020,456)
02	201	Psychiatric Inpatient Hospital	Psychiatric Inpatient Hospital Rates		3,431,017	-	-	3,431,017
03	301	Capacity - Behavior Health	SMI Crisis Stabilization Unit - NCHSC		1,444,661	-	-	1,444,661
03	302	Capacity - Behavior Health	CD Residential Facility - SEHSC		939,159	-	-	939,159
03	303	Capacity - Behavior Health	Residential Adult Crisis Beds - WCHSC		309,128	-	-	309,128
			Total Inflation Category		2,692,948	-	-	2,692,948
04	401	Enhancement of Services	Transfer Child Support System off mainframe		468,396	909,239	-	1,377,635
04	402	Enhancement of Services	5% Increase - In-home Child Care Providers		902,581		-	902,581
04	403	Enhancement of Services	Pilot for Medical Home Program		204,518	233,815	-	438,333
04	404	Enhancement of Services	Section 13 of 2009 HB 1012		250,000	250,000	-	500,000
04	405	Enhancement of Services	Adult Family Foster Care rate increase		1,134,072	1,172,224	9,103	2,315,399
04	406	Enhancement of Services	Medication Assistance - HCBS		280,568	-	14,010	294,578
04	407	Enhancement of Services	New ICF/MR Beds for DC Transitioning		2,712,968	3,382,849	-	6,095,817
04	408	Enhancement of Services	Guardianship Program Enhancements		65,275	-	-	65,275
04	409	Enhancement of Services	Long Term Care Ombudsman	1.00	135,665	-	-	135,665
04	410	Enhancement of Services	Family Preservation Services		938,301		-	938,301
04	411	Enhancement of Services	Post Adoption Services		129,188	66,582	-	195,770
04	412	Enhancement of Services	Sex Offender Community Treatment - MH/SA		498,028	-	-	498,028
04	413	Enhancement of Services	Enhancement of Transitional Youth - MH/SA		500,000	-	-	500,000
04	414	Enhancement of Services	Enhance contracted staffing - NEHSC		210,875	139,125	-	350,000
04	415	Enhancement of Services	Enhance Services at Cooper House - SEHSC		219,690	20,000	-	239,690
04	416	Enhancement of Services	SMI Work Activity - SCHSC		450,000	-	-	450,000
04	417	Enhancement of Services	New Office Facility - BLHSC		174,111	16,104	-	190,215
			Total Expansion/Enhancement Category	1.00	9,274,236	6,189,938	23,113	15,487,287
05	501	Capital Projects	State Hospital Capital Projects		1,961,840	-	-	1,961,840
05	502	Capital Projects	Developmental Center Capital Projects		650,000	-	-	650,000
			Total Capital Projects		2,611,840	-	-	2,611,840
06	601	Inflation	Program & Policy Other Inflation		797,127	102,544	44,846	944,517
06	602	Inflation	Medicaid Provider Inflation		7,004,116	9,673,066	-	16,677,182
06	603	Inflation	LTC Provider Inflation		14,553,888	16,999,624	36,152	31,589,664
06	604	Inflation	Child Welfare Provider Inflation		2,067,749	1,133,827	619,975	3,821,551
06	605	Inflation	HSC Inflation		1,093,928	133,534	13,814	1,241,276
			Total Inflation Category		25,516,808	28,042,595	714,787	54,274,190
07	701	Health Care Reform	Eligibility System Rewrite	1.00	18,370,221	24,247,421	283	42,617,925
07	702	Health Care Reform	Health Care Reform - Central Office	17.00	648,523	925,347	-	1,573,870
07	703	Health Care Reform	Health Care Reform Grant - IMD Demo	-	1,140,306	1,440,156	-	2,580,462
			Total Health Care Reform Category	18.00	20,159,050	26,612,924	283	46,772,257
08	801	Completion of One-Time ARRA Funding	ARRA Contracts through 9/30/11	-	-	519,175	-	519,175
			Report Totals	19.00	36,720,959	27,309,116	738,183	64,768,258

Fully funded in Governor's budget.

Partially funded in Governor's budget.

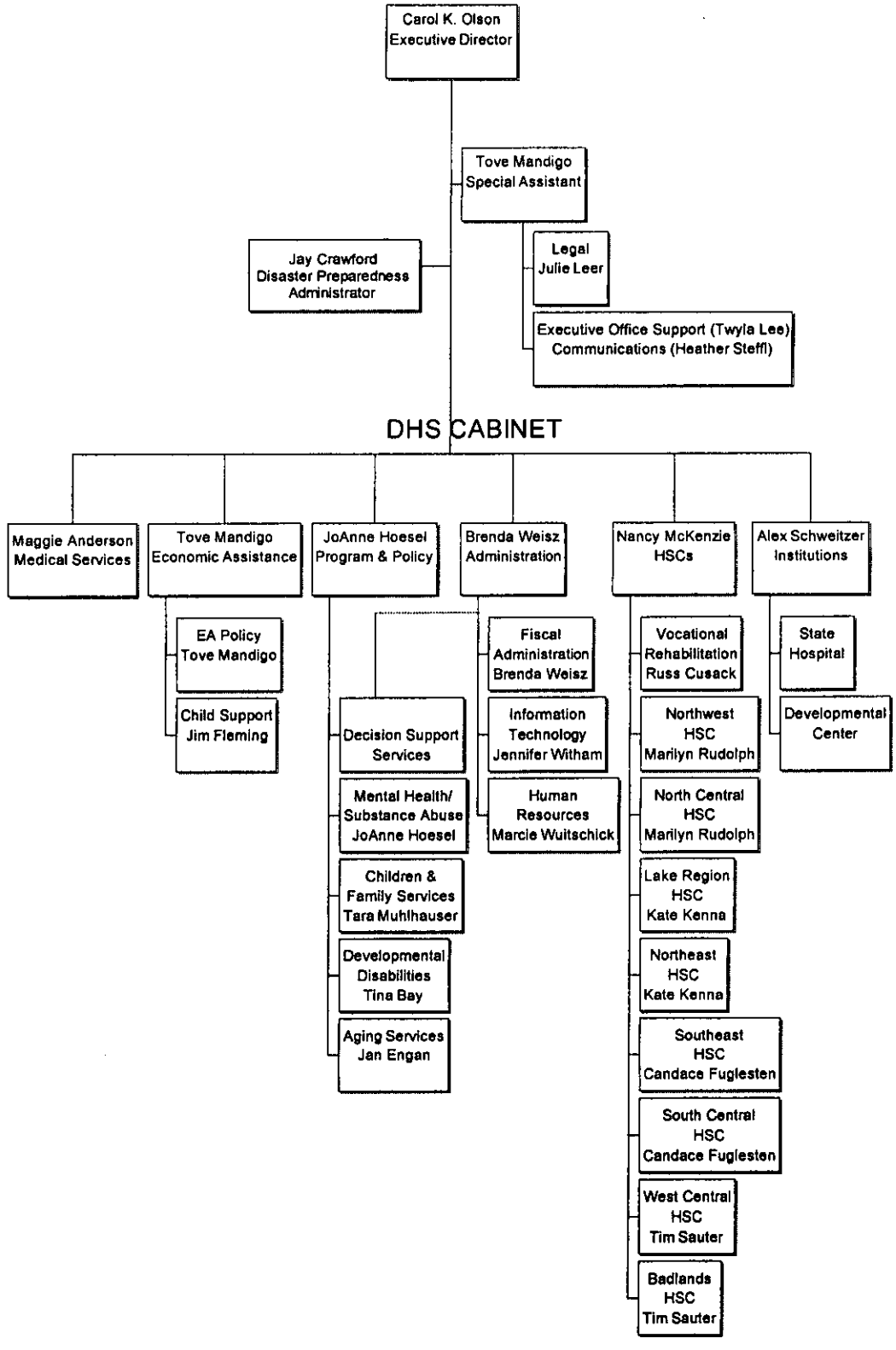
Department of Human Services
SB 2012
FTEs Reduced compared to FTEs Added

Division	FTE	General	Federal / Other	Total
Developmental Center	(40.53)	(1,364,525)	(2,226,318)	(3,590,843)
13 Redistributed by Department in Budget Request to OMB:				
Information Technology Services (ITS)				
Health Information Technology	1.00	21,482	193,337	214,819
3 Temporary Employees - over four years w/o benefits (increase is for fringe benefits only as salary has been in the budget for past two biennia)	3.00	25,528	57,437	82,965
Medical Services Division				
1 Temporary Employee - over four years w/o benefits (increase is for fringe benefits only as salary has been in the budget for past two biennia)	1.00	7,559	15,974	23,533
Mental Health / Substance Abuse Service				
Prevention Coordinator Positions - previously contracted	6.00	-	837,637	837,637
North Central HSC				
Psychiatrist	1.00	269,920	141,355	411,275
State Hospital				
Pharmacist	1.00	222,970	-	222,970
TOTAL of Added FTE as Submitted to OMB	13.00	547,459	1,245,740	1,793,199

Health Care Trust Fund
Status Statement

	Actual 1999 - 2001		Actual 2001 - 2003		Actual 2003 - 2005		Actual 2005-2007		Actual for 2007-2009		Estimated for 2009-2011		Estimated for 2011-2013	
Beginning Balance		$ -		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,946		$238,644
Revenue:														
April 2000 pool payment	$ 25,902,739													
Sept. 2000 pool payment	17,340,685													
August 2001 pool payment			$15,398,174											
July 2002 pool payment			19,572,291											
Net interest earnings / (loss)	2,171,632		(1,442,407)		2,313,279		1,808,207		136,644		28,944		7,498	
July 2003 pool payment					13,646,405									
July 2004 pool payment					6,349,417									
Principal and interest repayments			329,314		1,182,277		988,573		1,131,466		1,099,260		1,107,884	
Total Revenue		45,415,056		33,857,372		23,491,378		2,796,780		1,268,110		1,128,204		1,115,382
Expenditures:														
Dept. of Human Services														
SPED	(4,262,410)		(6,898,302)											
Loans	(701,477)		(10,859,661)											
Grants	(445,937)		(8,182)											
Administrative costs	(57,700)		(58,830)											
Special Payment to Govt Facilities	(800,000)													
HIPAA			(2,632,773)											
Nursing home bed reduction			(3,435,874)											
Nursing facility			(8,997,758)											
Basic care facility			(382,080)											
Personal care allowance - ICFMR			(43,200)											
Mill levy			(250,000)											
Targeted case management			(139,542)											
Independent living centers			(100,000)											
QSP training grants			(24,158)											
Long term care needs assessment			(237,285)											
Deficiency appropriation			(5,244,576)											
Transfer to State General Fund					(35,990,650)		(16,900,000)							
Provider Inflationary Increase - 0.65%							(3,001,852)							
DD provider Increase							(198,148)							
Nursing Home Provider Inflationary Increase									(525,597)					
Health Care Trust Funding NH											(3,800,000)			
Nursing Facility Bed Limit											(324,506)			
Remodel of assisted living and basic care grant											(200,000)			
Health Department														
Quick response unit pilot project			(50,000)		(30,000)		(10,000)		(5,000)		(50,000)		-	
Nursing student loan repayment			(489,500)		(489,500)		-							
Evaluate State Trauma System			-		-		-		(73,758)					
Total Expenditures		(6,267,524)		(39,851,721)		(36,510,150)		(20,110,000)		(604,355)		(4,374,506)		-
Ending Balance		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,946		**$238,644**		**$1,354,026**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES



Effective 11/3/10

SB 2012
1-24-11

A

North Dakota Department of Human Services
Health Care Reform FTEs
Cost to Continue Salaries for the 2013 - 2015 Biennium

Position	Salaries Included in the 2011 - 2013 Executive Budget (Amounts do not Include Governor's Salary Package) Total Funds	General Funds	Start Date
Economic Assistance Policy Trainer	17,058	17,058	April 1, 2013
Child Support Enforcement Attorney	174,612	59,368	July 1, 2011
Medical Services			
Eligibility Policy	110,919	55,460	July 1, 2011
Program Integrity	103,961	51,980	January 1, 2012
Nurse	52,896	13,224	October 1, 2012
SURS Analyst *	24,221	5,888	January 1, 2013
Administrative Support	20,612	11,145	January 1, 2013
Total	**$ 504,279**	**$ 214,123**	

Position	Salaries for 2013 - 2015 Biennium (full 24 months) ** Total Funds	General Funds
Economic Assistance Policy Trainer	137,396	68,698
Child Support Enforcement Attorney	176,060	59,860
Medical Services		
Eligibility Policy	112,368	56,184
Program Integrity	139,921	69,961
Nurse	142,362	35,591
SURS Analyst *	98,114	23,852
Administrative Support	83,832	45,328
Total	**$ 890,053**	**$ 359,474**

Position	Cost to Continue Salaries for 2013 - 2015 Total Funds	General Funds
Economic Assistance Policy Trainer	120,338	51,640
Child Support Enforcement Attorney	1,448	492
Medical Services		
Eligibility Policy	1,449	724
Program Integrity	35,960	17,981
Nurse	89,466	22,367
SURS Analyst *	73,893	17,964
Administrative Support	63,220	34,183
Total	**$ 385,774**	**$ 145,351**

* Surveillance and Utilization Review System (SURS)
** The health insurance cost in the 2011 - 2013 Executive Budget was used for this analysis.

B

The listing for Nursing Facilities reflects the low and high rates for the range of 34 case mix classifications.
Rates are only effective as of the date at the top of the page. Please contact the individual facility for current desk rates.

ND Department of Human Services - Division of Medical Services

Nursing Facilities -- Rates effective January 1, 2011

CITY	FACILITY	RATES Low Rate	High Rate
Aneta	Aneta Parkview Health Center-30322	$146.13	$331.27
Arthur	Arthur Good Samaritan Center-30058	$152.50	$358.06
Ashley	Ashley Medical Center SNF-30188	$134.05	$353.83
Beulah	Knife River Care Center-30002	$191.75	$408.81
Bismarck	Baptist Home-30003	$162.71	$406.51
Bismarck	Bismarck Good Samaritan Society - 30494	$190.30	$421.86
Bismarck	Medcenter One St. Vincent's Care Center-30005	$164.48	$407.84
Bismarck	Missouri Slope Lutheran Care Center-30004	$175.81	$431.33
Bismarck	St. Gabriel's Community - 30497	$223.00	$454.56
Bottineau	Bottineau Good Samaritan Center-30118	$162.98	$380.54
Bowman	Southwest Healthcare Services-30403	$169.99	$405.79
Cando	Towner County Living Center-30379	$157.67	$321.83
Carrington	Golden Acres Manor-30008	$145.86	$350.12
Cavalier	Wedgewood Manor-30424	$166.79	$385.69
Cooperstown	Cooperstown Medical Center-30095	$151.75	$370.95
Crosby	Crosby Good Samaritan Center-30122	$142.47	$317.51
Devils Lake	Devils Lake Good Samaritan Center-30115	$149.03	$350.73
Devils Lake	Heartland Care Center-30010	$171.73	$406.21
Dickinson	St. Benedict's Health Center-30237	$150.93	$356.43
Dickinson	St. Luke's Home-30011	$150.70	$361.38
Dunseith	Dunseith Community Nursing Home-30052	$145.54	$331.94
Elgin	Jacobson Memorial Care Center-30077	$149.15	$331.65
Ellendale	Prince of Peace Care Center-30012	$141.99	$305.23
Enderlin	Maryhill Manor-30421	$152.20	$359.00
Fargo	Bethany Homes-30060	$172.27	$411.95
Fargo	Bethany on 42nd Skilled Care - 30492	$217.67	$473.19
Fargo	Elim Home-30051	$157.86	$375.74
Fargo	Manorcare Health Services-30478	$140.34	$332.16
Fargo	Rosewood on Broadway-30420	$174.76	$393.00
Fargo	Villa Maria Healthcare-30419	$176.26	$396.50
Forman	Four Seasons Health Care Center-30406	$123.70	$258.34
Garrison	Benedictine Living Center of Garrison-30247	$146.48	$329.76
Garrison	Garrison Memorial Hospital NF-30134	$172.03	$418.57
Glen Ullin	Marian Manor HealthCare Center-30067	$151.49	$400.37

CITY	FACILITY	RATES Low Rate	High Rate
Grafton	Lutheran Sunset Home-30016	$165.30	$415.62
Grand Forks	Valley Eldercare Center-30017	$175.19	$403.91
Grand Forks	Woodside Village-30201	$178.39	$405.49
Hankinson	St. Gerard's Community NH-30163	$146.89	$344.89
Harvey	St. Aloisius Medical Center-30129	$148.56	$356.64
Hatton	Tri-County Retirement & NH-30018	$176.60	$414.88
Hettinger	Western Horizons Living Center-30477	$180.52	$436.04
Hillsboro	Hillsboro Medical Center NH-30019	$211.77	$467.29
Jamestown	Ave Maria Village -30422	$172.36	$407.98
Jamestown	Eventide at Hi-Acres - 30498	$161.16	$409.86
Killdeer	Hill Top Home of Comfort-30271	$166.60	$396.88
Lakota	Lakota Good Samaritan Center-30097	$142.65	$322.85
LaMoure	St. Rose Care Center-30119	$151.34	$350.64
Langdon	Maple Manor Care Center-30083	$176.75	$350.73
Larimore	Larimore Good Samaritan Center-30113	$152.16	$339.66
Lisbon	North Dakota Veterans Home-30293	$177.64	$433.16
Lisbon	Parkside Lutheran Home-30109	$177.82	$411.10
Mandan	Dacotah Alpha-30225	$363.61	same for all residents
Mandan	Medcenter One Care Center Off Collins-30106	$170.78	$409.04
Mandan	Medcenter One Mandan Living Center-30288	$188.07	$439.43
Mayville	Luther Memorial Home-30024	$155.73	$397.41
McVille	Nelson County Health System Care Ctr-30384	$157.83	$354.63
Minot	Manorcare Health Services-30479	$133.73	$316.01
Minot	Trinity Nursing Home-30028	$168.92	$416.26
Mohall	North Central Good Samaritan Center-30173	$148.30	$343.10
Mott	Mott Good Samaritan Nursing Center-30142	$132.58	$299.96
Napoleon	Napoleon Care Center-30114	$148.07	$344.01
New Rockford	Lutheran Home of the Good Shepherd-30029	$172.13	$402.55
New Salem	Elm Crest Manor-30116	$180.81	$398.99
Northwood	Northwood Deaconess Health Center-30031	$193.34	$448.86
Oakes	Oakes Manor Good Samaritan Center-30124	$125.74	$288.66
Osnabrock	Osnabrock Good Samaritan Center-30117	$136.97	$319.99
Park River	Park River Good Samaritan Center-30154	$145.51	$335.37
Parshall	Rock View Good Samaritan Center-30155	$163.23	$364.29
Richardton	Richardton Health Center CC-30487	$183.37	$438.89
Rolla	Rolette Community Care Center-30466	$191.46	$371.14
Rugby	Heart of American Nursing Facility-30135	$169.99	$401.19
Stanley	Mountrail Bethel Home-30032	$163.65	$394.41
Strasburg	Strasburg Nursing Home-30033	$147.83	$368.17
Tioga	Tioga Medical Center LTC-30176	$159.63	$382.33

CITY	FACILITY	RATES Low Rate	High Rate
Underwood	Prairieview Nursing Home-30053	$152.06	$369.28
Valley City	Sheyenne Care Center-30418	$154.35	$387.25
Valley City	Sheyenne Care Center Geropsych-30423	$216.25	same for all residents
Velva	Souris Valley Care Center-30216	$140.60	$308.48
Wahpeton	St. Catherine's Living Center-30034	$140.54	$287.78
Walhalla	Pembilier Nursing Center-30035	$129.03	$314.79
Watford City	McKenzie County Healthcare-30449	$170.24	$415.74
West Fargo	Sheyenne Crossings Care Center - 30496	$195.19	$426.75
Williston	Bethel Lutheran Home-30038	$158.52	$389.16
Wishek	Wishek Home for the Aged-30039	$158.04	$384.84

LTC CONTINUUM FUNCTIONAL & FINANCIAL ELIGIBILITY REQUIREMENTS COMPARISON (7/2010)

North Dakota Depart[redacted] of Human Services

ExSPE.	SPED	Medicaid State Plan Personal Care (M[redacted])			Medicaid Waiver for HCBS (Elderly and Disabled)	PACE (Program of all Inclusive Care of the Elderly)	[redacted]rsing Home
		(Level A) Basic Care/Daily/Rate	(Level B)	(Level C)			
Services • Adult Day Care • Adult Foster Care • Chore • Emergency Response System • Environmental Modification • Family Home Care • HCBS Case Management • Homemaker • Non-Med Transportation • Respite	**Service** • Adult Day Care • Adult Foster Care • Chore • Emergency Response System • Environmental Modification • Family Home Care • HCBS Case Management • Homemaker • Non-Med Transportation • Respite • Personal Care Services	**Service** • Personal Care Services	**Service** • Personal Care Services	**Service** • Personal Care Services	**Service** • Adult Day Care • Adult Foster Care • Adult Residential • Chore & ERS Systems • Environmental Modification • HCBS Case Management • Homemaker • Non-Med Transportation • Respite • Specialized Equipment/Supplies • Supported Employment • Transitional Care • Extended Personal Care • Home Delivered Meals • Family Personal Care **Technology Dependent Medicaid Waiver** **Service** • Attendant Care Service	**Service** • All Medicare and Medicaid Services • Primary Medical Care • Meals • Nutritional Counseling • Home Health Care • Personal Care • Dentistry • Prescription Drugs • Social Services • Adult Day Care • Therapies • Transportation • Hospital Care • Hospital ER • Nursing Service • Nursing Home Care • Other services as team determines	**Service** 24 hour care, including; personal care, nursing care, restorative services, social service, recreational activities, room and board etc.
	Personal Care Service: Assistance with activities of daily living such as bathing, dressing, toileting, transferring, eating, mobility and incontinence care. Assistance with instrumental activities of daily living may also be provided in conjunction with the tasks for activities of daily living. Personal Care Services allow individuals to live as independently as possible.						
Functional Eligibility Not severely impaired in ADLs: Toileting, Transferring, Eating **And** Impaired in 3 of the 4 following IADLs: • Meal Preparation • Housework • Laundry • Medication Assistance Or Have health, welfare, or safety, supervision or structured environment needs	**Functional Eligibility** Impaired in 4 ADLs, OR in at least 5 IADLs, totaling eight (8) or more points or if living alone totaling at least six (6) points **Or** If under age 18, meet **LOC** screening criteria **And** • Impairments must have lasted or are expected to last 3 months or more	**Functional Eligibility** Impaired in 1 ADL **Or** Impaired in 3 of the 4 following IADL's • Meal Prep • Housework • Laundry • Medication Assistance **And** Meet **LOC** criteria	**Functional Eligibility** Impaired in 1 ADL **Or** Impaired in 3 of the following 4 IADL's • Meal Prep • Housework • Laundry • Medication Assistance **And** Meet **LOC** criteria	**Functional Eligibility** Impaired in 5 ADL's **And** Meet **LOC** criteria **And** No units allocated to the tasks of laundry, shopping, & housekeeping **And** Prior approval from the Dept.	**Functional Eligibility** Meet **LOC** screening criteria **Functional Eligibility**	**Functional Eligibility** Be 55 years of age or older **And** Be able to live safely in the community **And** Meet **LOC** screening criteria	**Functional Eligibility** Meet **LOC** screening criteria
		Nursing Facility Level of Care Screening- **(LOC)** Eligibility may include a medical need, example: vent dependent, unstable medical condition, dementia; or an individual may qualify by needing assistance with 2 ADLs 60 % or more of the time. Complete criteria for LOC Screening - NDAC 75-02-02-09.					
Financial Eligibility Medicaid Eligible	**Financial Eligibility** Income & Asset/Based Sliding Fee Scale Resources $50,000 or less	**Financial Eligibility** Medicaid Eligible			**Financial Eligibility** Medicaid Eligible	**Financial Eligibility** Medicaid and/or Medicare Eligible	**Financial Eligibility** Medicaid Eligible
Program Cap $1930.00 per month	**Program Cap** $1930.00 per month	**Program Cap** Level A- 480 units per month (a unit it 15 minutes) Level B- 960 units per month Level C- 1200 units per month			**Program Cap** Limited to the highest monthly rate allowed to a nursing facility.	**Program Cap** Managed care rate per/ member per/month	**Program Cap** Average rate: $5948.00 per/mo. $195.55 per/ day

Individual QSP Rate $4.16 per/unit - **Agency QSP Rate** $ 5.80 per/unit (In addition some rates may be daily, one time, half day, and also specific to the service)

D

North Dakota Department of Human Services
Medical Services Division
January 2011
Services Payments for the Elderly and Disabled (SPED)
Reasons for lower growth in the SPED program

When personal care services were implemented, the rationale was that North Dakota could save state funds and capture federal match by offering personal care under Medicaid. As a result, the Department moved all personal care out of the Medicaid waivers.

Some people will not apply for Medicaid; and for some this is to avoid having a Recipient Liability and to avoid future estate recovery.

There are times when clients are not required to apply for Medicaid; for example, if they are requesting Family Home Care as this program is not available under any Medicaid funding source. Also, clients are not required to apply for Medicaid if the client is clearly not Level of Care screenable and would not be eligible for a "like" service under the Medicaid waiver (chore/ERS/homemaker/respite-etc).

For those who have applied for SPED since 2007, the data shows the following about why clients were denied SPED services:

SPED Denials / Closures		
Year	Not Financially Eligible	Not Functionally Eligible
2007	13	13
2008	26	37
2009	30	59
2010	18	57

Another change is the oil income in the state. Some otherwise eligible individuals are now over the financial limit.

Department of Human Services

Comparison of Current 2009-2011 Budget to the 2011-2013 Budget to the Senate

Subdivision	Fund	Current Budget 2009 - 2011	To the Senate 2011 - 2013	Total Budget Changes	Percentage of Change
100-15 ADMINISTRATION - SUPPORT	1 General	$6,727,982	$7,775,396	$1,047,414	15.57%
100-15 ADMINISTRATION - SUPPORT	2 Federal	$6,468,144	$7,090,067	$621,923	9.62%
100-15 ADMINISTRATION - SUPPORT	3 Special	$1,063,678	$1,169,952	$106,274	9.99%
100-15 ADMINISTRATION - SUPPORT Total		**$14,259,804**	**$16,035,415**	**$1,775,611**	**12.45%**
100-20 INFORMATION TECHNOLOGY SRVCS	1 General	$20,703,546	$23,746,066	$3,042,520	14.70%
100-20 INFORMATION TECHNOLOGY SRVCS	2 Federal	$52,180,431	$37,243,950	($14,936,481)	-28.62%
100-20 INFORMATION TECHNOLOGY SRVCS	3 Special	$4,349,870	$2,034,443	($2,315,427)	-53.23%
100-20 INFORMATION TECHNOLOGY SRVCS Total		**$77,233,847**	**$63,024,459**	**($14,209,388)**	**-18.40%**
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	1 General	$10,676,487	$11,439,272	$762,785	7.14%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	2 Federal	$322,674,475	$318,286,921	($4,387,554)	-1.36%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	3 Special	$18,038,981	$18,745,883	$706,902	3.92%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS Total		**$351,389,943**	**$348,472,076**	**($2,917,867)**	**-0.83%**
300-02 CHILD SUPPORT ENFORCEMENT	1 General	$3,585,371	$6,874,824	$3,289,453	91.75%
300-02 CHILD SUPPORT ENFORCEMENT	2 Federal	$17,591,107	$15,175,197	($2,415,910)	-13.73%
300-02 CHILD SUPPORT ENFORCEMENT	3 Special	$2,788,509	$2,990,900	$202,391	7.26%
300-02 CHILD SUPPORT ENFORCEMENT Total		**$23,964,987**	**$25,040,921**	**$1,075,934**	**4.49%**
300-03 MEDICAL SERVICES	1 General	$148,519,693	$239,977,645	$91,457,952	61.58%
300-03 MEDICAL SERVICES	2 Federal	$365,011,673	$433,243,028	$68,231,355	18.69%
300-03 MEDICAL SERVICES	3 Special	$34,093,582	$34,871,219	$777,637	2.28%
300-03 MEDICAL SERVICES Total		**$547,624,948**	**$708,091,892**	**$160,466,944**	**29.30%**
300-10 LONG TERM CARE	1 General	$283,801,911	$422,308,643	$138,506,732	48.80%
300-10 LONG TERM CARE	2 Federal	$554,326,370	$524,438,836	($29,887,534)	-5.39%
300-10 LONG TERM CARE	3 Special	$11,572,047	$3,275,060	($8,296,987)	-71.70%
300-10 LONG TERM CARE Total		**$849,700,328**	**$950,022,539**	**$100,322,211**	**11.81%**
300-42 DD COUNCIL	2 Federal	$1,015,718	$915,889	($99,829)	-9.83%
300-42 DD COUNCIL Total		**$1,015,718**	**$915,889**	**($99,829)**	**-9.83%**
300-43 AGING SERVICES	1 General	$3,784,842	$4,676,276	$891,434	23.55%
300-43 AGING SERVICES	2 Federal	$13,261,552	$13,174,591	($86,961)	-0.66%
300-43 AGING SERVICES	3 Special	$310,192	$280,000	($30,192)	-9.73%
300-43 AGING SERVICES Total		**$17,356,586**	**$18,130,867**	**$774,281**	**4.46%**
300-46 CHILDREN AND FAMILY SERVICES	1 General	$25,060,229	$31,053,237	$5,993,008	23.91%
300-46 CHILDREN AND FAMILY SERVICES	2 Federal	$85,194,925	$82,978,058	($2,216,867)	-2.60%
300-46 CHILDREN AND FAMILY SERVICES	3 Special	$19,071,085	$21,062,704	$1,991,619	10.44%
300-46 CHILDREN AND FAMILY SERVICES Total		**$129,326,239**	**$135,093,999**	**$5,767,760**	**4.46%**
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	1 General	$6,180,518	$7,128,641	$948,123	15.34%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	2 Federal	$6,743,842	$12,026,270	$5,282,428	78.33%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	3 Special	$584,659	$570,860	($13,799)	-2.36%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE Total		**$13,509,019**	**$19,725,771**	**$6,216,752**	**46.02%**
300-51 VOC REHAB	1 General	$4,844,905	$4,859,126	$14,221	0.29%
300-51 VOC REHAB	2 Federal	$22,770,553	$22,326,268	($444,285)	-1.95%
300-51 VOC REHAB	3 Special	$91,462	$94,999	$3,537	3.87%
300-51 VOC REHAB Total		**$27,706,920**	**$27,280,393**	**($426,527)**	**-1.54%**
300-52 DEVELOPMENTAL DISABILITIES DIVISION	1 General	$2,947,015	$3,151,429	$204,414	6.94%
300-52 DEVELOPMENTAL DISABILITIES DIVISION	2 Federal	$5,969,513	$5,874,450	($95,063)	-1.59%
300-52 DEVELOPMENTAL DISABILITIES DIVISION	3 Special	$9,915	$150,003	$140,088	1412.89%
300-52 DEVELOPMENTAL DISABILITIES DIVISION Total		**$8,926,443**	**$9,175,882**	**$249,439**	**2.79%**

Department of Human Services

Comparison of Current 2009-2011 Budget to the 2011-2013 Budget to the Senate

Subdivision	Fund	Current Budget 2009 - 2011	To the Senate 2011 - 2013	Total Budget Changes	Percentage of Change
410-71 NORTHWEST HSC	1 General	$4,724,962	$4,958,832	$233,870	4.95%
410-71 NORTHWEST HSC	2 Federal	$3,436,804	$3,321,230	($115,574)	-3.36%
410-71 NORTHWEST HSC	3 Special	$348,888	$469,006	$120,118	34.43%
410-71 NORTHWEST HSC Total		**$8,510,654**	**$8,749,068**	**$238,414**	**2.80%**
410-72 NORTH CENTRAL HSC	1 General	$10,459,768	$13,410,027	$2,950,259	28.21%
410-72 NORTH CENTRAL HSC	2 Federal	$8,073,938	$8,104,420	$30,482	0.38%
410-72 NORTH CENTRAL HSC	3 Special	$848,895	$919,437	$70,542	8.31%
410-72 NORTH CENTRAL HSC Total		**$19,382,601**	**$22,433,884**	**$3,051,283**	**15.74%**
410-73 LAKE REGION HSC	1 General	$6,066,003	$6,882,190	$816,187	13.46%
410-73 LAKE REGION HSC	2 Federal	$4,450,221	$4,063,599	($386,622)	-8.69%
410-73 LAKE REGION HSC	3 Special	$438,918	$472,442	$33,524	7.64%
410-73 LAKE REGION HSC Total		**$10,955,142**	**$11,418,231**	**$463,089**	**4.23%**
410-74 NORTHEAST HSC	1 General	$11,259,927	$13,209,723	$1,949,796	17.32%
410-74 NORTHEAST HSC	2 Federal	$13,557,216	$12,967,908	($589,308)	-4.35%
410-74 NORTHEAST HSC	3 Special	$1,150,276	$2,004,978	$854,702	74.30%
410-74 NORTHEAST HSC Total		**$25,967,419**	**$28,182,609**	**$2,215,190**	**8.53%**
410-75 SOUTHEAST HSC	1 General	$14,235,049	$22,185,733	$7,950,684	55.85%
410-75 SOUTHEAST HSC	2 Federal	$14,748,761	$15,145,044	$396,283	2.69%
410-75 SOUTHEAST HSC	3 Special	$1,355,842	$1,133,943	($221,899)	-16.37%
410-75 SOUTHEAST HSC Total		**$30,339,652**	**$38,464,720**	**$8,125,068**	**26.78%**
410-76 SOUTH CENTRAL HSC	1 General	$8,464,433	$9,343,547	$879,114	10.[illegible]
410-76 SOUTH CENTRAL HSC	2 Federal	$6,486,699	$6,691,551	$204,852	3.[illegible]
410-76 SOUTH CENTRAL HSC	3 Special	$751,732	$918,601	$166,869	22.20%
410-76 SOUTH CENTRAL HSC Total		**$15,702,864**	**$16,953,699**	**$1,250,835**	**7.97%**
410-77 WEST CENTRAL HSC	1 General	$11,918,377	$14,109,532	$2,191,155	18.38%
410-77 WEST CENTRAL HSC	2 Federal	$11,756,689	$11,430,961	($325,728)	-2.77%
410-77 WEST CENTRAL HSC	3 Special	$1,208,459	$1,200,000	($8,459)	-0.70%
410-77 WEST CENTRAL HSC Total		**$24,883,525**	**$26,740,493**	**$1,856,968**	**7.46%**
410-78 BADLANDS HSC	1 General	$5,511,630	$6,529,292	$1,017,662	18.46%
410-78 BADLANDS HSC	2 Federal	$4,648,886	$4,426,122	($222,764)	-4.79%
410-78 BADLANDS HSC	3 Special	$814,766	$834,240	$19,474	2.39%
410-78 BADLANDS HSC Total		**$10,975,282**	**$11,789,654**	**$814,372**	**7.42%**
420-00 STATE HOSPITAL	1 General	$40,114,197	$42,061,882	$1,947,685	4.86%
420-00 STATE HOSPITAL	2 Federal	$4,803,599	$2,609,783	($2,193,816)	-45.67%
420-00 STATE HOSPITAL	3 Special	$15,132,542	$17,536,620	$2,404,078	15.89%
420-00 STATE HOSPITAL Total		**$60,050,338**	**$62,208,285**	**$2,157,947**	**3.59%**
421-00 SH SECURED SERVICES	1 General	$10,429,000	$11,264,915	$835,915	8.02%
421-00 SH SECURED SERVICES	2 Federal	$17,824	$0	($17,824)	-100.00%
421-00 SH SECURED SERVICES	3 Special	$33,299	$0	($33,299)	-100.00%
421-00 SH SECURED SERVICES Total		**$10,480,123**	**$11,264,915**	**$784,792**	**7.49%**
430-00 DEVELOPMENTAL CENTER	1 General	$14,595,729	$20,417,430	$5,821,701	39.89%
430-00 DEVELOPMENTAL CENTER	2 Federal	$35,363,271	$27,823,460	($7,539,811)	-21.32%
430-00 DEVELOPMENTAL CENTER	3 Special	$4,143,340	$3,568,357	($574,983)	-13.88%
430-00 DEVELOPMENTAL CENTER Total		**$54,102,340**	**$51,809,247**	**($2,293,093)**	**-4.24%**
Grand Total		**$2,333,364,722**	**$2,611,024,908**	**$277,660,186**	**11.9**

Department of Human Services

Comparison of Current 2009-2011 Budget to the 2011-2013 Budget to the Senate

Subdivision	Fund	Current Budget 2009 - 2011	To the Senate 2011 - 2013	Total Budget Changes	Percentage of Change
999-99 DHS TOTALS	1 General	$654,611,574	$927,363,658	$272,752,084	41.67%
999-99 DHS TOTALS	2 Federal	$1,560,552,211	$1,569,357,603	$8,805,392	0.56%
999-99 DHS TOTALS	3 Special	$118,200,937	$114,303,647	($3,897,290)	-3.30%
Grand Total		**$2,333,364,722**	**$2,611,024,908**	**$277,660,186**	**11.90%**

Prepared by the North Dakota Legislative Council staff

January 2011

SENATE BILL NO. 2012 - DEPARTMENT OF HUMAN SERVICES - ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE BUDGET OPTIONS

Description	Option A (2011-13 Executive Budget)	Option B
	Provide for the continuation of the Department of Human Services' unexpended 2009-11 general fund appropriation authority to the 2011-13 biennium. The continued funding is to be used for medical assistance grants during the 2011-13 biennium. The department estimates the amount to be $12.8 million. This funding is not included in the department's $927.4 million general fund appropriation recommended in the 2011-13 executive budget.	Require the Department of Human Services to turn back at the end of the 2009-11 biennium any unexpended general fund appropriation and increase the department's general fund appropriation for the 2011-13 biennium to account for funding needed for medical assistance grants. This funding would be included in the department's 2011-13 general fund appropriation.
2009-11 general fund turnback	$0	$12,800,000
2009-11 general fund carryover	$12,800,000	$0
2011-13 general fund appropriation	$0	$12,800,000

NOTE: Option B would require a section to be added to Senate Bill No. 2012 in order to comply with the American Recovery and Reinvestment Act of 2009 rainy day fund prohibition. A similar section was added by the 2009 Legislative Assembly.

A

ND Department of Human Services
Medical Services Division
Comparison of
Home and Community Based Services
and Institutional Services

	Personal Care Level A	Basic Care Facility	Additional Cost for Institutional Care
Monthly Cost	3,161.80	3,462.33	300.53

	Personal Care Level B	Nursing Facility	Additional Cost for Institutional Care
Monthly Cost	5,158.60	8,175.39	3,016.79

	Personal Care Level C	Nursing Facility	Additional Cost for Institutional Care
Monthly Cost	6,157.00	8,758.18	2,601.18

None of the costs for personal care or for institutional care include medical costs such as hospitalization, pharmacy, physician services, etc.

Based on highest number of units available for each level of personal care. Although the rates for personal care are calculated at the highest number of units per level, there are many individuals in each level that do not receive the highest number of units available.

Room and board is not included in personal care; however, it is included the Basic Care and Nursing Facility costs. Basic Care room and board is 100% general funds.

Based on Basic Care Facility Desk Rates as of July 1, 2010.

Based on Nursing Facility Desk Rates effective January 1, 2011.

DHS does not pay for room and board in Assisted Living. Personal care services are available to Medicaid eligible individual residing in an Assisted Living community. However, not many individuals who qualify for Medicaid reside in an Assisted Living community.

B.

North Dakota Department of Human Services
Comparison of Estimated Monthly Cost for a Child on Medicaid as Compared to a Child on Children's Health Insurance Plan (CHIP)
January 2011

	Total monthly Cost	General	Federal
SFY 2012			
Child with CHIP (FMAP 69.36%)*	274.03	83.96	190.07
Child on Medicaid (FMAP 56.23)*	255.21	111.71	143.50
Monthly Difference Per Child	18.82	(27.75)	46.57
Yearly Difference Per Child	225.84	(333.00)	558.84

	Total monthly Cost	General	Federal
SFY 2013			
Child with CHIP (FMAP 68.78%)	274.03	85.55	188.48
Child on Medicaid (FMAP 55.40)	262.86	117.24	145.62
Monthly Difference Per Child	11.17	(31.69)	42.86
Yearly Difference Per Child	134.04	(380.28)	514.32

From the chart above you will see the total monthly cost of a Child on CHIP is higher than the cost of Medicaid, however, it requires less general fund because of the enhanced FMAP provided for CHIP.

Assumptions:

The CHIP premium of $274.03 is Blue Cross\Blue Shield's current estimate for each year of the 2011-2013 biennium.

The per month cost of a child on Medicaid was determined by using the SFY 2010 Per Member Per Month ($233.75) cost inflated by 6% for SFY 2011 and then increased 3% in each year for the inflationary increase recommended in the Executive Budget.

* The FMAP percentage provided is an aggregate FMAP as the State Fiscal Year contains rates from two Federal Fiscal Years.

	Medicaid FMAP	CHIP FMAP
FFY 2011	60.35%	72.25%
FFY 2012	55.40%	68.78%

DD Providere Wage and Fringe Benefit Increase
2011-2013 Biennium

Start Date: July 1, 2011

Description	Recipients	11-13 Biennial Cost	General Fund	Federal Funds	Other
Individual effects of wage increase & fringe benefit increase:					
$0.50 wage increase		$11,364,049	$5,021,489	$6,342,560	$0
7% Fringe benefit increase		$17,533,141	$7,747,457	$9,785,684	$0
Cumulative effect of doing both:					
$0.50 wage increase		$11,364,049	$5,021,489	$6,342,560	$0
7% Fringe benefit increase with $0.50		$18,158,434	$8,023,758	$10,134,676	$0
Total		$29,522,483	$13,045,247	$16,477,236	$0

Notes:

Based on current providers with 3% inflationary increases calculated on each year.

Both the .50 wage increase and the 7% fringe benefit increase were calculated prior to the 3% inflationary increases being applied.

The $.50 per hour wage increase does include the cost of additional FICA and Medicare taxes at 7.65%

Change in salaries would be effective July 1, 2011

This proposed increase is calculated independently of other proposals and of the 2011-2013 Executive Budget request.

Steele Ozone & Kidder County Press 10-07-09 Page 11

Golden Manor update

The Golden Manor board wishes to keep the community advised as to the progress of the proposed use of the facility. A significant amount of time and energy has been invested in attempting to work with Elim Care, Inc. The Golden Manor board still hopes this is a strong option, but with the months passing, the board must proceed with alternate options. The Golden Manor Board at the October 2nd meeting has recommended hiring a consultant to assist in the process.

Below is a synapses of the Golden Manor and Central Dakota Convalescent Home activity since the passage of House Bill 1327.

October 2, 2009 - Board meeting, agenda: (1) Consultant proposal review; (2) Elim update

October 1, 2009 - Call to Bob Dahl, President Elim Care, Inc.

September 23, 2009 - Meeting held with a prospective consultant with 19 years of experience as a Program Administrator for ND Department of Human Services.

September 21, 2009 - Communication with Tim Hager, Administrator of Elim Nursing Home of Fargo. Mr. Hager indicates there has been discussion in regard to Golden Manor at their meetings.

September 18, 2009 - Communicate with contractor to coordinate with subcontractors to meet at facility.

September 18, 2009 - Board meeting agenda: (1) Eide Bailly - tax return preparation ; (2) Elim Update; (3) Other options if Elim not interested; (4) Time line for legislative funding; (5) Room conversion costs; (6) ND Assisted Living Work Group meeting report; (7) Board replacements

September 16, 2009 - Contact Tim Hager, Administrator Elim Nursing Home of Fargo.

September 15, 2009 - Discussion with Eide Bailly in regard to tax return information.

August 26, 2009 - Board member attends ND Assisted Living Work Group Meeting. This meeting is attended by Linda Wright, Darleen Bartz and Kenan Bullinger from the Department of Health; LeeAnn Thiel, Medical Services; Shelly Peterson, Long Term Care Association; and other Assisted Living operating officers from across the state. The group is eager to assist Golden Manor with our process.

August 24, 2009 - Contact Bob Dahl, President Elim Care, Inc.

August 4, 2009 - Contacted Tim Hager, Administrator Elim Nursing Home of Fargo.

July 29, 2009 - Contact contractor to arrange visit to Golden Manor.

June 22, 2009 - Board member meets caretaker at Golden Manor in regard to possible vandalism. No damage was noticed.

June 8, 2009 - Discussion with Bob Dahl, President of Elim Care, Inc. Elim indicates interest in moving to the next step. Mr. Dahl requests to delay our next meeting until after the closing of the merger with the Bismarck Baptist Home in July. The board agrees to the request.

June 2, 2009 - Meet with prospective consultant.

May 27, 2009 - Discussion with Tim Hager, Administrator Elim Nursing Home of Fargo. Elim indicates strong interest in meeting with Golden Manor.

May 21, 2009 - Discussion with Rep. Weisz about any necessary details required by June 1, 2009 in regard to HB1327. Rep. Weisz indicates he would follow up with Department, but understood Golden Manor had no additional work to complete by June 1, 2009.

May 20, 2009 - Board meeting, agenda: (1) HB 1327 review; (2) Consultant discussion, retired ND Department of Health professional; (3) Eide Bailly Health Care Services; (4) Elim Care, Inc.; (5) Housing survey; (6) Helenske and Associates, Craig Helenske - room conversion estimates; (7) Kidder County Community of Care - Carol Johnson

May 14, 2009 - Communication with Tim Hager, Administrator Elim Nursing Home of Fargo.

May 8, 2009 - Contact Tim Hager, Administrator Elim Nursing Home of Fargo.

May 4, 2009 - Contact Rep. Weisz about HB 1327 passage.

Volunteers make a difference

Submitted by Carol Johnson

What a difference volunteers can make when they provide a little TLC (tender loving care) to a facility!

On the evening of July 27th about 30 volunteers between the ages of 9 and 90 descended upon the Golden Manor determined to restore the grounds to its original beauty and to begin preparing the inside for the

See "Volunteers" on Page 7

Lucie Bjorn 08-11-2010

Volunteers...

(Continued from Page 1)

renovation project that will begin shortly. Armed with yard equipment, rakes, saws, ladders, and other power tools, the outside crew trimmed trees, pulled weeds, mowed, and swept sidewalks. Meanwhile, the inside crew took down pictures, moved furniture, removed nails, and generally got the place ready for the renovation phase. Throughout the week and on Saturday, the work continued. As a result, the grounds around the Golden Manor look fabulous. Be sure to drive by and take a peek at the yard! Demolition costs for the inside of Golden Manor were greatly reduced and the building is now ready for some much needed cleaning and maintenance.

The Golden Manor Board of Directors would like to take this opportunity to thank each of the volunteers who helped in whatever capacity. Thanks to the work crews, especially the young, strong high school boys who came to our aid when our energy was too zapped to do much more and to the GM Auxiliary and others who brought food, sodas, and water to keep us going.

The teamwork, enthusiasm, and work ethic was unbelievable and a sight to see! By working as a team, our dreams can become reality. Thanks again for your help in preparing for the reopening of Golden Manor as a basic care/assisted living facility.



Rosemarie Birrenkott and Tabea Mueller



Marcus Gengler



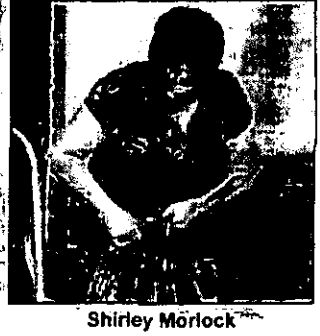
Bev Johnson



Doug Kallanoff



Russ Hanson



Shirley Morlock

Kidder County Press

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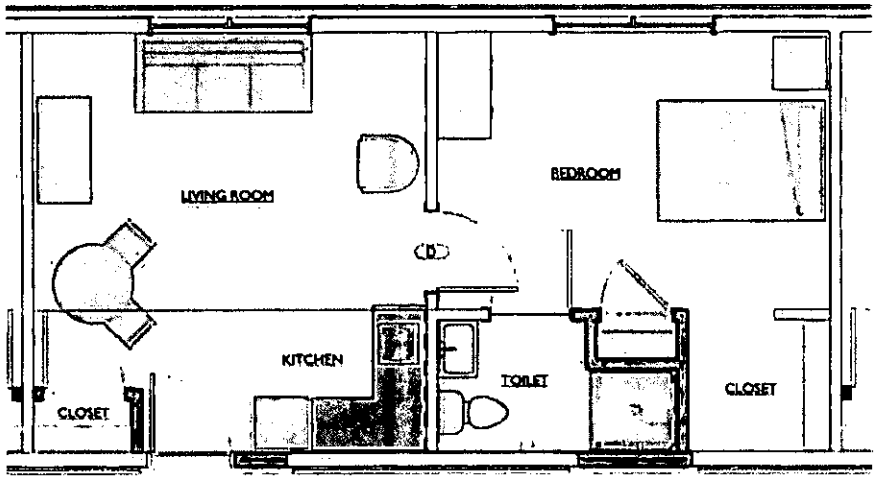
In need of a little help from our friends

Volunteer work schedules are planned in the upcoming days

In the last two months, the following progress toward the reopening of the Golden Manor has been accomplished: seventeen basic care beds have been secured and are awaiting transfer from the North Dakota bed bank to Golden Manor; the application for a North Dakota license to run a basic care facility along with the policy and procedures manual has been submitted to the proper authorities; volunteers have generously donated their time to spruce up the grounds by weeding, mowing, and trimming; volunteers have moved furniture, linens, wall hangings and removed window coverings in preparation for the renovation project and upcoming auction; a search for a manager for Golden Manor is being conducted; ***an auction of excess beds and other miscellaneous items is scheduled for October 9th through RC Auction. Please watch for auction bills;*** and finally, the Golden Manor Board continues to meet weekly to review the progress made by the various committees.

The renovation project will be done in two phases with the basic care wings completed first, followed by the assisted living wing. The basic care wing is projected to be completed this fall and a waiting list with names of people possibly interested in residing at Golden Manor has been established. If interested in placing your name on the waiting list, please contact Mary Rohrich at the Steele Senior Center. Her work number is 701-475-2708 and her home number is 701-475-2489. Once the assisted living wing is completed, residents in the basic care wing will be given the first opportunity to move into the assisted living wing if they so desire and meet the criteria.

In order to meet the projected opening date for this fall, much work still needs to be completed. New energy efficient windows will be installed in some areas, all areas need to be cleaned and prepared for painting, painting must be completed, carpet and other flooring installed, and window treatments hung. To minimize cost and to accelerate the renovation process, ***two more volunteer work sessions are planned for Wednesday, September 15th and Wednesday, September 22nd from 5-9 PM.*** If you have other commitments for the above evenings, but would like to volunteer at a different time, please call Carol Johnson at 701-475-2283 so other arrangements can be made. A list of work details will be made readily available. Please bring your own bucket and supplies for cleaning, tools for removing nails and screws, and lots of energy and enthusiasm.



helenske design group

ASSISTED LIVING UNIT
1/4" = 1'-0"

Assisted Living Unit at Golden Manor after remodeling

SB 2012
2-7-11
P

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

February 2, 2011

Senator Kilzer;

Thank you for the opportunity to provide you and the Sub-Committee information on Hospital Reimbursement. I want to re-iterate that what was approved in 2007 for Critical Access Hospitals and in 2009 for the six (6) large hospitals was to reimbursement at the Medicare Allowable Costs based on the Cost report.

The Medicare Allowable Cost is approximately 92 to 93% of the total costs or expenses to provide care in a Critical Access Hospital. In the Large hospitals the Medicare Allowable Costs ranges from the mid-seventies to the upper eighty percentile. This difference is a seven to eight percent short fall for Critical Access Hospitals and approximately twenty-two percent to twelve percent for the large hospitals. The numbers for the Critical Access Hospitals comes from Eide Bailly and the numbers for the large hospitals comes from the hospitals.

I was asked if I had to make a decision regarding reimbursing hospitals what I would do. After contemplating this question my answer is:

I would use the numbers supplied by Maggie Anderson as they are verifiable through departmental studies or with CMS data. I would consider reimbursing rural health clinics at actual cost, adding $844,300. Second, I would consider reimbursing Critical Access Hospitals for lab and Anesthesia at actual costs using the Supplemental Payment process that was used for Rolla. Again these numbers came from Maggie using CMS data; $3,454,061. I believe that these numbers are verifiable and accurate. Paying for lab and anesthesia at cost will eliminate the Supplemental payment request for Rolla on a biennium bases, $400,000.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

Finally I would request a study by the Human Service Department to determine the true or actual costs of Critical Access Hospitals and the six large hospitals. I would ask that the study be ready for the 2013 Legislative session. The 29.8 million dollar estimate is based on data supplied by each hospital to our office based on their financials. I believe the numbers are accurate and are provided in good faith; however, they are provided by each hospital and then aggregated.

Again thank you for the opportunity to answer your questions. I hope that the information was of value to you and the Sub-Committee.

Respectfully,

Jerry E. Jurena, President
North Dakota Hospital Association

Jerry Jurena

From: Nelson, Jon O. <jonelson@nd.gov>
Sent: Friday, January 28, 2011 1:27 PM
To: Boe, Tracy L.; Jerry Jurena; Devlin, Bill R.
Subject: FW: Critical Access Hospital Information

From: Anderson, Maggie D.
Sent: Friday, January 28, 2011 1:27 PM
To: Nelson, Jon O.
Subject: RE: Critical Access Hospital Information

Yes, that is accurate. It is based on the methodology approved by the Centers for Medicare and Medicaid Services for the supplemental payment to Rolla. All payments would be subjected to the Upper Payment Limit, but it is the same methodology that was used for Presentation Medical in Rolla.

From: Nelson, Jon O.
Sent: Friday, January 28, 2011 1:14 PM
To: Anderson, Maggie D.
Subject: RE: Critical Access Hospital Information

Maggie: Just to confirm that this information includes both lab and CRNA coverage which would mirror what we did for Presentation Medical in Rolla last session. Thanks for the information.

Jon

From: Anderson, Maggie D.
Sent: Friday, January 28, 2011 10:36 AM
To: Nelson, Jon O.
Cc: Weisz, Brenda M.
Subject: Critical Access Hospital Information

Rep. Nelson,

The estimated cost to implement a Medicaid supplemental payment for all Critical Access Hospitals for the 2011-2013 Biennium is $3,454,061, of which $1,527,802 would be general funds.

The estimate is calculated based on the methodology approved by the Centers for Medicare and Medicaid Services for the supplemental payment to Rolla.

Please let me know if you have questions.
Maggie

for bienniums 2011-2013
13 15
15 17
17 19

Total 13,816,244
General funds 6,111,208

SB 2012

Numbers below represent entire biennium (two year)

- Rebasing "Rural Health Clinics" to Cost — $844,300
  - Department of Human Services performed study

- Rebasing PPS and CAHs to Actual Cost — $29,800,000
  - PPS = 22.4
  - CAH = 7.4
  - Based on an estimate received from hospitals

- Supplemental Payment for CAHs — $400,000
  - 25% of Medicaid payments > Total Revenue
  - Cost Reimbursement for Lab/Anesth.
  - Presentation Medical Center – **Rolla**
  - Contain in HB 1012 last biennium (amendment)

- Reimbursing Lab and Anesthesia at actual cost for CAHs — $2,200,000

Maggie Anderson working with Information from CMS estimated Cost is: 3,459,061

general funds: 1527,502

#3

Budget Adjustment for PACE Expansion Testimony
Timothy C. Cox

Northland Healthcare Alliance and Northland PACE Senior Care Services

Chairman Fischer and members of the Medicaid Appropriations Subcommittee, my name is Tim Cox and I am President of Northland Healthcare Alliance. Northland is a member driven provider based organization of 25 hospitals and long-term care facilities located throughout North Dakota. For more than 6 years Northland Healthcare Alliance has worked to bring a PACE program to North Dakota. PACE is a (P) program of (A) all-inclusive (C) care for the (E) elderly. This program is a relatively new program that works to keep the frail elderly independent and healthy. In developing Northland PACE we have pursued funding opportunities and were fortunate enough to receive one of 14 Rural PACE grants from CMS. We have expended great resource to became a licensed PACE site and in August 2008 were awarded a PACE license to provide healthcare services to locations in Bismarck and Dickinson. The PACE program is growing nationally and is being implemented in many states. When we were approved as a PACE site there were 46 programs in operation. Today there are more than 75 approved. CMS loves PACE and feels that it is a good value for their investment and that it provides excellent care to recipients.

The Northland PACE program is already making a difference. Several of our current participants moved into our PACE Program right out of a Long-term Facility. In visiting with them and members of their family they indicate that they have seen remarkable improvement in the health and quality of life. This is amazing given the short time in which we have been in operations. The PACE model is in many ways the future of healthcare. We have a steadily growing graying population and we need to figure out how to take care of their healthcare needs. This model is one that is working. Statistics show that is reduces

A

hospitalizations and makes them shorter when they occur. It will save the state many dollars as it keep individuals from moving into the Long-term Care Environment and even when the PACE participant do move to long-term care, the PACE program pays for the services..

Two years ago when we presented information to the legislature and many of the legislators asked when the program was going to be available in their community. It was our intention to insure that we developed a solid foundation and learned how to operate PACE effectively before venturing into other North Dakota communities. I believe that we have accomplished this and have developed a model that fits the urban and rural environment. With our experience in Dickinson and Bismarck, we are prepared to expand into Jamestown and Fargo, Jamestown this year and Fargo next year.

We see several key benefits that come to the state of North Dakota as the result of this PACE expansion. Let me spend just a few minutes to elaborate.

- PACE will save North Dakota money
- PACE will bring additional healthcare dollars into the state.
- The PACE Model is the future of healthcare. It keeps individuals healthy using a proactive approach to care delivery with a fixed dollar attached to that care. It is supported in Washington DC because of its innovative approach that delivers healthy results.
- With a moratorium of Long-term Care beds in the state, PACE provides a mechanism to provide coverage without having to build additional infrastructure and it does it for less money per participant. It will enable that moratorium on beds to be extended into the future.
- PACE takes care of individuals that are nursing home eligible and are mostly Medicaid eligible. The benefit to the State is PACE effectively

keeps these frail elderly out of Long-term care facilities and when they are admitted into the Nursing home or Acute Care Settings, the costs of that care is still the responsibility of PACE in most cases until they pass away.

In the budget there are key dollars to pay for the current PACE operation. We believe that expansion of the PACE program into additional communities is a prudent economic decision for the legislature and will have a positive impact on the state by exchanging dollars that will be flowing into long-term skilled facilities into a program that provides documented more efficient care and improves the quality of life for the frail elderly in our state at a fixed rate with substantial savings. The expansion is a prudent decision and we encourage the adjustments in the budget to allow for this expansion over the next two years.

Couple lives more independently with help of PACE program

By KAREN HERZOG Bismarck Tribune | Posted: Thursday, December 2, 2010 12:15 am

Clara Feist will mark her 77th birthday today in a much better place than she might have expected to be just a couple of years ago.

For Charles and Clara Feist, being accepted to the Northland PACE program in Bismarck in September 2009 has meant the difference between immobility and a greater measure of independence.

The physical therapy and other services offered by PACE have brought them back from needing nursing home care.

When Clara fell at her home in Zeeland nearly two years ago, her leg was broken so severely that she now has 32 bolts and screws holding the bone together. She was confined in a cast, received her nourishment through a feeding tube and needed a wheelchair to get around.

Her husband, Charles, 79, had limited use of his right arm and hand as the result of a stroke in 2004. He could bring his arm up to his waist — barely — but for the most part, it hung useless.

After Clara's fall, the couple moved from Zeeland to Bismarck. Clara initially spent several months in a nursing care facility, but through PACE, the couple now live in Bismarck's Crescent West complex.

They live independently in an apartment, they get around with PACE's transportation, and a PACE staff nurse visits them to set up their medications.

Twice a week, on Mondays and Wednesdays, the Feists go to physical therapy at PACE's facility at 201 N. 24th St. Clara Feist can step right along with only a walker for support, and Charles can reach his hand up and over his head with the alacrity of a third-grader who knows the answer to a teacher's question.

The Feists have six children who live nearby; one of their daughters and a daughter-in-law both recommended PACE for them.

"If it weren't for PACE, I wouldn't be where I am right now," Clara said.

That includes birthday parties in PACE's activities room, a Thanksgiving meal, music programs, company, social times and more.

When Charles extends his arm to shake a visitor's hand "goodbye," he notes, "if it weren't for PACE, I couldn't do this."

Until you've been through it, you don't imagine the daily toll it takes.

People in the so-called "sandwich generation" can be stretched to the breaking point, trying to do right by both their growing children

and their aging parents.

And in fact, many of the needs of growing children and aging parents are similar — staying healthy, becoming, or remaining, independent, eating right, having a happy social life and getting around town.

And those trying to do it all for both groups are, at the same time, trying to hold down their own jobs, pay the bills, take care of the house and have some semblance of a social life as well.

The programs of Northland PACE in Bismarck and Dickinson have been created to offer better options for older folks than living alone in declining health, get hit-or-miss care, rely on grown children to take time off from work to get them to doctors' appointments, shopping and other necessities, or go the full nursing home route.

Keeping people living in their homes for as long as possible by providing a central location where many of those needs can be met is what Northland PACE does.

Two years ago, Northland PACE began with a grand opening at its facility. Today, between the Bismarck and Dickinson locations, it has 55 people enrolled.

PACE offers transportation, meals, physical therapy, medication monitoring, examination rooms, activities, and a social circle for people who otherwise would have one choice — nursing home care.

Northland PACE has nothing against such care, said Dan Spilovoy, marketing director. But most people want to stay in their homes for as long as they can, for emotional and financial reasons, he said.

Grown children carve out time from their lives to check in on their parents, but in the meantime, they worry whether mom or dad is taking care of themselves, taking their medications properly or are left with only a constantly-running television for company.

Perhaps the greatest benefit from PACE's programs is the peace of mind it gives families, Spilovoy said.

Site manager Tami Anderson said that the PACE facility now has a

13-member staff, including social workers, nurse practitioners, physical therapists and more. The center is open from

8 a.m. to 4:30 p.m. Monday through Friday and nurses are available 24/7 with a call-in line.

Holiday parties, birthday parties and meals keep people socializing and connected with others. Physical therapy and exercise facilities offer opportunities to stay active. Members can have their medications set up and monitored. Transportation delivers them to the door.

"It improves quality of life," Spilovoy said. "It really is like one big family."

Facts about the PACE program

■ To qualify for PACE, which stands for Program of All-inclusive Care for the Elderly, persons must be 55 or older, live in the Bismarck, Mandan or Dickinson ZIP codes, need care and services but are able to live safely in their own home and are eligible for Medicare, Medicaid, pay privately or have appropriate insurance.

■ A person applying to enter the PACE program goes through a screening process to see if they qualify. If so, a care plan is developed specifically for them and they can remain in the PACE program for life, wherever they

Continued on 9A



Charles, left, and Clara Feist of Zeeland now live in Bismarck and appreciate the freedom that the PACE program has given them. (TOM STROMME/ Tribune)

north dakota department of human services

Fact Sheet

March 2009

Program of All-inclusive Care for the Elderly (PACE)

Background:

- The Balanced Budget Act of 1997 established the PACE model for both Medicaid and Medicare programs.
- PACE providers receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide patient-centered and coordinated care to frail elderly individuals living in the community.
- PACE has been approved by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced based model of care.

What is PACE?

PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Who Can Participate?

Participants must:

- Be a Medicare or Medicaid enrollee who is age 55 or older,
- Be eligible for nursing home level of care, and
- Live in a PACE service area.

PACE Services:

The emphasis of the PACE program is on enabling participants to remain in their community and enhancing their quality of life. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services if necessary). Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. The services are provided primarily in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs. PACE is a voluntary program.

Location:

The Northland Healthcare Alliance has developed two PACE organizations in North Dakota. They are located in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

Contact Information:

For information about PACE and how to enroll into the program, contact Northland PACE:

- Bismarck 701-751-3050
- Dickinson 701-456-7387
- Toll Free 1-888-883-8959



ADVANTAGES OF PARTICIPATING IN NORTHLAND PACE SENIOR CARE SERVICES INCLUDE:

- Dedicated, qualified healthcare professionals
- Long-Term Care Services
- Coordinated care 24 hours a day, 365 days a year
- Support for family caregivers
- Personalized individual care

THE COST

The **Northland PACE Senior Care Services** program accepts Medicare and Medicaid.

There are no hidden costs, co-payments or deductibles for any **PACE** services. Your Care Team will determine what medications, services and supplies are necessary for your care. The cost for these services are paid for and provided by **Northland PACE Senior Care Services.**

PARTICIPATION AND DISENROLLMENT:

- Participants receive all of their health care from Northland PACE, except for emergency services.
- Because PACE provides and is responsible for all of your care, you may be held financially responsible for any care you receive outside the program that is not approved by the PACE program.
- Participants may disenroll from the program at any time.
- Northland PACE offers Medicare Part D prescription drug coverage. If you are in a PACE program, you don't need to join a separate Medicare drug plan. If you do, you will lose your PACE health and prescription drug benefits. If you enroll in another Part D program, it will result in your disenrollment from PACE.

Mission Statement

Northland PACE Senior Care Services promotes independence through the coordination of all health services, allowing participants to continue living safely and with dignity at home.

Northland PACE Bismarck
201 N. 24th Street • Bismarck, ND 58501
701-751-3050

In Bismarck, we serve the following zip codes:
58501-58502-58503-58504-58554-58558

Northland PACE Dickinson
830 2nd Ave. East, Suite 212
Dickinson, ND 58601 • 701-456-7387

In Dickinson, we serve the following zip codes:
58601-58602-58652-58655-58680

NORTHLAND PACE

Senior Care Services

Program of All-Inclusive Care for the Elderly



DEDICATED TO PROVIDING THE *highest level* OF CARE TO SENIORS IN OUR COMMUNITY



Northland PACE
Senior Care Services
(Program of All-inclusive Care for the Elderly)

HOME. It is where we want to be. Home is where the heart is. It is where people who love each other gather, and it is where older adults want to live out their days.

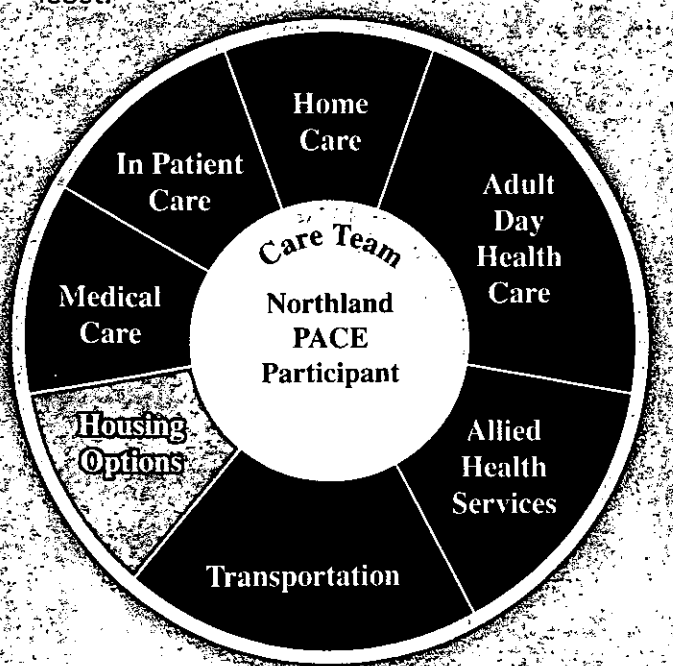
Northland PACE Senior Care Services is designed to keep seniors who are at risk for nursing home care, living independently at home by providing the highest level of healthcare. This includes health care appointments to help participants remain as healthy and independent as possible.

The program includes medications, eye glasses, hearing aids and other assistance that **PACE** doctors may prescribe. Additional services may include In-home assistance - personal care such as bathing, dressing, housecleaning, meals and nutritional counseling.

THE TEAM APPROACH

Northland PACE Senior Care Services employs a group of professionals called a Care Team that coordinates all aspects of healthcare and in-home services for **PACE** participants. This team of specialists includes a physician, nurse practitioner, registered nurse, social worker, health aides and several others who will assist in your healthcare. Families are encouraged to be actively involved in decision making.

As a participant's needs change, their care plan will change to meet any new situation. If hospitalization or nursing home placement is required, **Northland PACE Senior Care Services** covers the cost.



ELIGIBILITY REQUIREMENTS

- Be at least 55 years old
- Be in need of long-term care services
- Be able to live safely at home
- Live within an area served by **Northland PACE**

RANGE OF SERVICES

These services are based on the needs of each individual. Additional services may be necessary to maintain and improve the health of the individual. These are determined by the Care Team.

- Primary Care and Specialty Medical Care
- All Prescription drugs
- Adult Day Center with therapists
  • Physical • Occupational • Recreational
- Healthcare Specialists
  • Audiology • Dentistry • Optometry
- Dietary Services
  • Meals and Nutritional Counseling
- In-Home Support and Care
- Rehabilitation and Restorative Therapies
  • Speech Therapy • Physical Therapy
  • Recreation Therapy • Occupational Therapy
- Social Services
- Transportation
- Hospital Emergency Care and Nursing Home Care when necessary

#12

Estimated State Expense - 2-year Site Expansion

Year 1: 1-Site

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 1 PPTs
James - # of PPTs	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*12*
M/Caid-Jmst	$4,500	$9,000	$13,500	$18,000	$22,500	$27,000	$31,500	$36,000	$40,500	$45,000	$49,500	$54,000	**$351,000**
Medicare	$2,000	$4,000	$6,000	$8,000	$10,000	$12,000	$14,000	$16,000	$18,000	$20,000	$22,000	$24,000	**$156,000**
Total Expense	**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**	**$71,500**	**$78,000**	**$507,000**

Year 2: 2-Sites

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 2 PPTs
James - # of PPTs	*13*	*14*	*15*	*15*	*16*	*16*	*17*	*17*	*17*	*18*	*18*	*18*	*18*
Fargo - # of PPTs	*2*	*4*	*6*	*8*	*10*	*12*	*14*	*16*	*18*	*20*	*22*	*24*	*24*
M/Caid-Jmst	$58,500	$63,000	$67,500	$67,500	$72,000	$72,000	$76,500	$76,500	$76,500	$81,000	$81,000	$81,000	**$873,000**
M/Caid-Fargo	$9,550	$19,100	$28,650	$38,200	$47,750	$57,300	$66,850	$76,400	$85,950	$95,500	$105,050	$114,600	**$744,900**
Medicare	$30,000	$36,000	$42,000	$46,000	$52,000	$56,000	$62,000	$66,000	$70,000	$76,000	$80,000	$84,000	**$700,000**
Total Expense	**$98,050**	**$118,100**	**$138,150**	**$151,700**	**$171,750**	**$185,300**	**$205,350**	**$218,900**	**$232,450**	**$252,500**	**$266,050**	**$279,600**	**$2,317,900**

2-Year Totals

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL PPTs
# of PPTs	*15*	*18*	*21*	*23*	*26*	*28*	*31*	*33*	*35*	*38*	*40*	*42*	*42*
Medicaid	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Medicare	$32,000	$40,000	$48,000	$54,000	$62,000	$68,000	$76,000	$82,000	$88,000	$96,000	$102,000	$108,000	**$856,000**
Total Expense	**$104,550**	**$131,100**	**$157,650**	**$177,700**	**$204,250**	**$224,300**	**$250,850**	**$270,900**	**$290,950**	**$317,500**	**$337,550**	**$357,600**	**$2,824,900**

Estimate[illegible]vings: PACE vs. Nursing Home

2-Year Totals

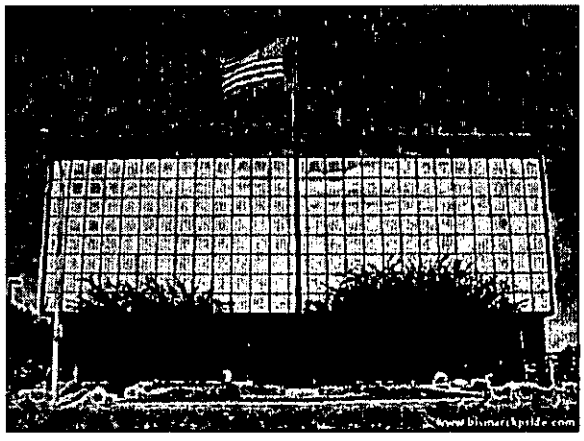
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL
SNF	$101,680	$127,100	$152,520	$171,585	$197,005	$216,070	$241,490	$260,555	$279,620	$305,040	$324,105	$343,170	**$2,719,940**
PACE	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Total Savings	**$29,130**	**$36,000**	**$42,870**	**$47,885**	**$54,755**	**$59,770**	**$66,640**	**$71,655**	**$76,670**	**$83,540**	**$88,555**	**$93,570**	**$751,040**

Current Average Savings:

**** 15 % of 56 PPTS are in SNF**

SNF Avg Cost =	$53,340	($6355 average per month)
PACE Avg Cost =	$35,860	($4269 average per month)
	$17,480	**Current avg. savings per month**

Comparison of lease rates for Gold Seal Building and Capitol Lanes Plaza
Prepared by Senator Warner for Human Services Subcommittee of Appropriations
16 February 2011

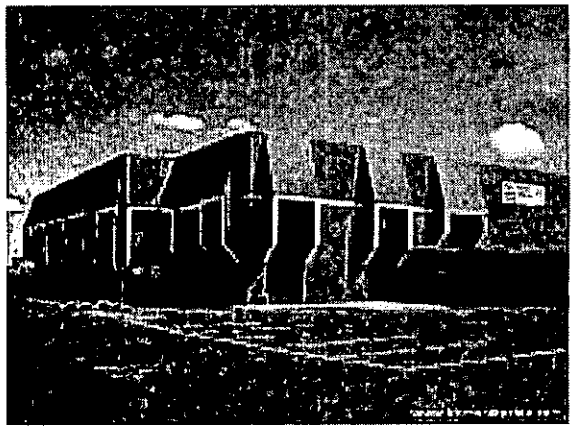


Gold Seal Building
918 East Divide
Tenant-Health
40,025 square feet
First leased 2007

2007-09 lease at $11.44
2009-11 lease at $11.90
2011-13 lease at $12.38

Est. annual payment=$495,510

Inflator in lease=4%/yr



Capitol Lanes Plaza
1237 West Divide
Tenant-Human Services
64,160 square feet
First leased in 2005

2007-09 lease at $11.26 +$1.74
2009-11 lease at $14.21
2011-13 lease at $15.39

Est. annual payment=$987,422

Inflator in lease=3%+ cost of operation at $1.74 inflated at actual increase not to exceed 10%/yr

Other issues-has had two overlapping 5 year property tax exemptions, the first expiring this year and the second in 2013 which the owner is building into the operating costs

A

Department of Human Services Ov for the 2011-2013 Biennium

as of December 9, 2010

Cabinet Priority	IBARS OAR #	Cabinet Category	Description	FTE	General	Federal	Other	Total
01	101	Optional 3% Savings Plan	Optional 3% Savings Plan		(26,964,940)	(34,055,516)	-	(61,020,456)
02	201	Psychiatric Inpatient Hospital	Psychiatric Inpatient Hospital Rates		3,431,017	-	-	3,431,017
03	301	Capacity - Behavior Health	SMI Crisis Stabilization Unit - NCHSC		1,444,661	-	-	1,444,661
03	302	Capacity - Behavior Health	CD Residential Facility - SEHSC		939,159	-	-	939,159
03	303	Capacity - Behavior Health	Residential Adult Crisis Beds - WCHSC		309,128	-	-	309,128
			Total Inflation Category		2,692,948	-	-	2,692,948
04	401	Enhancement of Services	Transfer Child Support System off mainframe		468,396	909,239	-	1,377,635
04	402	Enhancement of Services	5% Increase - In-home Child Care Providers		902,581		-	902,581
04	403	Enhancement of Services	Pilot for Medical Home Program		204,518	233,815	-	438,333
04	404	Enhancement of Services	Section 13 of 2009 HB 1012		250,000	250,000	-	500,000
04	405	Enhancement of Services	Adult Family Foster Care rate increase		1,134,072	1,172,224	9,103	2,315,399
04	406	Enhancement of Services	Medication Assistance - HCBS		280,568	-	14,010	294,578
04	407	Enhancement of Services	New ICF/MR Beds for DC Transitioning		2,712,968	3,382,849	-	6,095,817
04	408	Enhancement of Services	Guardianship Program Enhancements		65,275	-	-	65,275
04	409	Enhancement of Services	Long Term Care Ombudsman	1.00	135,665	-	-	135,665
04	410	Enhancement of Services	Family Preservation Services		938,301		-	938,301
04	411	Enhancement of Services	Post Adoption Services		129,188	66,582	-	195,770
04	412	Enhancement of Services	Sex Offender Community Treatment - MH/SA		498,028	-	-	498,028
04	413	Enhancement of Services	Enhancement of Transitional Youth - MH/SA		500,000	-	-	500,000
04	414	Enhancement of Services	Enhance contracted staffing - NEHSC		210,875	139,125	-	350,000
04	415	Enhancement of Services	Enhance Services at Cooper House - SEHSC		219,690	20,000	-	239,690
04	416	Enhancement of Services	SMI Work Activity - SCHSC		450,000	-	-	450,000
04	417	Enhancement of Services	New Office Facility - BLHSC		174,111	16,104	-	190,215
			Total Expansion/Enhancement Category	1.00	9,274,236	6,189,938	23,113	15,487,287
05	501	Capital Projects	State Hospital Capital Projects		1,961,840			1,961,840
05	502	Capital Projects	Developmental Center Capital Projects		650,000	-	-	650,000
			Total Capital Projects		2,611,840	-	-	2,611,840
06	601	Inflation	Program & Policy Other Inflation		797,127	102,544	44,846	944,517
06	602	Inflation	Medicaid Provider Inflation		7,004,116	9,673,066	-	16,677,182
06	603	Inflation	LTC Provider Inflation		14,553,888	16,999,624	36,152	31,589,664
06	604	Inflation	Child Welfare Provider Inflation		2,067,749	1,133,827	619,975	3,821,551
06	605	Inflation	HSC Inflation		1,093,928	133,534	13,814	1,241,276
			Total Inflation Category		25,516,808	28,042,595	714,787	54,274,190
07	701	Health Care Reform	Eligibility System Rewrite	1.00	18,370,221	24,247,421	283	42,617,925
07	702	Health Care Reform	Health Care Reform - Central Office	17.00	1,648,523	925,347	-	1,573,870
07	703	Health Care Reform	Health Care Reform Grant - IMD Demo	-	1,140,306	1,440,156	-	2,580,462
			Total Health Care Reform Category	18.00	20,159,050	26,612,924	283	46,772,257
08	801	Completion of One-Time ARRA Funding	ARRA Contracts through 9/30/11	-	-	519,175	-	519,175
			Report Totals	19.00	36,720,959	27,309,116	738,183	64,768,258

Fully funded in Governor's budget.

Partially funded in Governor's budget.

4,545?

SB 2012
2-18-11

Q

North Dakota Department of Human Services
$0.50 an hour QSP Increase
2011 - 2013 Biennium

	Total	General	Federal	County
QSP Individual & Agency				
$0.50 Salary Increase	$ 931,606	$ 510,295	$ 412,262	$ 9,049

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 3.02% July 1, 2011				Increase (Decrease) from a 3% / 3% to 3.02%			
Provider Groups	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	11,073,342	4,639,996	6,433,346	-	(5,603,840)	(2,364,120)	(3,239,720)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	11,186,754	4,906,871	6,279,883	-	(5,791,641)	(2,568,147)	(3,223,494)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	7,733,560	3,444,602	4,284,386	4,572	(3,191,028)	(1,421,666)	(1,767,834)	(1,528)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	2,433,068	1,458,321	954,837	19,910	(1,253,613)	(754,281)	(489,190)	(10,142)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	2,536,195	1,373,839	750,985	411,371	(1,285,356)	(693,910)	(382,842)	(208,604)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	627,779	529,843	68,150	29,786	(316,738)	(267,284)	(34,394)	(15,060)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	824,748	726,840	88,730	9,178	(416,528)	(367,088)	(44,804)	(4,636)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**36,415,446**	**17,080,312**	**18,860,317**	**474,817**	**(17,858,744)**	**(8,436,496)**	**(9,182,278)**	**(239,970)**

Note
A 3.02% inflationary increase given on July 1, 2011 is comparable to a 2%/2% inflationary increase.

SB 2012
2-18-11

North Dakota Department of Human Services

2011-2013 Executive Budget Recommendation

	Executive Budget											
	All Providers Inflation @ 3% / 3%				All Providers Inflation @3.02% July 1, 2011, Except for Nursing Homes @ 2.97%				Increase (Decrease)			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	11,073,342	4,639,996	6,433,346	-	(5,603,840)	(2,364,120)	(3,239,720)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	11,186,754	4,906,871	6,279,883	-	(5,791,641)	(2,568,147)	(3,223,494)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	7,597,312	3,383,833	4,208,907	4,572	(3,327,276)	(1,482,435)	(1,843,313)	(1,528)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	2,433,068	1,458,321	954,837	19,910	(1,253,613)	(754,281)	(489,190)	(10,142)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	2,536,195	1,373,839	750,985	411,371	(1,285,356)	(693,910)	(382,842)	(208,604)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	627,779	529,843	68,150	29,786	(316,738)	(267,284)	(34,394)	(15,060)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	824,748	726,840	88,730	9,178	(416,528)	(367,088)	(44,804)	(4,636)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**36,279,198**	**17,019,543**	**18,784,838**	**474,817**	**(17,994,992)**	**(8,497,265)**	**(9,257,757)**	**(239,970)**

SB 2012
2-18-11
5

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation

	Executive Budget											
	Provider Inflation 3% / 3%				All Providers Inflation @4.545% July 1, 2011, Except for Nursing Homes @ 4.36%				Increase (Decrease)			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	16,671,960	6,987,068	9,684,892	-	(5,222)	(17,048)	11,826	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	16,951,559	7,439,569	9,511,990	-	(26,836)	(35,449)	8,613	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	10,910,375	4,859,423	6,044,347	6,605	(14,213)	(6,845)	(7,873)	505
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	3,662,382	2,194,964	1,437,465	29,953	(24,299)	(17,638)	(6,562)	(99)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	3,816,484	2,067,282	1,130,145	619,057	(5,067)	(467)	(3,682)	(918)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	944,515	797,124	102,545	44,846	(2)	(3)	1	-
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,239,858	1,092,670	133,387	13,801	(1,418)	(1,258)	(147)	(13)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**54,197,133**	**25,438,100**	**28,044,771**	**714,262**	**(77,057)**	**(78,708)**	**2,176**	**(525)**

SB 2012
2-18-11

T:\Bdgt 2011-13\Inflation\Comparison of 3_3 to 4.545, 3.02, and nursing homes at different rate.xlsxComparison of 3_3 to 4.545%

SB 2012
2-18-11
4

ND Department of Human Services
Medical Services
Cost To Increase Healthy Steps Eligibility From 160% (Net) To 175% (Net) Of Federal Poverty Level
2011-2013 Biennium
Premium Cost of $274.03

	# of Children	Total	General	Federal
Premium Cost From 160% (Net) to 175% (Net) of FPL :	445	1,834,357	567,367	1,266,990

Considerations:

Any increase in the income threshold for CHIP will have an impact on the Caring Program for Children. The income threshold for the Caring Program is currently at 200% (net).

The number of potential eligibles for the 175% (net) scenario above, is based on the number of families who applied for coverage from October 1, 2009 through September 30, 2010, and would have been eligible at 175% (net). It is possible that this number is understated, as it based on the number of families who previously applied for coverage. Families with incomes up to 175% (net) may not have applied for coverage.

As of April 1, 2009, 160% FPL is $35,280 (annually) for a family of four: and 175% FPL is $38,588 (annually) for a family of four. The poverty levels were not adjusted in 2010; therefore, the April 2009 levels are still in force.

ND Department of Human Services Kilzer Report

Comparison of Current 2009 - 2011 Budget to the 2011 - 2013 Engrossed Bill

Subdivision	Fund	Current Budget 2009 - 2011	Engrossed Bill SB 2012 2011 - 2013	Total Changes	Percentage of Change
100-15 ADMINISTRATION - SUPPORT	1 General	$6,727,982	$7,775,396	$1,047,414	15.57%
100-15 ADMINISTRATION - SUPPORT	2 Federal	$6,468,144	$7,090,067	$621,923	9.62%
100-15 ADMINISTRATION - SUPPORT	3 Special	$1,063,678	$1,169,952	$106,274	9.99%
100-15 ADMINISTRATION - SUPPORT Total		**$14,259,804**	**$16,035,415**	**$1,775,611**	**12.45%**
100-20 INFORMATION TECHNOLOGY SRVCS	1 General	$20,703,546	$23,746,066	$3,042,520	14.70%
100-20 INFORMATION TECHNOLOGY SRVCS	2 Federal	$52,180,431	$37,243,950	($14,936,481)	(28.62%)
100-20 INFORMATION TECHNOLOGY SRVCS	3 Special	$4,349,870	$2,034,443	($2,315,427)	(53.23%)
100-20 INFORMATION TECHNOLOGY SRVCS Total		**$77,233,847**	**$63,024,459**	**($14,209,388)**	**(18.40%)**
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	1 General	$10,676,487	$11,439,272	$762,785	7.14%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	2 Federal	$322,674,475	$318,286,921	($4,387,554)	(1.36%)
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	3 Special	$18,038,981	$18,745,883	$706,902	3.92%
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS Total		**$351,389,943**	**$348,472,076**	**($2,917,867)**	**(.83%)**
300-02 CHILD SUPPORT ENFORCEMENT	1 General	$3,585,371	$6,874,824	$3,289,453	91.75%
300-02 CHILD SUPPORT ENFORCEMENT	2 Federal	$17,591,107	$15,175,197	($2,415,910)	(13.73%)
300-02 CHILD SUPPORT ENFORCEMENT	3 Special	$2,788,509	$2,990,900	$202,391	7.26%
300-02 CHILD SUPPORT ENFORCEMENT Total		**$23,964,987**	**$25,040,921**	**$1,075,934**	**4.49%**
300-03 MEDICAL SERVICES	1 General	$148,519,693	$240,545,012	$92,025,319	61.96%
300-03 MEDICAL SERVICES	2 Federal	$365,011,673	$434,510,018	$69,498,345	19.04%
300-03 MEDICAL SERVICES	3 Special	$34,093,582	$34,871,219	$777,637	2.28%
300-03 MEDICAL SERVICES Total		**$547,624,948**	**$709,926,249**	**$162,301,301**	**29.64%**
300-10 LONG TERM CARE	1 General	$283,801,911	$427,330,132	$143,528,221	50.57%
300-10 LONG TERM CARE	2 Federal	$554,326,370	$530,781,396	($23,544,974)	(4.25%)
300-10 LONG TERM CARE	3 Special	$11,572,047	$3,275,060	($8,296,987)	(71.70%)
300-10 LONG TERM CARE Total		**$849,700,328**	**$961,386,588**	**$111,686,260**	**13.14%**
300-42 DD COUNCIL	2 Federal	$1,015,718	$915,889	($99,829)	(9.83%)
300-42 DD COUNCIL Total		**$1,015,718**	**$915,889**	**($99,829)**	**(9.83%)**
300-43 AGING SERVICES	1 General	$3,784,842	$4,666,276	$881,434	23.29%
300-43 AGING SERVICES	2 Federal	$13,261,552	$13,174,591	($86,961)	(.66%)
300-43 AGING SERVICES	3 Special	$310,192	$280,000	($30,192)	(9.73%)
300-43 AGING SERVICES Total		**$17,356,586**	**$18,120,867**	**$764,281**	**4.40%**
300-46 CHILDREN AND FAMILY SERVICES	1 General	$25,060,229	$31,053,237	$5,993,008	23.91%
300-46 CHILDREN AND FAMILY SERVICES	2 Federal	$85,194,925	$82,978,058	($2,216,867)	(2.60%)
300-46 CHILDREN AND FAMILY SERVICES	3 Special	$19,071,085	$21,062,704	$1,991,619	10.44%
300-46 CHILDREN AND FAMILY SERVICES Total		**$129,326,239**	**$135,093,999**	**$5,767,760**	**4.46%**
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	1 General	$6,180,518	$7,128,641	$948,123	15.34%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	2 Federal	$6,743,842	$12,026,270	$5,282,428	78.33%
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	3 Special	$584,659	$570,860	($13,799)	(2.36%)
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE Total		**$13,509,019**	**$19,725,771**	**$6,216,752**	**46.02%**
300-51 VOC REHAB	1 General	$4,844,905	$4,859,126	$14,221	.29%
300-51 VOC REHAB	2 Federal	$22,770,553	$22,326,268	($444,285)	(1.95%)
300-51 VOC REHAB	3 Special	$91,462	$94,999	$3,537	3.87%
300-51 VOC REHAB Total		**$27,706,920**	**$27,280,393**	**($426,527)**	**(1.54%)**
300-52 DEVELOPMENTAL DISABILITIES DIVISION	1 General	$2,947,015	$3,151,429	$204,414	6.94%
300-52 DEVELOPMENTAL DISABILITIES DIVISION	2 Federal	$5,969,513	$5,874,450	($95,063)	(1.59%)
300-52 DEVELOPMENTAL DISABILITIES DIVISION	3 Special	$9,915	$150,003	$140,088	1412.89%
300-52 DEVELOPMENTAL DISABILITIES DIVISION Total		**$8,926,443**	**$9,175,882**	**$249,439**	**2.79%**

ND Department of Human Services
Comparison of Current 2009 - 2011 Budget to the 2011 - 2013 Engrossed Bill

Subdivision	Fund	Current Budget 2009 - 2011	Engrossed Bill SB 2012 2011 - 2013	Total Changes	Percentage of Change
410-71 NORTHWEST HSC	1 General	$4,724,962	$4,958,832	$233,870	4.95%
410-71 NORTHWEST HSC	2 Federal	$3,436,804	$3,321,230	($115,574)	(3.36%)
410-71 NORTHWEST HSC	3 Special	$348,888	$469,006	$120,118	34.43%
410-71 NORTHWEST HSC Total		**$8,510,654**	**$8,749,068**	**$238,414**	**2.80%**
410-72 NORTH CENTRAL HSC	1 General	$10,459,768	$13,410,027	$2,950,259	28.21%
410-72 NORTH CENTRAL HSC	2 Federal	$8,073,938	$8,104,420	$30,482	.38%
410-72 NORTH CENTRAL HSC	3 Special	$848,895	$919,437	$70,542	8.31%
410-72 NORTH CENTRAL HSC Total		**$19,382,601**	**$22,433,884**	**$3,051,283**	**15.74%**
410-73 LAKE REGION HSC	1 General	$6,066,003	$6,882,190	$816,187	13.46%
410-73 LAKE REGION HSC	2 Federal	$4,450,221	$4,063,599	($386,622)	(8.69%)
410-73 LAKE REGION HSC	3 Special	$438,918	$472,442	$33,524	7.64%
410-73 LAKE REGION HSC Total		**$10,955,142**	**$11,418,231**	**$463,089**	**4.23%**
410-74 NORTHEAST HSC	1 General	$11,259,927	$13,209,723	$1,949,796	17.32%
410-74 NORTHEAST HSC	2 Federal	$13,557,216	$12,967,908	($589,308)	(4.35%)
410-74 NORTHEAST HSC	3 Special	$1,150,276	$2,004,978	$854,702	74.30%
410-74 NORTHEAST HSC Total		**$25,967,419**	**$28,182,609**	**$2,215,190**	**8.53%**
410-75 SOUTHEAST HSC	1 General	$14,235,049	$22,185,733	$7,950,684	55.85%
410-75 SOUTHEAST HSC	2 Federal	$14,748,761	$15,145,044	$396,283	2.69%
410-75 SOUTHEAST HSC	3 Special	$1,355,842	$1,133,943	($221,899)	(16.37%)
410-75 SOUTHEAST HSC Total		**$30,339,652**	**$38,464,720**	**$8,125,068**	**26.78%**
410-76 SOUTH CENTRAL HSC	1 General	$8,464,433	$9,343,547	$879,114	10.39%
410-76 SOUTH CENTRAL HSC	2 Federal	$6,486,699	$6,691,551	$204,852	3.16%
410-76 SOUTH CENTRAL HSC	3 Special	$751,732	$918,601	$166,869	22.20%
410-76 SOUTH CENTRAL HSC Total		**$15,702,864**	**$16,953,699**	**$1,250,835**	**7.97%**
410-77 WEST CENTRAL HSC	1 General	$11,918,377	$14,109,532	$2,191,155	18.38%
410-77 WEST CENTRAL HSC	2 Federal	$11,756,689	$11,430,961	($325,728)	(2.77%)
410-77 WEST CENTRAL HSC	3 Special	$1,208,459	$1,200,000	($8,459)	(.70%)
410-77 WEST CENTRAL HSC Total		**$24,883,525**	**$26,740,493**	**$1,856,968**	**7.46%**
410-78 BADLANDS HSC	1 General	$5,511,630	$6,529,292	$1,017,662	18.46%
410-78 BADLANDS HSC	2 Federal	$4,648,886	$4,426,122	($222,764)	(4.79%)
410-78 BADLANDS HSC	3 Special	$814,766	$834,240	$19,474	2.39%
410-78 BADLANDS HSC Total		**$10,975,282**	**$11,789,654**	**$814,372**	**7.42%**
420-00 STATE HOSPITAL	1 General	$40,114,197	$42,223,722	$2,109,525	5.26%
420-00 STATE HOSPITAL	2 Federal	$4,803,599	$2,609,783	($2,193,816)	(45.67%)
420-00 STATE HOSPITAL	3 Special	$15,132,542	$17,536,620	$2,404,078	15.89%
420-00 STATE HOSPITAL Total		**$60,050,338**	**$62,370,125**	**$2,319,787**	**3.86%**
421-00 SH SECURED SERVICES	1 General	$10,429,000	$11,264,915	$835,915	8.02%
421-00 SH SECURED SERVICES	2 Federal	$17,824		($17,824)	(100.00%)
421-00 SH SECURED SERVICES	3 Special	$33,299		($33,299)	(100.00%)
421-00 SH SECURED SERVICES Total		**$10,480,123**	**$11,264,915**	**$784,792**	**7.49%**
430-00 DEVELOPMENTAL CENTER	1 General	$14,595,729	$20,417,430	$5,821,701	39.89%
430-00 DEVELOPMENTAL CENTER	2 Federal	$35,363,271	$27,823,460	($7,539,811)	(21.32%)
430-00 DEVELOPMENTAL CENTER	3 Special	$4,143,340	$3,568,357	($574,983)	(13.88%)
430-00 DEVELOPMENTAL CENTER Total		**$54,102,340**	**$51,809,247**	**($2,293,093)**	**(4.24%)**
999-99 DEPARMENT OF HUMAN SERVICES TOTALS	1 General	$654,611,574	$933,104,354	$278,492,780	42.54%
999-99 DEPARMENT OF HUMAN SERVICES TOTALS	2 Federal	$1,560,552,211	$1,576,967,153	$16,414,942	1.05%
999-99 DEPARMENT OF HUMAN SERVICES TOTALS	3 Special	$118,200,937	$114,303,647	($3,897,290)	(3.30%)
999-99 DEPARMENT OF HUMAN SERVICES TOTALS Total		**$2,333,364,722**	**$2,624,375,154**	**$291,010,432**	**12.47%**

SB 2012 2-21-11

Developments That Have Shaped the Delivery of Human Services in N.D. Since the 1960s

Prepared Jan. 2011 at the request of Sen. Tony Grindberg

1950s – 1960s

American society tended to place people with disabilities into institutions.

- **1953** – ND **State Hospital's (NDSH) patient census** peaked at **2,136** patients
- **1960s** – A total of **1,324** people resided at the **Developmental Center** and **San Haven** institutions (peak)

The Kennedy administration made **federal funds** available to states to **establish community Mental Health and Retardation Centers**

1960s – Implementation of federal ***Great Society*** **and** ***War on Poverty*** initiatives

- Food Stamps, Welfare, Medicaid, Medicare
- **1965 – Head Start** established to address the needs of underprivileged children in a comprehensive way

1970s

ND worked to comply with **amendments to the Social Security Act** passed in the 1960s requiring states to **establish social service systems by 1975** to ensure:

- Full array of statewide services
- Outreach to people in-need of services (to prevent child abuse and neglect)
- Trained social workers

- **1974 – Federal Child Abuse Protection and Treatment Act** led to state laws:
  - Created child protective services program and mandatory reporting

ND Lawmakers studied **consolidation of Area Social Services Centers and regional Mental Health and Retardation Service Units**

- **1973** – First **Regional Human Service Centers (HSC)** established in Dickinson and Williston adding mental health and developmental disabilities services to the social service centers' duties

1980s

- **1981 – ND Department of Human Services was created** by the Legislature consolidating programs formerly operated under multiple agencies
  - Mental Health and Retardation Division (including the State Hospital) and the Division of Alcoholism and Drug Abuse from the Department of Health,
  - Social Service Board of North Dakota, and
  - State Council on Developmental Disabilities.

- **1982** – U.S. District Court ruling in the case of the ***Association of Retarded Citizens of North Dakota, et al., vs. State of ND***, resulted in substantial, court-ordered changes to ND's service system for people with developmental disabilities
  - Provided momentum for deinstitutionalization
    - **1987** – The state's **San Haven** facility closed
  - DHS worked with public and private providers to **continue the development of a system of community-based residential services**

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- In response to growing divorce rates, federal requirements related to state **child support enforcement** services grew

1990s

- 1989 -1991 – **Patient movement in public mental health system**
  - Average daily census decreased to 270 at NDSH (down from 440 in 1980s)
  - NDSH merged 17 wards to 10 wards

- Regional Human Service Centers started **pre-screening** all **State Hospital** and **Developmental Center admissions** for appropriateness

- **1996** – Congress passed **welfare reform** (*Personal Responsibility and Work Opportunity Reconciliation Act or PRWORA*) creating the Temporary Assistance for Needy Families **(TANF)** program
  - Added **job readiness, and work participation requirements** to the cash assistance program for low-income families
  - New philosophy: promote self sufficiency while maintaining safety-net for low-income children
  - 60-month life-time limit on benefits
  - At its **peak (April 1993)**, the AFDC Program served **6,625** ND families *(Source: AFDC FR007 Report by R & S, 5/6/93)*
  - July **1997** – ND launched welfare reform; an average of **3,859** families per month received TANF *(Source: 1995-1997 Biennial Report)*
  - December 2010 – **1,988** families received TANF
  - **Also** required **states to create a centralized State Disbursement Unit (SDU)** to process child support payments (**1999 – ND completed SDU** conversion)
- **1997 – Children's Health Insurance Program** created by Congress to meet the needs of low-income children who did not qualify for Medicaid
  - **1999 – Children's Health Insurance Program** established in ND [**140%** Net Federal Poverty Level (FPL)]

- **1997** – federal **Adoption and Safe Families Act** shifted the emphasis in child welfare services toward child permanency, well-being, and safety and away from a policy of reuniting children with parents without regard to prior abusiveness
  - Created **federal performance goals** and **Child and Family Services Reviews (CFSR)** - on-site case file reviews and stakeholder interviews
    - 2001 – ND's **first CFSR;** no states passed. ND met 9 of 14 outcomes - more than any other state
    - 2007 – Subsequent review; no states passed

- **1990s – Newer antipsychotic medications** allow more seriously mentally ill people to be treated outside of institutions

- **1998** – Three State Hospital buildings were renovated to house inmates of the **James River Correctional Center**, which was **co-located on** the **grounds**

- **1997-1999 – Sex offender evaluation and treatment services developed** at the State Hospital; Secure Unit for sex offenders opened

- **1998-2000 – 3 offenders civilly committed** to the State Hospital

2000s

On June 22, 1999, the United States Supreme Court issued a decision in ***Olmstead vs. L.C.*** that continues to shape Human Services

- Fueled continued **growth in home and community-based services for people with disabilities – including the elderly**
  - **Development of community capacity**
  - **Contacts with local hospitals for inpatient care**
  - Implemented **core wrap-around services for children's mental health statewide** (1999-2001 biennium)

ND State Hospital:

- Provided specialized inpatient psychiatric and substance addition treatment
- Became **safety net inpatient facility** for the Devils Lake, Dickinson, Jamestown, and the Williston regions
- Worked with HSCs to achieve **shorter average lengths of stay**
- Established a **Geropsych program** contract *(1999-2001)*
- Adopted **shared management**
  - Combined **State Hospital** and **Developmental Center** administrative support areas under one superintendent
  - Combined director positions at the **regional human service centers** *(4 regional directors, instead of 8)*

ND Developmental Center

- **Vacant buildings** used by other entities
- **2005 Transition Task Force** established
  - **Jan. 2011 – Has discharged or has discharge plans for 54 people**
- **2009 – Expanded** the Center's **CARES team** to consult **statewide** with community providers to keep people in communities/prevent readmissions

- **Interest in addressing needs of an aging population emerged**
  - 2003 – Established **Family Caregiver Support program**
  - 2004 – **Alzheimer's Disease demonstration grant**
  - 2007 – **Money Follows the Person demonstration grant**
  - 2009 – Aging and Disability Resource Center (**ADRC**) pilot project grant

- **Nov. 2003 – Abduction and murder of UND student Dru Sjodin**
  - 2003 Secure Unit Census = 15 offenders
  - 2005 Secure Unit Census = 30 2006 – DHS signed a contract with **RULE-CPC** for community-based treatment of sex offenders under the supervision of DOCR
  - 2007 Secure Unit Census = 54 offenders
  - 2011 (January) = 59 offenders
  - 16 sex offenders have been **discharged** by court order since program began

- **Technology Advancements**
  - Implemented **online child support enforcement services**

- Changed from paper checks to **debit cards** to distribute TANF and child support (2003-2005 biennium)
  - Implemented direct deposit and payroll withholding for child support
  - ND's Supplemental Nutrition Assistance Program implemented Electronic Benefit Transfer (EBT) cards earlier - in 1997

- **Program/Service alignment** – In **July 2007**, funding and the administration of the **8 Regional Child Support Enforcement Units transferred** from the counties **to DHS**

- **Implementation of State legislation addressing health coverage needs**
  - 2004 – ND **Medicaid Workers with Disabilities Program** established
    - Buy-in program to support work by addressing coverage gap
  - 2008 – **Children with Disabilities coverage** (buy-in program to address gaps/limits in private coverage, income up to 200% FPL)
  - 2008 – Feds approved ND's **Medicaid waiver** to provide services at home for up to 15 **medically fragile children** who meet institutional level of care
  - 2008 – started 12-month **continuous eligibility** for children on Medicaid
  - 2008 – **CHIP eligibility level increased to 150%** FPL (net)
  - 2009 – **CHIP eligibility** level increased **to 160%** FPL (net) income

2010s

Efforts to address child health coverage gaps continued

- July 2010 – **Children's hospice waiver** approved by CMS
- Nov. 2010 – Feds approve ND's **Children's Autism Waiver**

ND State Hospital

- **Jan. 2011 – 132 individuals** were **receiving traditional** mental health and substance abuse inpatient treatment **services** at the NDSH
  - **90** at the **Tompkins** program; **59 sex offenders** in the **Secure Unit**

Developmental Center

- **Jan. 2011** – Provided services to **105** individuals
- **July 2011** – Resident population **goal = 95 residents**
- Opportunities for residents to be active in the Grafton area abound and include involvement in local churches; City Council meetings; and community events and activities

FUTURE

- **National economy and debt** – shaping federal policy and fiscal realities
- Ongoing tension related to **federal mandates, states' rights and flexibility in program implementation** and administration (i.e. TANF flexibility)
- Federal **Health Care Reform**
  - Impact on number of Medicaid clients (estimated up to 50% increase)
  - Health insurance exchange relationship to Medicaid/ CHIP eligibility system
- 2011 – **TANF & Beyond** initiative to promote self-sufficiency and end dependence
- **Demographic changes**
  - Aging Baby Boomers and service utilization & cultural diversity
- **Scientific advances**/evidence-based practices in services for people with disabilities
- **New technology** to improve client access to services (telemedicine, on-line applications, screening tools, monitoring, and training and technical assistance)

loved one to a care facility. We can anticipate with a growing population of adults age 60 and over within Region VI that program needs will continue to grow and be impacted by the availability of staffing resources and programmatic funds in the future.

- There was a decreasing rate of staff turnover which was 3.64% in CY 2009. SCHSC also saw the positive results of its efforts to "grow our own professionals" in the filling of all open licensed addiction counselor positions.
- A workforce analysis of staff at SCHSC was completed which indicated a labor force of skilled experienced individuals with a high number of years of service in their current positions. A significant percentage of individuals will reach the "rule of 85" within next few years and will be eligible for state retirement. For succession planning purposes, we have made administrative and supervisory training available to interested staff to minimize the impact of retirements and to prepare individuals to compete and perform in the near future in leadership roles.
- An essential new element in the south central region's recovery oriented mental health system has been the introduction and development of the peer support program. As a means to model recovery and resiliency in overcoming everyday obstacles common to those who live with serious mental illness (SMI), 3 trained peer support specialists (individuals who have experienced SMI) coordinate weekly peer support groups with 70-80 consumers actively participating in recovery-based activities.
- SCHSC participates in the Network for the Improvement of Addiction Treatment (NIATx) project, which utilizes a rapid change process to look at program and process improvement. The Center

reviewed barriers consumers face in attending assessments and follow-up appointments. As a result, we have implemented strategies which have resulted in no show rate for intakes at 21% and the no show rates for follow up appointments between 12.6% and 15%, both of which are well below industry standards.

Program Trends

- Citizens age 65 and older comprised 25% of the total population in Region VI. The south central region has the oldest average age in the state. The current estimate for individuals 65 and older in McIntosh County is 37.2% which makes it one of the highest in the country.
- The baby boomers, the large group of individuals born between 1946 and 1964, will continue to create a sizable bulge in the region's future age distribution. Projections indicate that between 2010 and 2015, 35% of the region's residents will be age 60 and over.
- The changing age profile of Region VI has implications for both the caregiver program and adult abuse and neglect reporting and interventions. Requests for interventions remain strong due to several factors including declining health status of older adults, poverty which hits certain old age subgroups the hardest, and other vulnerabilities associated with advanced age. These factors, in conjunction with Department's goal to assist this population to remain independent as long as possible, impacts referrals and workloads of SCHSC staff.
- During CY 2010, Stutsman County within Region VI has seen 40 Somali families move to the Jamestown area, with 27 of those families receiving housing assistance. Additionally Stutsman County Housing received housing assistance requests from 1,400

Somali families and received completed applications from 400 of these requests. They continue to receive about ten new applications monthly from Somali families. This has resulted in the housing assistance wait list being frozen with 123 households on the wait list. This means about a minimum of a one year wait for housing assistance in Jamestown and a three to four year wait for housing assistance in the outlying areas surrounding Jamestown. This has a significant impact on meeting the housing needs of the vulnerable consumers served by the Center.

- In the child welfare area, the region continues to increase in the number of full assessments done in response to reports of child abuse, completing 243 in SFY 2009 and 262 in SFY 2010. Region VI is also placing increased emphasize on the placement of children with relatives as well as county social services serving children who at one time were served in the juvenile justice system as they are not delinquent but impacted by abuse and neglect.
- SCHSC continued to strengthen consumer care through multiple collaborative efforts with local inpatient and outpatient facilities on such issues as social detoxification, transportation, consumer medication distribution efforts, homelessness, licensed addiction counselor development and recruitment, outpatient sex offender evaluations, and substance abuse prevention efforts.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
SCHSC	15,702,864	16,953,699	1,250,835
General Funds	8,464,433	9,343,547	879,114
Federal Funds	6,486,699	6,691,551	204,852
Other Funds	751,732	918,601	166,869
Total	15,702,864	16,953,699	1,250,835
FTE	85.50	85.50	-

The major changes can be explained as follows:

The salaries and fringe benefits portion of the budget increased $1,059,336.

- $636,693 in total funds of which $516,333 is general fund needed to fund the Governor's salary package for state employees.
- $243,504 in total funds of which $190,308 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $90,063 to cover an underfunding of salaries from the 2009 – 2011 budget.
- A decrease of $58,043 to underfund the 2011 – 2013 pay plan.
- The remaining increase of $147,119 in the salaries and fringe benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 85.50 FTEs in this area of the budget.

The operating portion of the budget increased by $87,222 and can be attributed to the following two items.

- Travel – The increase is made up of an increase in utilization for services to outreach areas and for staff training.
- Operating fees and services - The increase is due to the provision of Aging Outreach services at the HSC and is all federal funds.

The grant portion of the budget increased by $104,277. The net increase is a combination of the 3% inflationary increase for the contracted providers for each year of the biennium and a decrease in the contract cost for residential services. The net increase is all general funds.

General fund also increased due to a substantial reduction in the federal medical assistance percentage (FMAP).

This concludes my formal testimony on the 2011–2013 budget requests for the SEHSC and SCHSC portions of the DHS budget.

I

Testimony
SB 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January XX, 2011

Chairman Holmberg and members of the Senate Appropriations Committee, I am Tim Sauter, Director of West Central Human Service Center(WCHSC) and Badlands Human Service Center (BHSC) for the Department of Human Services (DHS). I am submitting this testimony to provide you an overview of the budget for both of these centers.

West Central Human Service Center

West Central Human Service Center serves the residents of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties.

Caseload/Customer Base

- 5,348 individuals received service in Fiscal Year 2010 (4,059 adults and 1,289 children).
- 1,719 individuals received vocational rehabilitation services.
- A high percentage of adults who receive services (92%) and parents whose children receive services (86%) report satisfaction.
- 94% of Vocational Rehabilitation Service clients report satisfaction.
- 91% of the WCHSC Vocational Rehabilitation clients placed on jobs remain employed after 5 months.

Program Trends

- The number of individuals with developmental disabilities receiving services has stabilized over the past two years, serving 1,131 in SFY 2010.
- Alcohol remains the biggest drug problem, there continues to be decrease in methamphetamine numbers, but an increasing number of adult clients who abuse prescription drugs, and adolescents abusing marijuana.
- Continues to be a significant number of referrals from the Department of Corrections and Rehabilitation (DOCR); a point in time review, reveals a decline in the percent of WCHSC adult addiction clients, from 72% in 2008 to 51% in 2010, who were referred for the DOCR.
- The WCHSC Region is seeing an increase in the number of foster home placements.
- The WCHSC Aging Services Unit was selected in October 2009 as the 3 year pilot region for the federally funded Aging and Disability Resource Center project.
- WCHSC is a member of the Standing Rock Sioux Tribe Psychology Internship Training Program.
- We continue to have a minimal number of residents from Region VII enter the North Dakota State Hospital or the Developmental Center.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
WCHSC	$24,883,525	$26,740,493	$1,856,968
General Funds	$11,918,377	$14,109,532	$2,191,155
Federal Funds	$11,756,689	$11,430,961	($325,728)
Other Funds	$1,208,459	$1,200,000	($8,459)
Total	$24,883,525	$26,740,493	$1,856,968

FTE	135.30	135.30	0.00

Budget Changes from Current Budget to Executive Budget:

The Budget increased by $1,856,968 which can be primarily attributed to the following:

- $979,454 for the Governor's salary package of which $737,567 are general funds.
- $348,402 in total funds of which $249,992 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $94,610 to cover an underfunding of salaries from the 2009-2011 budget.
- A decrease of ($81,909) to underfund the 2011-2013 Payplan.
- A decrease of ($25,095) for a part-time Support Services student trainee.
- $26,262 to provide for the annual and sick leave lump sum payouts for five FTE expected to retire.
- The remaining decrease in salaries and benefits, totaling ($121,586), is a combination of increases and decreases needed to sustain the salary of the 135.50 FTE's.

- Decrease of ($29,834) for travel based on motor pool rental rates and our projected utilization.
- Increase in postage of $9,070 based on utilization and rate increases.
- Decrease of ($8,605) in IT Equipment under $5,000. Any purchases made for the VR Technology Lab will be made by the DHS Central Office VR Division.
- Increase of $7,579 for Office Equipment and Furniture under $5,000. Funding would be used to replace aging office furniture with more functional modular furniture and desk chairs.
- Increase of $84,237, for office building rent, as a result of an increase in the projected rental rate.
- Increase in IT-Communications of $7,565 based on utilization and rate changes.
- Reduction of Professional Development by ($19,461) based on Department guidelines.
- Increase in Operating Fees and Services of $67,538 as a result of additional federal funding for Aging Outreach Services.
- Increase of $8,500 for client medication purchases based on utilization and cost.
- Decrease of ($16,500) for Equipment over $5,000. No major equipment purchases are planned.
- Increase in Grants of $539,588 which includes $309,128 to increase the bed capacity, from 10 beds to 14 beds, for our contracted Adult Crisis Residential facility and $231,378 for provider inflationary increases. The remaining decrease in grants, totaling ($918), is a combination of increases and decreases needed to sustain our existing contracts.

- The remaining decrease of ($12,847) is a combination of expenditure increases and decreases needed to sustain the budget for West Central Human Service Center.

The general fund request increased by $2,191,155 and can be primarily attributed to the following:

- An increase of $737,567 for the Governor's salary package.
- An increase of $249,992 to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $537,481 to fund the capacity expansion of the Adult Crisis Residential facility and provider inflationary increases.
- The remaining increase of $666,115 is related to ongoing cost to continue operations and the reduction in the Federal Medical Assistance Percentage (FMAP).

The net change in federal and other funds is primarily the result of a decrease in projected Medical Assistance collections and other changes mentioned previously.

Badlands Human Service Center

Badlands Human Service Center (BHSC) serves the people of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties.

Caseload/Customer Base

- Badlands served 1,860 individuals (1,322 adults and 538 children) in SFY 2010.
- 308 individuals received vocational rehabilitation services.

- 89% of adults receiving services, and 94% of the parents whose children receive services, report satisfaction with those services.
- 91% of clients receiving vocational rehabilitation services report satisfaction.
- 93% of BLHSC clients remain employed 6 months after being placed in a job.

Service Trends

- The number of individuals receiving developmental disabilities services has remained stable since SFY 2006.
- The number of referrals from the Department of Corrections and Rehabilitation comprises 48% of the individuals in adult addiction programs in this region.
- Due to oil impact on housing in Dickinson, finding and maintaining housing has become a bigger issue for the people we serve.
- Following the closure of the inpatient mental health unit at St. Joseph's Hospital there was an increase in admission to the North Dakota State Hospital, and the numbers have remained consistent.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
BLHSC	$10,975,282	$11,789,654	$814,372
General Funds	$5,511,630	$6,529,292	$1,017,662
Federal Funds	$4,648,886	$4,426,122	($222,764)
Other Funds	$814,766	$834,240	$19,474
Total	$10,975,282	$11,789,654	$814,372
FTE	72.70	72.70	0.00

Budget Changes from Current Budget to Executive Budget:

The Budget increased by $814,372 which can be primarily attributed to the following:

- $503,605 in total funds of which $416,095 is general fund needed to fund the Governor's salary package for state employees.
- $185,410 in total funds of which $141,559 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $491,554 increase in salaries needed to convert a support services position to medical services. This position will be filled by a full-time Psychiatrist.
- A decrease of ($38,080) to underfund the 2011-2013 Payplan.
- $31,853 to provide for the annual and sick leave lump sum payouts for six FTE expected to retire.
- An increase of $28,097 to cover an underfunding of salaries from the 2009-2011 budget.
- The remaining decrease in salaries and benefits, totaling ($79,552), is a combination of increases and decreases needed to sustain the salary of the 72.70 FTE's.
- $132,798 increase in building rent based primarily on a rent increase from $12 to $15 per square foot.
- $41,960 increase in IT-Data Processing needed for the wiring costs associated with the new Human Service Center facility.
- Professional Development was increased by $5,091 based on Department guidelines.

- $79,051 increase in Operating Fees and Services of which $53,675 is tied to additional federal funds for Aging Outreach Services and $30,000 for moving costs associated with relocating the Human Service Center. The remaining decrease of ($4,624) is related to miscellaneous operating fees.
- The net decrease in grants of ($563,222) relates primarily to the shifting of the psychiatric services budget to salaries and $10,808 for provider inflationary increases.
- The remaining decrease of ($4,193) is a combination of expenditure increases and decreases needed to sustain the budget for Badlands Human Service Center.

The general fund request increased by $1,017,662 which can be primarily attributed to the following:

- $416,095 to fund the Governor's salary package.
- $141,559 to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $174,111 for increased building rent and one-time costs associated with relocating the Human Service Center office facility.
- The remaining increase of $285,897 is related to ongoing costs to continue operations and the reduction in Federal Medical Assistance Percentage (FMAP).

The net change in federal and other funds is a result of the decrease in projected Medical Assistance collections, other changes mentioned previously.

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SB 2012

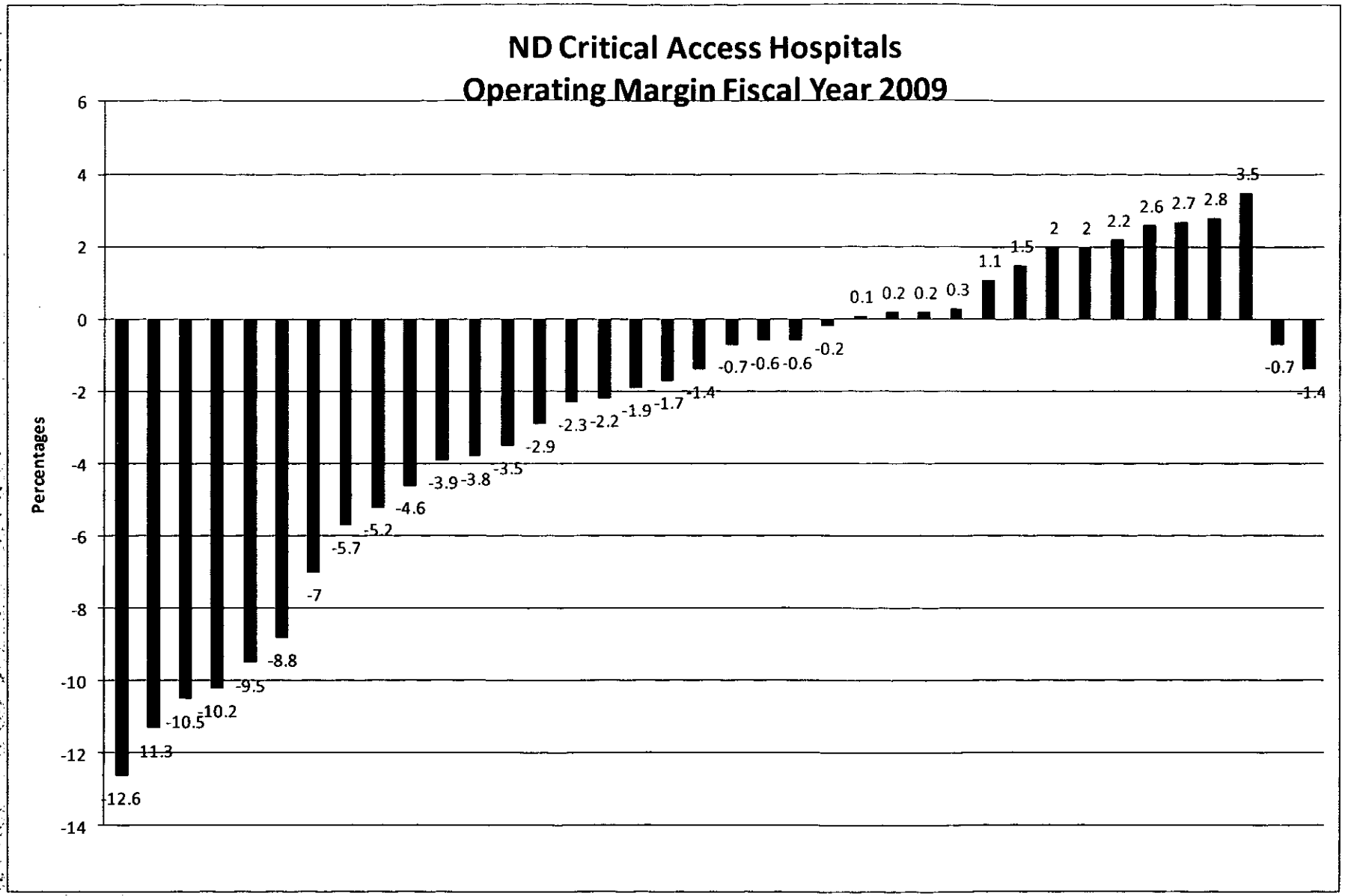
Numbers below represent entire biennium (two year)

- Rebasing "Rural Health Clinics" to Cost — $844,300
  - Department of Human Services performed study

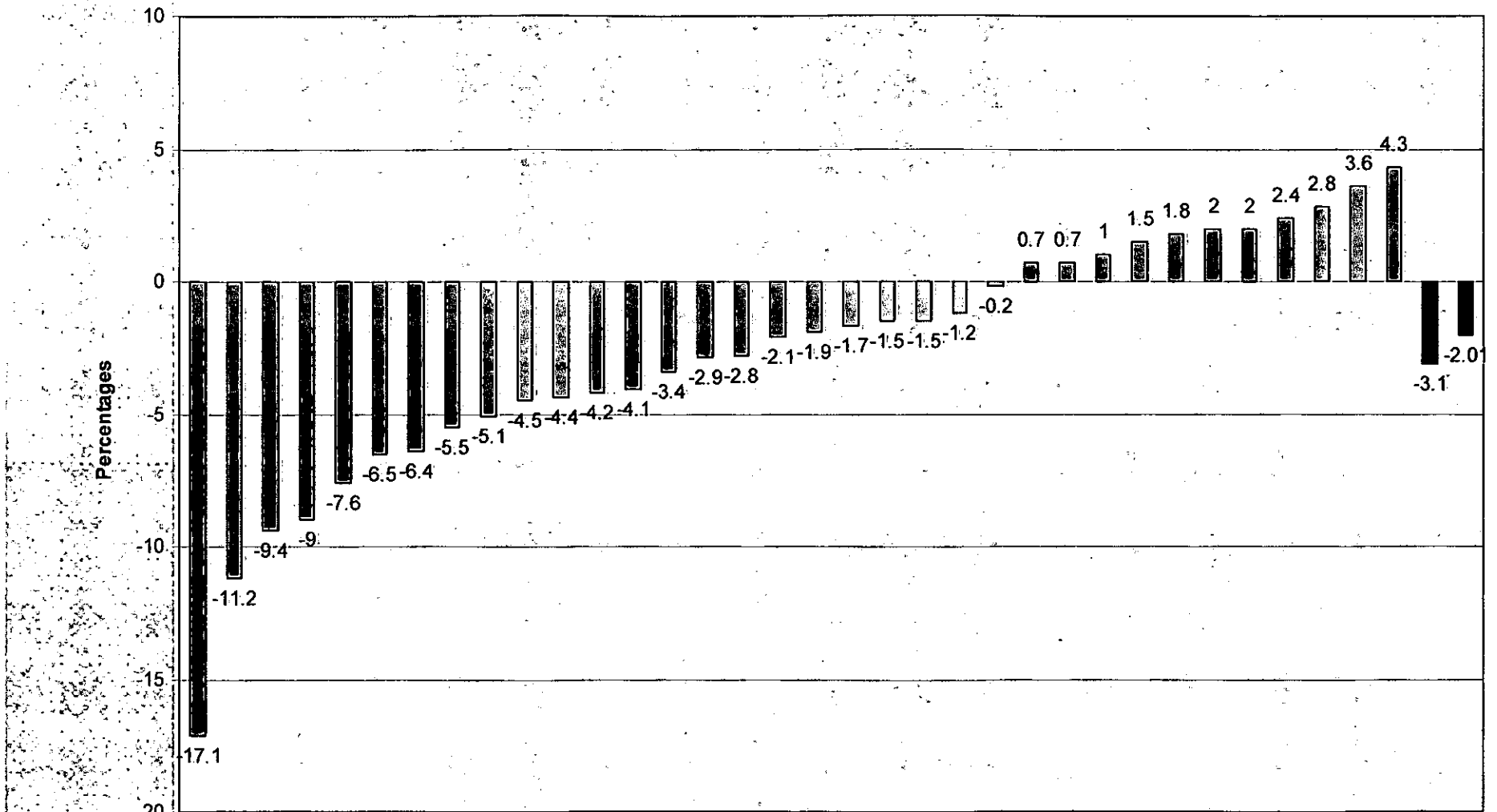
- Rebasing PPS and CAHs to Actual Cost — $29,800,000
  - PPS = 22.4
  - CAH = 7.4
  - Based on an estimate received from hospitals

- Supplemental Payment for CAHs — $400,000
  - 25% of Medicaid payments > Total Revenue
  - Cost Reimbursement for Lab/Anesth.
  - Presentation Medical Center – **Rolla**
  - Contain in HB 1012 last biennium (amendment)

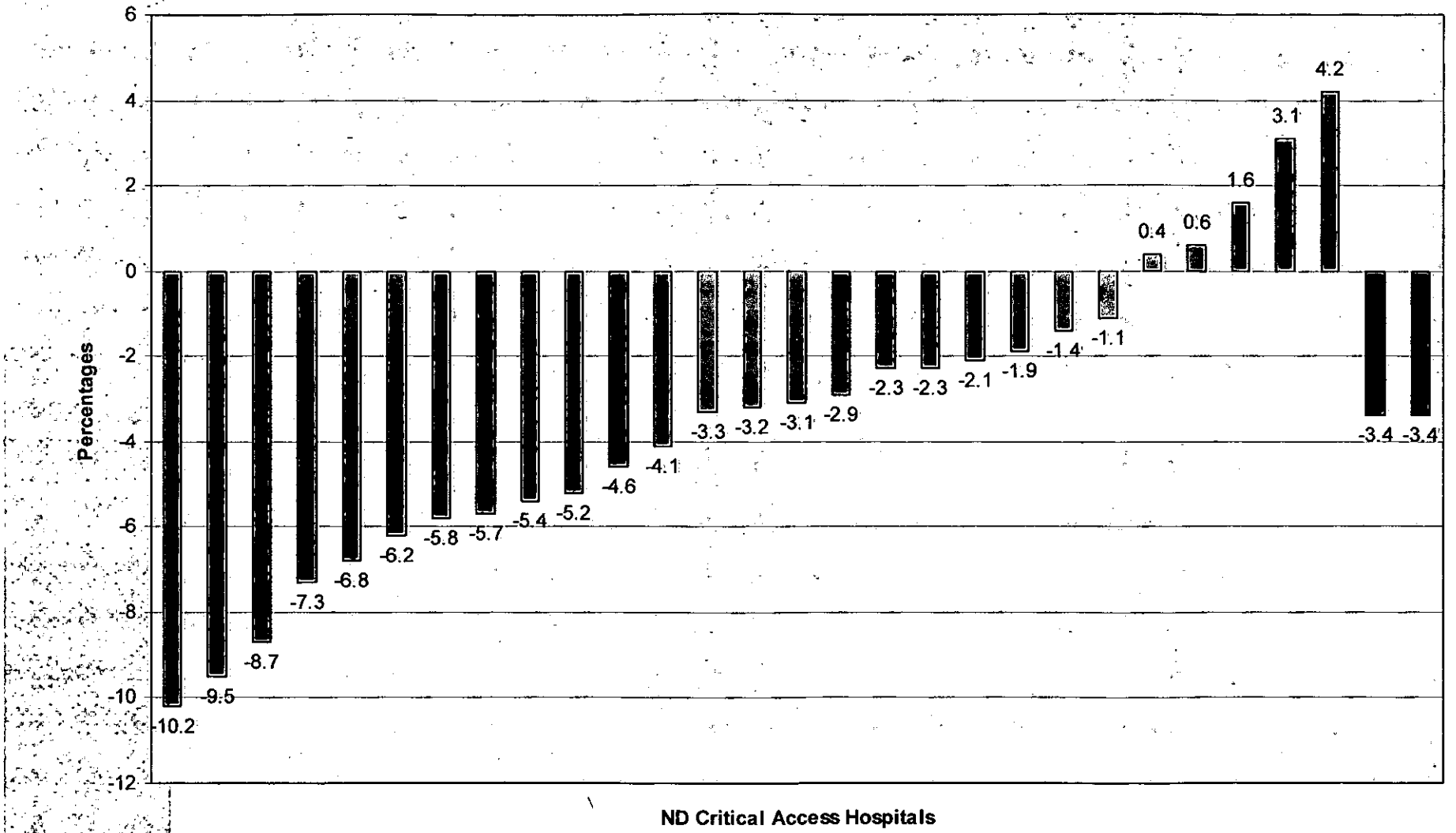
- Reimbursing Lab and Anesthesia at actual cost for CAHs — $2,200,000


ND Critical Access Hospitals
Operating Margin Fiscal Year 2009
Percentages
6
4
2
0
-2
-4
-6
-8
-10
-12
-14
-12.6
-11.3
-10.5
-10.2
-9.5
-8.8
-7
-5.7
-5.2
-4.6
-3.9
-3.8
-3.5
-2.9
-2.3
-2.2
-1.9
-1.7
-1.4
-0.7
-0.6
-0.6
-0.2
0.1
0.2
0.2
0.3
1.1
1.5
2
2
2.2
2.6
2.7
2.8
3.5
-0.7
-1.4

ND Critical Access Hospitals
Operating Margin Fiscal Year 2008



Operating Margin Fiscal Year 2007



NDHA
MEMBER HOSPITALS BY REGION

Critical Access Hospitals

Northwest (11)

Bottineau	St. Andrew's Health Center	Jodi Atkinson
Crosby	St. Luke's Hospital	Les Urvand
Harvey	St. Aloisius Medical Center	Rocky Zastoupil
Kenmare	Trinity Kenmare Comm. Hosp.	Shawn Smothers
Minot	Trinity Health	John Kutch
Rolla	Presentation Med Center	Mike Pfeifer
Rugby	Heart of America Med. Center	Jeff Lingerfelt
Stanley	Mountrail Co. Med. Center	Mitch Leupp
Tioga	Tioga Medical Center	Randy Pederson
Watford City	McKenzie Co. Healthcare Sys	Daniel Kelly
Williston	Mercy Medical Center	Matthew Grimshaw

Northeast (11)

Cando	Towner Cnty Med. Center.	Jac McTaggart
Carrington	Carrington Health Center	MariAnn Doeling
Cavalier	Pembina Cnty Mem. Hospital	Everett Butler
Cooperstown	Cooperstown Medial Center	Greg Stomp
Devils Lake	Mercy Hospital	James Marshall
Grafton	Unity Med. Center	Everett Butler
Grand Forks	Altru Health System	Dave Molmen
Mayville Sanford	Medical Center – Mayville	Roger Baier
Langdon	Cavalier County Memorial Hosp.	Lawrence Blue
Northwood	Northwood Deaconess Health	Pete Antonson
Park River	First Care Health Center	Louise Dryburgh

Southwest (12)

Ashley	Ashley Medical Center	Kathy Hoeft
Bismarck	Medcenter One Health System	Craig Lambrecht, MD
Bismarck	St. Alexius Medical Center	Andrew Wilson
Bowman	Southwest HC Services	Dennis Goebel
Dickinson	St. Joseph's Hospital	Reed Reyman
Elgin	Jacobson Memorial Hosp	Jim Opdahl
Hazen	Sakakawea Medical Center	Darrold Bertsch
Hettinger	West River Health Services	Jim Long
Garrison	Garrison Memorial Hospital	Dean Mattern
Linton	Linton Hospital	Roger Unger
Mandan	Triumph Hosp. Central Dakota	April Bishop
Wishek	Wishek Comm. Hospital	Trina Schilling

Southeast (11)

Fargo	Essentia Health	Kevin Pitzer
Fargo	Sanford Medical Center	Dennis Millirons
Fargo	Prairie St. Johns	Emmet Kenney, MD
Fargo	Triumph Healthcare-Fargo	Custer Huseby
Fargo	VA Hospital	Michael Murphy
Jamestown	Jamestown Hospital	Martin Richman
Lisbon	Lisbon Area Health Services	Peggy Larson
Jamestown	ND State Hospital	Alex Schweitzer
Hillsboro	Hillsboro Medical Center	John Rieke
Oakes	Oakes Community Hospital	Lee Boyles
Valley City	Mercy Hospital	Keith Heuser

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K

DD Providere Wage Increase
2011-2013 Biennium

[redacted]Start Date: July 1, 2011

Description	Recipients	11-13 Biennial Cost	General Fund	Federal Funds	Other
Individual effects of $.1.00 wage increase					
$1.00 wage increase		$22,728,112	$10,042,984	$12,685,128	$0

Notes:

Based on current providers with 3% inflationary increases calculated on each year.

Wage increase was calculated prior to the 3% inflationary increases being applied.

The $1.00 per hour wage increase does include the cost of additional FICA and Medicare taxes at 7.65%

Change in salaries would be effective July 1, 2011

This proposed increase is calculated independently of other proposals and of the 2011-2013 Executive Budget request.

[redacted]

[redacted]

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2-2-11

L

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

February 2, 2011

Senator Kilzer;

Thank you for the opportunity to provide you and the Sub-Committee information on Hospital Reimbursement. I want to re-iterate that what was approved in 2007 for Critical Access Hospitals and in 2009 for the six (6) large hospitals was to reimbursement at the Medicare Allowable Costs based on the Cost report.

The Medicare Allowable Cost is approximately 92 to 93% of the total costs or expenses to provide care in a Critical Access Hospital. In the Large hospitals the Medicare Allowable Costs ranges from the mid-seventies to the upper eighty percentile. This difference is a seven to eight percent short fall for Critical Access Hospitals and approximately twenty-two percent to twelve percent for the large hospitals. The numbers for the Critical Access Hospitals comes from Eide Bailly and the numbers for the large hospitals comes from the hospitals.

I was asked if I had to make a decision regarding reimbursing hospitals what I would do. After contemplating this question my answer is:

I would use the numbers supplied by Maggie Anderson as they are verifiable through departmental studies or with CMS data. I would consider reimbursing rural health clinics at actual cost, adding $844,300. Second, I would consider reimbursing Critical Access Hospitals for lab and Anesthesia at actual costs using the Supplemental Payment process that was used for Rolla. Again these numbers came from Maggie using CMS data; $3,454,061. I believe that these numbers are verifiable and accurate. Paying for lab and anesthesia at cost will eliminate the Supplemental payment request for Rolla on a biennium bases, $400,000.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

Finally I would request a study by the Human Service Department to determine the true or actual costs of Critical Access Hospitals and the six large hospitals. I would ask that the study be ready for the 2013 Legislative session. The 29.8 million dollar estimate is based on data supplied by each hospital to our office based on their financials. I believe the numbers are accurate and are provided in good faith; however, they are provided by each hospital and then aggregated.

Again thank you for the opportunity to answer your questions. I hope that the information was of value to you and the Sub-Committee.

Respectfully,

Jerry E. Jurena, President
North Dakota Hospital Association

Jerry Jurena

From: Nelson, Jon O. <jonelson@nd.gov>
Sent: Friday, January 28, 2011 1:27 PM
To: Boe, Tracy L.; Jerry Jurena; Devlin, Bill R.
Subject: FW: Critical Access Hospital Information

From: Anderson, Maggie D.
Sent: Friday, January 28, 2011 1:27 PM
To: Nelson, Jon O.
Subject: RE: Critical Access Hospital Information

Yes, that is accurate. It is based on the methodology approved by the Centers for Medicare and Medicaid Services for the supplemental payment to Rolla. All payments would be subjected to the Upper Payment Limit, but it is the same methodology that was used for Presentation Medical in Rolla.

From: Nelson, Jon O.
Sent: Friday, January 28, 2011 1:14 PM
To: Anderson, Maggie D.
Subject: RE: Critical Access Hospital Information

Maggie: Just to confirm that this information includes both lab and CRNA coverage which would mirror what we did for Presentation Medical in Rolla last session. Thanks for the information.

Jon

From: Anderson, Maggie D.
Sent: Friday, January 28, 2011 10:36 AM
To: Nelson, Jon O.
Cc: Weisz, Brenda M.
Subject: Critical Access Hospital Information

Rep. Nelson,

The estimated cost to implement a Medicaid supplemental payment for all Critical Access Hospitals for the 2011-2013 Biennium is $3,454,061, of which $1,527,802 would be general funds.

The estimate is calculated based on the methodology approved by the Centers for Medicare and Medicaid Services for the supplemental payment to Rolla.

Please let me know if you have questions.
Maggie

for bienniums 2011-2013

13 15
15 17
17 19

Total 13,816,244
General funds 6,111,208

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Numbers below represent entire biennium (two year)

- Rebasing "Rural Health Clinics" to Cost — $844,300
  - Department of Human Services performed study

- Rebasing PPS and CAHs to Actual Cost — $29,800,000
  - PPS = 22.4
  - CAH = 7.4
  - Based on an estimate received from hospitals

- Supplemental Payment for CAHs — $400,000
  - 25% of Medicaid payments > Total Revenue
  - Cost Reimbursement for Lab/Anesth.
  - Presentation Medical Center – **Rolla**
  - Contain in HB 1012 last biennium (amendment)

- Reimbursing Lab and Anesthesia at actual cost for CAHs — $2,200,000

Maggie Anderson working with Information from CMS estimated cost is: 3,459,061

general funds: 1527,502

North Dakota Department of Human Services

2011-2013 Executive Budget Recommendation

Provider Groups	Executive Budget Provider Inflation 3% / 3% Total	General	Federal	Other	Provider Inflation 4.545% July 1, 2011 Total	General	Federal	Other	Increase (Decrease) from a 3% / 3% to 4.545% Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	16,671,960	6,987,068	9,684,892	-	(5,222)	(17,048)	11,826	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	16,951,559	7,439,569	9,511,990	-	(26,836)	(35,449)	8,613	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	11,338,607	5,050,146	6,281,577	6,884	414,019	183,878	229,357	784
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	3,662,382	2,194,964	1,437,465	29,953	(24,299)	(17,638)	(6,562)	(99)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	3,816,484	2,067,282	1,130,145	619,057	(5,067)	(467)	(3,682)	(918)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	944,515	797,124	102,545	44,846	(2)	(3)	1	-
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,239,858	1,092,670	133,387	13,801	(1,418)	(1,258)	(147)	(13)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**54,625,365**	**25,628,823**	**28,282,001**	**714,541**	**351,175**	**112,015**	**239,406**	**(246)**

Provider Groups	Executive Budget Provider Inflation 3% / 3% Total	General	Federal	Other	Provider Inflation 4% July 1, 2011 Total	General	Federal	Other	Decrease from a 3% / 3% to 4% Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	14,669,774	6,147,666	8,522,108	-	(2,007,408)	(856,450)	(1,150,958)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	14,905,592	6,540,879	8,364,713	-	(2,072,803)	(934,139)	(1,138,664)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	10,072,210	4,486,147	5,580,005	6,058	(852,378)	(380,121)	(472,215)	(42)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	3,223,048	1,931,669	1,265,022	26,357	(463,633)	(280,933)	(179,005)	(3,695)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	3,358,904	1,825,196	989,342	544,366	(462,647)	(242,553)	(144,485)	(75,609)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	831,973	702,257	90,252	39,464	(112,544)	(94,870)	(12,292)	(5,382)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,092,381	962,702	117,521	12,158	(148,895)	(131,226)	(16,013)	(1,656)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**48,153,882**	**22,596,516**	**24,928,963**	**628,403**	**(6,120,308)**	**(2,920,292)**	**(3,113,632)**	**(86,384)**

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2-7-11

Inflation Scenarios

M

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 5% July 1, 2011				Increase from a 3% / 3% to 5%			
Provider Groups	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	18,343,326	7,687,408	10,655,918	-	1,666,144	683,292	982,852	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	18,631,576	8,177,675	10,453,901	-	1,653,181	702,657	950,524	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	12,417,295	5,530,536	6,879,186	7,573	1,492,707	664,268	826,966	1,473
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	4,029,257	2,414,817	1,581,489	32,951	342,576	202,215	137,462	2,899
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	4,198,660	2,271,181	1,246,164	681,315	377,109	203,432	112,337	61,340
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	1,036,948	874,802	112,806	49,340	92,431	77,675	10,262	4,494
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,365,479	1,203,379	146,904	15,196	124,203	109,451	13,370	1,382
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**60,022,541**	**28,159,798**	**31,076,368**	**786,375**	**5,748,351**	**2,642,990**	**3,033,773**	**71,588**

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2-7-11

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab	Certified Registered Nurse Anesthetist (CRNA)
Ashley	9,226	-
Bottineau	14,178	579
Bowman	8,059	-
Cando	15,216	2,967
Carrrington	16,314	26,431
Cavalier	10,977	-
Cooperstown	8,896	-
Crosby	-	-
Devils Lake	223,819	8,741
Dickinson	198,389	1,875
Elgin	22,438	-
Garrison	15,955	-
Grafton	23,426	495
Harvey	41,002	-
Hazen	14,615	-
Hettinger	19,686	340
Hillsboro	9,535	-
Jamestown	135,876	17,560
Kenmare	-	-
Langdon	18,604	-
Linton	9,399	-
Lisbon	49,379	1,161
Mayville	14,772	-
McVille	4,420	-
Northwood	7,852	-
Oakes	60,073	10,394
Park River	17,807	10,593
Rolla	167,461	-
Rugby	3,790	4,978
Stanley	15,708	-
Tioga	10,637	-
Turtle Lake	10,627	-
Valley City	33,094	12,730
Watford City	24,141	-
Williston	246,997	3,338
Wishek	4,522	173
Estimated Supplemental Payment *(Based upon 2009 data)*	1,486,890	102,355

ND Department of Human Services
Medical Services Division
Estimate of Critical Access Hospital Supplemental Payment
January 2011

	Lab		Certified Registered Nurse Anesthetist (CRNA)		Totals
July 1, 2010 Inflationary Increase	44,607	*	6,141	^	
Estimated Supplemental Payment (SFY 2011)	1,531,497		108,496		
3% / 3% Inflation *(SFY 2012 / 2013)*	139,213		9,862		
Estimated Supplemental Payment for the 2011-2013 Biennium	3,202,206		226,855		
Administrative Cost				25,000	
Total General	1,415,055		100,247	12,500	1,527,802
Total Federal	1,787,151		126,608	12,500	1,926,259
			Total 2011-2013 Estimated Cost		3,454,061

* July 1, 2010 lab inflation is 3%, as they are paid based upon Medicare fee schedule.

^ July 1, 2010 CRNA inflation is 6%, as services are paid on the Department's fee schedule.

Estimate is based on 2009 data, which is the latest year complete data is available. Actual payments made to facilities will not match these estimates.

Any supplemental payment is subject to the Medicaid Upper Payment Limit regulations and State Plan approval from the Centers for Medicare and Medicaid Services (CMS).

Estimate is based on the same criteria approved by the CMS for the supplemental payments authorized by the 2009 Legislative Assembly for Rolla. CMS has indicated that a similar supplemental payment would be available for all CAHs.

The Department currently has a contract in place with a vendor to do cost settlements of CAHs. This supplemental payment would be most efficiently handled in conjunction with those cost settlements. The estimated cost to complete these supplemental payment calculations for the biennium is $25,000.

SB 2012
2-7-11

Golden Manor Inc.'s Report to Department of Human Services

By
Muriel M Peterson, Consultant
December 1, 2010

In accordance with the conditions set forth in the contract entered into by the Board of Directors, Golden Manor Inc., this first report is submitted to the North Dakota Department of Human Services within the agreed upon timeframe. The report summarizes the struggles and successes of Golden Manor's Board from the time Medcenter One notified the Board it would not renew its lease after 10 years of managing the skilled facility through the transition to a basic care and assisted living facility.

In the late 1960's and early 1970's, individuals had the opportunity to purchase shares in Central Dakota Convalescent Home. The money was raised to build a care center for the elderly. The Golden Manor first opened in July of 1971 as a 42 bed intermediate care facility. Then in 1990, when federal law phased out intermediate care facilities, Golden Manor began an extensive construction and renovation project to meet licensure requirements for skilled nursing care facility. The Golden Manor became a 50-bed skilled nursing home in July of 1991. An all-faiths chapel was added to the facility in 1996. In 1998, the Golden Manor Inc.'s Board of Directors entered into a leasing agreement with Medcenter One of Bismarck whereby Medcenter One leased the facility until June 30, 2010.

In early 2008 Medcenter One notified Golden Manor's Board it would not continue to rent the building beyond the lease termination of June 30, 2010 and further would move the 50 skilled bed licenses to their new facility in Mandan. This left Golden Manor as a vacant building a few months later. The Board considered various uses of the building as it prepared for return to the Board's control in 2010.

The Board investigated other uses for the building. Considerable study was under taken

– an architectural firm was retained and renderings completed for a multi-medical/health practice setting. Considerable remodeling would be required; it was determined such an undertaking was too costly. There was dialogue with administrators of the State Hospital in Jamestown about Golden Manor becoming a residential group facility for persons with mental illness. That too was not a feasible option. Contacts were made with current long-term care operators to determine their interest in entering into a management agreement with Golden Manor Inc. Some contacts lead to meetings for further exploration but for various reasons a management agreement was not obtained.

Prior to the 2009 North Dakota legislative session, a group in the community, Citizens To Save Golden Manor, sought to re-establish Golden Manor as a skilled nursing facility by seeking replacement licenses from the State of ND. Local legislators Representative Robin Weisz, Representative Jerry Klein and Senator Duane Dekrey introduced legislation to increase North Dakota's maximum skilled bed licenses by 50. The result was passage of hoghoused HB1327. The final bill appropriated $200,000 for the facility agreeing to:

1. "Meet the requirements of both an assisted living facility and a basic care facility.
2. Use at least $50,000 of the grant to conduct a rent subsidy pilot project for at least four assisted living residents; and
3. Report to the department of human services on the success of the rent subsidy pilot project compared to the basic care assistance program."

Golden Manor agreed to the conditions by entering into a contract with the Department of Human Services March 1, 2010.

At Golden Manor's annual meeting in November 2009, five (5) new board members were elected, only two (2) members continued on the seven (7) members Board. Not only did the Board have a majority of new members, none of the members of the re-organized board had experience in long-term care. Two members are retired; the other members employed in fields that bring diverse backgrounds to the Board. At that

time a consultant was hired to assist the Board with meeting the conditions of HB 1327. The consultant was a retired Department of Human Services' employee familiar with the licensing process for basic care and assisted living. She also would be responsible for development of the rent subsidy program as prescribed by the Department in the contract.

There have been numerous set-backs or hurdles in the process of obtaining licensure as both a basic care and assisted living facility. The assumption that converting a licensed skilled facility to lesser level of care would be easy proved wrong. And licensing requirements are more challenging for a free-standing facility such as Golden Manor. Re-opening a building that has been vacant for two (2) years had its own challenges as well.

The first shock was the cost of remodeling to meet licensing requirements for assisted living as well as upgrades to the rest of the building. The Board expected to do the remodeling within the $150,000 contained in HB 1327 and monies on hand. The first estimate in excess of $1 million far exceeded that amount. A configuration of 17 basic care and 5 assisted living units fit within budget parameters. Further it was determined work on the west and north wings to be licensed for basic care would be readied for occupancy before moving forward with remodeling the east wing for assist living. This enables cash flow to begin earlier than waiting till all remodeling was completed.

While the building was vacant was an opportune time to do a complete "housecleaning" and general repair work. The two (2) wings comprising the basic care facility received new paint and carpet and the windows in the west wing were replaced. All non-resident areas were also painted. Additional insulation was added in the attic of the oldest section of the building.

Golden Manor came into being by community effort in 1971 and it continues to have that same community support to this day. Although there was considerable disappointment when skilled beds were not made available, the community has rallied

behind the new concept of basic care and assisted living. An estimated 100 volunteers have committed innumerable hours to cleaning both inside and outside the building. The volunteer efforts were lead by the Board members themselves. Members have assumed specific responsibilities to assure progress toward re-opening of the facility. Until the manager is hired, the Board has coordinated all aspects of the project. Volunteers have ranged in ages 9 to 90 years. Church youth groups and school groups have donated hours of labor that older adults could not handle. See news clippings at Attachment A-1, A-2, A-3.

The assisted living, east wing, requires extensive remodeling to meet licensure requirements. Two resident rooms will be combined for each assisted living unit. The units are 510 square feet and the handicapped unit 578 sq. ft. Each unit will have a kitchenette area consisting of refrigerator, sink, cupboards and pantry, adjoining living area and a separate bedroom with bath. The most costly undertaking is the work needed to add a shower in each bathroom. See Attachment B for layout of assisted living units.

Bids have been entered into for work in the assisted living units. Contractors began work in November with a contractual completion date of May 1, 2011. And, the Board is pursuing a Flex Pace loan thru the Bank of North Dakota in addition to approaching the Steele City Sales Tax Fund for an interest buy down match. The loan is for the construction costs not covered by the State Legislative appropriation and to protect working capital for the operation of the facility.

The required final report due June 30, 2011 will focus on the assisted living operation compared to basic care as stipulated in the contact. It will include a report on the rent subsidy [rental assistance] program at that time.

SB 2012
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Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January XX, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Marilyn Rudolph, Director of Northwest Human Service Center (NWHSC) and North Central Human Service Center (NCHSC) of the Department of Human Services (DHS). I am here today to provide you an overview of the budgets for both Northwest and North Central Human Service Centers.

Northwest Human Service Center

Caseload / Customer Base

- Northwest HSC serves the three county area of Divide, McKenzie and Williams counties, with an estimated population of 28,211.
- Northwest HSC serves 1,545 unduplicated clients annually.
- In addition Northwest Human Service Center's Vocational Rehabilitation program serves 401 individuals.
- The impact of the growing population is evident in the number of calls for information and referral. In 2009, Northwest HSC received 181 calls, and in 2010 that number increased to 465. Information and referral calls often eventually become ongoing clients.

Program Trends / Major Program Changes

- Northwest Human Service Center has developed a full continuum of Alcohol and other Drug Treatment since 2009. The Center has drawn staff from the allocated 45.75 FTE's by reclassifying positions that were vacated in Outpatient and Extended Care. This has all units operating at capacity.
- Catholic Health Initiatives, the parent company of Mercy Hospital, notified Northwest Human Service Center of its intention to close Mercy Mental Health Unit and eventually Mercy Recovery Center. Two thousand ten has been a year of challenge because of the closing of Mercy Mental Health.
- In 2009 seventy-six individuals were referred for commitment to the North Dakota State Hospital; fifty-two were placed in community based treatment because we could stabilize individuals in the Mercy Mental Health Unit and then place them in a safe community setting. After closure of Mercy Mental Health, we had seventy-one individuals referred for commitment; twenty-three were served in the community, thirty were placed in the North Dakota State Hospital and eighteen were transferred to Trinity Hospital in Minot for stabilization or detoxification. Having the mental health unit allowed twice as many individuals to be served in the community, which is more cost effective, as well as providing "close to home" care for the clients. It also does not burden partnering agencies, such as the Sheriff's Department, with the cost of transportation to Minot or Jamestown. I must commend Trinity Hospital for being and excellent resource when detoxification or mental health stabilization was necessary in the short term, prior to admission to the North Dakota State Hospital.
- A critical resource for Williston has been our partnership with North Dakota Association for the Disabled and the ability to contract to

develop residential options to provide safe supervised living situations for individuals in crisis or in treatment. Williston has twenty-six beds available ranging from crisis residential, to long term addiction treatment, to supportive housing for individuals with serious mental illness. This allows clients to maintain stability and receive the full benefit of treatment. The availability of these beds allows for medication monitoring, maintenance of nutritional meals and the ability for community based care, as opposed to hospitalization. It is a cost effective solution.

- In the past year, staff from Northwest responded to a critical community incident. In Williston, a team of three clinicians assisted school counselors and ministerial staff in grief counseling and debriefing after the tragic murder/suicide of two young people. Family and community members wrote notes to us thanking us for the availability of our staff and the support.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Northwest HSC	8,510,654	8,749,068	238,414
General Funds	4,724,962	4,958,832	233,870
Federal Funds	3,436,804	3,321,230	(115,574)
Other Funds	348,888	469,006	120,118
Total	8,510,654	8,749,068	238,414
FTE	45.75	45.75	0.00

Salaries and benefits increased by $197,803 and can be attributed to the following:

- $332,043 in total funds of which $257,326 is general fund needed to fund the Governor's salary package for state employees.

- $142,174 in total funds of which $110,928 is general fund needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.
- An increase of $68,293 to cover underfunding of salaries from the 2009 – 2011 budgets.
- A decrease of $32,035 to underfund the 2011 – 2013 pay plans.
- The remaining decrease of $312,672 is based on the replacement of long time staff with new staff and the reclassification of positions as well as lower temporary salaries, overtime and fringe benefit cost.

Operating expenses decreased by $22,518 (2.1%). This reduction is a combination of increases expected next biennium offset by decreases as follows:

- A decrease in the travel budget based on usage when the budget was being prepared.
- A decrease in the purchase of office equipment and furniture.
- A decrease in building rent.
- A decrease in professional development based on the setting of a consistent amount per FTE.
- Smaller decreases in miscellaneous supplies, postage, IT equipment and medical supplies account for balance of the overall reduction.

Total budgeted expenses for grants increased $63,129 (4.9%). The inflationary increase of 3%/3% accounts for $58,663 of the total increase. Without the inflationary increase the biennium to biennium increase would be $4,466 (.3%).

The general fund request increased $233,870. The governor's salary package for state employees included $257,326 in general fund.

Federal funds decreased $115,574 while other funds increased $120,118.

North Central Human Service Center

Caseload / Customer Base

- North Central Human Service Center serves the seven county area of Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward counties, with an estimated population of 83,384.
- Annually North Central HSC serves 3,225 unduplicated clients.
- In addition North Central Human Service Center's Vocational Rehabilitation program serves 351 individuals.
- The number of information and referral calls increased from 104 in 2009 to 268 in 2010.

Program Trends / Major Program Changes

- North Central Human Service Center has been the pilot site for specialized services for transition youth, ages 18-24 years. The challenge is securing housing and work for youth who often have no credit history or work experience and usually exhibit behaviors that create poor impressions. Bonnie Schriock has worked diligently with community partners to secure housing and provide guidance and direction for transition youth. Usually these individuals have been receiving services from the human service center or the county in the form of case management or foster care thus the transition care facilitator assists in that leap to adulthood.
- One area of concern is the shortage of psychiatrists nationwide and the need for psychiatric care in rural areas. North Central Human Service Center section of the DHS budget includes one additional FTE to hire a full time psychiatrist. If a full time psychiatrist is hired, this position would serve both North Central and Northwest Human Service Center providing psychiatric expertise and collaboration to all staff.
- The Governor's Budget includes funding to fill a capacity gap by implementing a crisis stabilization unit to specifically serve individuals with serious mental

illness. This would allow Region II the ability to serve individuals who need immediate supervision and structure in a safe environment in the community, reducing the need for local hospitalization or transport to the North Dakota State Hospital. This allocation includes funds to contract for staffing to serve ten individuals including psychiatric time, psychiatric nursing, a program supervisor and direct care staff for 24/7 coverage. The ability to serve individuals close to home reduces trauma, allows family input, reduces length of stay and is cost effective.

- North Central staff responded to the community of Stanley after young man's suicide. Three clinicians were available at the school to counsel students, faculty and community members. Staff successfully intervened on three occasions of potential suicide attempts. The interventions involved talking the individual down, confiscating weapons and follow up to assure community safety. Again we have received notes from these individuals expressing gratitude.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
North Central HSC	19,382,601	22,433,884	3,051,283
General Funds	10,459,768	13,410,027	2,950,259
Federal Funds	8,073,938	8,104,420	30,482
Other Funds	848,895	919,437	70,542
Total	19,382,601	22,433,884	3,051,283

FTE	116.78	117.78	1.00

North Central Human Service Center's budget includes one new FTE. This FTE will be used to hire a full time psychiatrist.

Salaries and benefits increased by $1,392,768 and can be attributed to the following:

- $807,765 in total funds of which $618,694 is general fund needed to fund the Governor's salary package for state employees.
- $312,818 in total funds of which $245,183 is general fund needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.
- An increase of $86,078 to cover underfunding of salaries from the 2009 - 2011 budget.
- A decrease of $70,821 to underfund the 2011 - 2013 pay plan.
- The remaining $256,928 is a combination of increases and decreases needed to sustain the salary of the 117.78 FTE in this area of the budget.

Operating expenses increased by $272,957 (15.4%). Two major items created this increase.

- Building rent is increasing $170,840 because of the following:
    - The center's lease includes a 4% increase. This amounts to $21,620 for the biennium.
    - The center leased and additional 5,661 square feet for Rehab Employment Services Assistive Technology Lab that was not in the 2009-11 budget. The lease for this space is $113,220.
    - Since 2002 space has been rented for an A&D residential program called The House. The cost of this rent has been paid for by a grant in the Mental Health & Substance Abuse Division until June 30, 2010 when the grant ran out. The cost to continue renting space for this program is $36,000. This supportive housing provides a much needed option for individuals completing treatment and beginning employment.

- North Central was asked to operate the Aging Services Outreach program for Region II during the current biennium. The center pays for a number of option counselors, located throughout its catchment area, to visit seniors to assess what services they may be eligible for to assist them to continue to live independently in their own homes. The budget for the option counselors is $102,320 in federal funds.
- After the above other operating increases and decreases come to a net decrease of $203.

Budgeted expenses for grants increased $1,385,558 (36.3%) with the majority of the increase explained as follows:

- The inflationary adjustment of 3%/3% accounts for $163,259 of the increase.
- The governor's budget for North Central includes $1,444,661 to fill a capacity gap by implementing an SMI crisis stabilization unit. This would give Region II the ability to serve individuals who need more structured, supervised care in the community reducing the need for local hospitalization or referral to the State Hospital.
- The center reduced other grants $255,543 to offset part of the expense for the psychiatric position in the budget. These were contract dollars for nurse practitioner services.

The general fund request increase is $2,950,259. The following items account for 83.7% of the total general fund increase:

- Governor's salary package - $618,694
- Continuation of the second year salary increase - $245,183
- 3%/3% increase for contracted providers - $161,668
- SMI crisis stabilization unit - $1,444,661

- The remaining increase of $480,053 is associated with the overall changes in the center's budgeted expenses and revenue sources.

Federal funds increased $30,482. Other funds increased $70,542.

Northwest and North Central North Dakota are experiencing an influx of population from every part of the United States. New clients often seek help with psychiatric medication; some come with prescriptions from other states but more often, they come with only a story and need to maintain their mental health

The economic prosperity comes with a price as you have often heard. People are living in campers, insulated with snow, eating sack lunches and showering at the local Recreation Center. It is a tough life and its toll is sleep deprivation and family disruption resulting in increased traffic to the Human Service Centers.

This concludes my testimony. I would be happy to answer any questions. Thank you.

Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January XX, 2011

Chairman Holmberg, members of the Senate Appropriations Committee, I am Kate Kenna, Director of the Lake Region Human Service Center (LRHSC) and Northeast Human Service Center (NEHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of both centers' budget requests.

Lake Region Human Service Center

The Lake Region Human Service Center provides services to the six counties of Ramsey, Cavalier, Rolette, Towner, Benson, and Eddy. In 2010 the population estimate in Region III was 40,143, or 6.2% of the total state population. Services are provided throughout Region III with one office in Devils Lake and an outreach office in Rolla. Case managers, clinicians, and program staff travel to other outreach sites in each of our six counties.

Caseload / Customer Base

The Lake Region Human Service Center provided services to 2,484 individuals in State Fiscal Year 2010 - 1,863 adults and 621 children received services. In addition, 407 individuals received Vocational Rehabilitation services and 131 received Older Blind services in Federal Fiscal Year 2010.

Program Trends

- The poverty rate and unemployment rate in Region III remains at essentially twice the state average. Based on data collected over the past decade, the percent of Region III recipients that benefit from DHS Programs (excluding child support, abuse and neglect, and Older American's Act recipients) is about twice the statewide average (one in three residents).
- Data from October, 2010 indicates that Temporary Aid to Needy Families (TANF) continues to be a major resource to low income families. Currently Region III has 2,065 TANF recipients – 42 percent of all TANF recipients in North Dakota. Rolette County alone has 1,500 recipients, essentially equal to the TANF caseloads of Grand Forks, Burleigh, and Cass counties combined (1,500 vs. 1,537 recipients).
- During SFY 2010, LRHSC saw 992 Native American consumers which are 40% of all LRHSC consumers served. This number represents 34% of the total 2,886 Native American consumers seen statewide by the Human Service Centers.
- During SFY 2010, LRHSC provided services to 105 consumers, age 80 and older, which is 32% of the 327 age 80+ consumers seen statewide by the Human Service Centers.
- The flood remains a vexing problem including offering ongoing challenges to human service, faith based organizations, and volunteer agencies active in this disaster. While there continue to be signs of substantial resiliency across the Region, the battle is a sustained one. People are experiencing loss and grief as well as financial losses in many cases.

- Regional population appears to be remaining stable and demand for clinical services has risen moderately by an additional 111 consumers for SFY 2010 compared to the numbers reported during the prior testimony we made before this body. Region III remains a designated Mental Health Professional Shortage area by the National Health Service Corp. All six counties have a shortage score of "18" which are the highest scores in North Dakota.
- Crisis Line calls numbered 460 for SFY 2010 with 70 admissions to the North Dakota State Hospital. These numbers suggest that increased efforts to screen potential NDSH admissions continue to be successful. In the mid-1980's, Region III averaged 322 NDSH admissions per year; in the mid-1990's, the average was 207; and in the early 2000's, this number hovered around 100. In the past three years the number has hovered around 60 to 70 admissions.
- Region III consumers report that transportation is a continuing barrier to accessing services. Outreach is important as part of the solution. One flood-related impact of the flood is that, in addition to the damaged or destroyed township roads affecting consumer access, there are major and long-duration road construction projects on the majority of highways around Devils Lake. Lake Region HSC is in the process of expanding telemedicine as an alternative means to sustain services to some populations served.
- The loan repayment offered by the National Health Service Corp has been helpful in recruitment on the mental health side. Lake Region HSC recently was able to hire two new psychologists allowing us to start to offer psychological evaluations and consultation to our Lake Region Outreach office in Rolla. Addiction counselors continue to be challenging to recruit and retain and do not qualify for this loan repayment.

- Health care reform, if it moves forward, may afford disproportionately higher benefits to the residents within Region III. For example, if implemented as currently proposed, the component that will offer Medicaid to cover single individuals who are at or below the 133 percent of poverty threshold, will include a potentially significant number of individuals particularly from Benson, Ramsey, and Rolette counties.
- Transition from Prison to Community Initiative: Under the local guidance of Judge Donovan Foughty a substantial number of stakeholders have implemented coordinated transition services with the goal of reducing recidivism and increasing community safety. Lake Region HSC is an active participant in this initiative at both the advisory committee and working committee levels and is broadly engaged as a treatment provider, particularly of mental health and substance abuse services. We have also implemented the Commitment to Change Program which is a cognitive behavioral group, known to be effective with populations who have criminal justice issues along with behavioral health problems.
- Both LRHSC and NEHSC continue to gain experience in evidenced-based models of service delivery. The Division of Mental Health and Substance Abuse recently secured and delivered training in Motivational Interviewing to substantial numbers of staff from all eight human service centers which has provided one more tool for the staff member's tool box. Motivational Interviewing is useful in conjunction with a variety of other services and is helpful in assisting consumers in exploring and resolving their ambivalence about facing some problems.
- Two new Suicide Prevention Committees have been formed; one represents the greater Devils Lake area and the other Spirit Lake

Nation. Staff of LRHSC has been very active with both committees. Lake Region HSC continues to participate in an array of community activities. Examples include Teen Maze and the Foster Care Recruitment and Retention Committee, and we have played a lead role in delivering community screenings during National Depression Screening Day.

- Current reports suggest the flooding in the Devils Lake Basin will likely continue in 2011. In partnership with Bonnie Turner, Lutheran Disaster Response, LRHSC coordinated an initial meeting of local representatives of faith-based, VOAD, agricultural, Tribal, and local helping agencies to discuss human service challenges and establish connections that should enhance a coordinated response when the need arises.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
Lake Region HSC	10,955,142	11,418,231	463,089
General Funds	6,066,003	6,882,190	816,187
Federal Funds	4,450,221	4,063,599	(386,622)
Other Funds	438,918	472,442	33,524
Total	10,955,142	11,418,231	463,089
FTE	60	60	-

Budget Changes from Current Budget to Executive Budget:

- Salary and Wages related expenses increased by $479,115 and can be attributed to the following:

- $432,484 in total funds of which $332,923 is general funds to fund the Governor's salary package for state employees.
- 89,977 in temporary salaries which represents a .7 fte for the Family Caregiver/Adult Protective Services program and a .25 fte for a SMI case manager.
- An increase of $73,337 to cover an underfunding of salaries from the 2009-2011 budget.
- An increase of $165,099 in total funds of which $124,747 is general funds needed to fund the second year employee increase to 24 months versus the 12 months that are contained in the current budget.
- A decrease of 40,856 to underfund the 2011-2013 payplan.
- The remaining decrease of $240,926 in the Salaries and Fringe Benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 60 FTEs in this area of the budget.

- The Operating cost increased by $59,287. While most all line items had small inflationary increases, the larger increases consisted of the following items:

  - An increase of $13,943 in travel related expenses. This increase represents the increased need for outreach services, the increases allowed in lodging rates, personal mileage reimbursement, and increased requests for local mileage reimbursement by staff as a result of increasing gas prices.
  - IT Communications increase of $8,872 based on projected increased telecommunications costs.

- An increase of $2650 in Professional Development to increase the funds available for staff from the current $100/fte to $150/fte.
- An increase of $17,923 in Operating Fees and Services. This increase is largely the result of Federal funding for Aging outreach services in the amount of $15,848.
- An increase of $3000 for Fees- Professional Services. This increase is the result of the increased use of sign language interpreters required in serving the deaf population.

- The Grants costs decreased $75,313. The following items make up this decrease:

  - A transfer of $111,076 of adolescent alcohol and drug federal funds to the NEHSC's program to fund two beds for Lake Region adolescents.
  - A decrease of $109,360 in long term A&D residential funding.
  - An increase of $25,000 to fund the Peer Support program at the Recovery Center for SMI clients.
  - An increase of $38,090 to fund the second year of last biennium's provider inflationary increases.
  - An increase of $82,033 to fund the Governors request for a 3% and 3% inflationary increase for the 2011-2013 biennium.

- The general fund request increased by $816,187 with 66% of that increase ($539,703) related to the Governors salary package for state employees and the 3% and 3% provider inflationary increases. The remaining increase of $276,484 is associated largely with the cost to continue the second year of provider inflationary increases from the 2009-2011 biennium, increased operating costs, and a decrease in the Federal Medical Assistance Percentage (FMAP).

Northeast Human Service Center

This area of the budget includes the programs of the Northeast Human Service Center (NEHSC). The NEHSC serves the citizens of Grand Forks, Nelson, Walsh, and Pembina counties. The center is located in Grand Forks with a satellite office in Grafton and an outreach site in Cavalier.

Caseload / Customer Base

- The population in Region IV is approximately 87,733; this represents 14 percent of the state's population. Twelve percent of the state's children, nearly 17,360, reside in our region.
- The Northeast HSC provided clinical services to 3,557 individuals in SFY 2010; 2,570 adults and 987 children received services. This represented a 6 percent increase in clients over SFY 2008. During SFY 2010, we averaged over 49 addiction evaluations per month and 35 clinical intakes per month.
- Vocational Rehabilitation (VR) served 1,174 clients; 135 clients were served through the Older Blind program.
- Other residents of our counties received indirect services provided through Aging Services, Foster Grandparent Program, Child Welfare, and community education.
- Priority is placed on serving the Region's most vulnerable individuals, including those who cannot otherwise access services.

Program Trends

- The Northeast HSC has had difficulty recruiting/retaining a psychologist, community home counselors, and fully qualified mental health clinicians.
- The Northeast Human Service Center has been successful in recruiting an additional full time psychiatrist.
- In addiction services, Northeast HSC continues to see an increased use of prescription medication, a decrease in methamphetamine as a primary substance of use, a need for longer residential stays and an increase in clients from County Social Services and the Department of Corrections and Rehabilitation who require additional case management and more frequent involuntary commitments.
- Northeast's addiction services noticed a significant surge in the use of synthetic marijuana, which is undetectable by traditional drug screening. A number of clients had their treatment impacted by this undetected continued use.
- Northeast has 37 clients involved in adult drug court and 12 clients involved in juvenile drug court.
- In Developmental Disabilities (DD), more families are struggling economically and are requesting assistance in helping meet the excess costs of having a child with a disability. Developmental Disability Program Managers (DDPM) are spending more time helping families meet basic needs. The number of clients in DD program management continues to grow each biennium, currently at 709 active cases. Developmental Disability Program Managers are working with the implementation of the Medicaid autism waiver, a new data system and the implementation of many policy changes for the Medicaid waiver renewal of 2009.

- Ruth Meiers Adolescent Center has experienced an increase in private placements in the facility over the past 2 years, including 42% of placements in 2009. The number of younger youth, ages 11- 13, increased for the second straight year, accounting for 26% of those admitted to the program. The program continues to see an increase in younger youth (ages 11-14) with sub 70 full-scale I.Q.'s referred for treatment. The percentage of youth served that are adopted or have no biological parents actively involved in their life increased to 36% of the youth admitted in the last 18 months. In 2009, 23% of youth admitted to the program were Native American and 42% of the youth discharged from the program were Native Americans, continuing a disproportionate (statistically according to census) number of Native American youth receiving RMAC services. The staff retention rate over the last 18 months was the best in over a decade.
- In Children and Family Services, from December, 2009 to December 2010 there has been an overall increase in licensed child care (primarily Family providers) and a decrease in Self-Declaration providers (a standard below licensing). Self-Declaration is a category that has no monitoring and cares for fewer children. This is the category that we have historically had a high number of revocations and denials, as there were few screening tools or monitoring. The initiation of fingerprinting and criminal background checks appears to be the primary factor in the decrease in numbers and capacity. As it was intended, criminal background checks has served as a screening tool for applications for child care. Consequently, as more screening occurs prior to the license being issued, the number of revocations and denials of child care licenses has decreased this year. Region IV has 265 licensed child

care providers with a capacity of 5,611 children. A trend in child care over the past biennium is the significant increase in the number of New Americans who are applying for child care. A number of these individuals have limited English capacity to communicate.

- Children and Family Services notes that there were 20 adoptions of foster care children in 2010, compared to 39 in 2008. There are currently 70 foster homes in Region IV and the number of therapeutic foster homes is 24. In the past 11 months, there have been 996 administrative and full Child Protective Services assessments.
- The Northeast HSC has been working with Network for the Improvement of Addiction Treatment (NIATx) to improve services to clients. We have focused on reducing wait time, increased customer satisfaction, and efficiency. This process looks at evaluating services and using a rapid change cycle in the delivery of services. We are currently working on a statewide effort for paperwork reduction.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
NEHSC	25,967,419	28,182,609	2,215,190
General	11,259,927	13,209,723	1,949,796
Federal	13,557,216	12,967,908	(589,308)
Other	1,150,276	2,004,978	854,702
Total	25,967,419	28,182,609	2,215,190

FTEs	138.10	138.30	.20

The FTE increase of .20 was a transfer from Southeast HSC to Northeast to add to a .80 FTE creating a 1.0 FTE for a psychiatrist.

Salary and Wages increased by $1,987,716 and can be attributed to the following:

- $990,524 in total funds of which $685,880 is general fund needed to fund the Governor's salary package for state employees.
- $320,108 in total funds of which $212,712 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $44,145 to cover an underfunding of salaries from the 2009 – 2011 budget.
- A decrease of $79,177 to underfund the 2011 – 2013 payplan.
- Temporary salaries are increased by $59,308 to meet additional staffing needs in our Ruth Meiers Psychiatric Residential Facility and an additional 50% FTE case aide for adults with Serious Mental Illness.
- Northeast hired an additional full time psychiatrist to replace two contracted part time psychiatrists. The salaries and benefits increase to cover this cost was $505,812.
- The remaining increase of $ 146,996 is a combination of increases and decreases needed to sustain the salary of the 138.3 FTE in this area of the budget.

The Operating budget increased by $82,529 (2.7%) and is a combination of the increases expected next biennium which are offset by decreases as follows:

- An increase of $ 93,054 in the Northeast's travel budget. This increase results from Northeast using actual motor pool rates and

utilization history in establishing the 2009-11 budget, then using the State Fleet Budget guideline rates for 2011-13. Northeast is also projecting a 52,720 mile increase in utilization for the 11-13 biennium, based on a projection of our current utilization. This increase in utilization results in about $ 19,500 of the budget increase. In addition, the increased costs of the changes to lodging rates and personal mileage rates are included in the budget increase.

- IT Communications increase of $19,863 based on new IT phone rates and increased use of communication devices.

Northeast's Grants cost includes a net increase of $144,945. This includes an increase of $268,856 to cover an inflationary increase of 3% each year offset by decreases of $94,458 from our psychiatry contract budget, $ 3,977 from our Adult Protective Services contract, and $ 25,476 from our SMI Supported Residential contract.

The general fund request increased by $1,949,796 with 35% of that increase ($685,880) related to the Governor's salary package for state employees. $212,712 of the increase is related to continuing 2nd year salary increases for 24 months. $217,111 of the increase is related to the contracted provider increases of 3% for each year of the biennium.

The remaining increase in general funds of $834,093 is a result of reductions in the federal medical assistance percentage (FMAP) and changes in the operating budget described above.

Northeast HSC is projecting an increase in other funding of $ 854,702, largely from increased 3rd party collections for our psychiatric residential treatment program and our CD adolescent treatment program.

This concludes my testimony on the 2011 – 2013 budget requests for Lake Region Human Service Center and Northeast Human Service Center. I would be happy to answer any questions.

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Testimony
Senate Bill 2012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
January XX, 2010

Chairman Holmberg, members of the Senate Appropriations Committee, I am Candace Fuglesten, Director of Southeast Human Service Center (SEHSC) and South Central Human Service Center (SCHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of the budgets for both Centers.

Southeast Human Service Center (SEHSC)

SEHSC provides community behavioral health and safety net services to individuals who live in Steele, Traill, Cass, Ransom, Sargent and Richland counties, in Region V of our State. The region is comprised of 178,472 residents (27.6% of the state's population) as estimated by the 2009 U.S. Census Bureau.

Caseload / Customer Base

- SEHSC provided behavioral health services to 5,102 individuals in State Fiscal Year (SFY) 2010 (4,003 adults and 1,099 children 17 years of age or younger). This total includes 1,247 individuals within the developmental disability (DD) service area. Thirty-seven percent of those individuals have no insurance and 45% are covered by Medicare, Medicaid or another public funding source.
- SEHSC also provided Vocational Rehabilitation (VR) services to 1,451 individuals.

- Due to demand issues and capacity limitations, SEHSC provides all of the established human service center core services, but prioritizes serving the most vulnerable individuals who cannot access services elsewhere in the community/region. Our Admission staff assists individuals requesting non-urgent services, who have the potential to access other community providers, by discussing alternative resources with the caller. Many of these individuals with acute needs then seek those services from other local providers.
- Due to the high demand for case management services for individuals with serious mental illness and/or chronic addiction, we provide those services to those individuals most often accessing higher level of care such as hospitalization, repeat law enforcement encounters, social detox and/or harm to self or others. Individuals who receive case management services require multiple and generally more intensive services.
- Thirty-three percent of all admissions to the North Dakota State Hospital (NDSH) in SFY 2010 came from this region. This is a significant increase from last biennium and a reversal in the trend of decreasing admissions for the region. When MeritCare partnered to become Sanford Medical Center, the mission and purpose of their psychiatric services changed to focus more on acute admissions. This has resulted in decreased local hospital options for SEHSC consumers with severe mental illness; and increased the number of individual with severe mental illness referred by Sanford to SEHSC for services. Hence, local short-term inpatient hospitalization for indigent clients is less available and consumers with severe mental illness referred to SEHSC for outpatient care is growing. Prairie St. John's has stepped up to

provide more hospital services to adult individuals with severe mental illness, but as they are a standalone psychiatric hospital they are unable to collect payment from Medical Assistance adult clients due to the federal institutions for mental disease (IMD) exclusion. All of this has played a role in the increased admissions to the NDSH. Prairie St. John's at this time is also restricting new admissions to their outpatient services, referring many of those individuals to SEHSC.

- We have one 15 bed crisis unit which continues to have high utilization. A triage process is used for admission access.
- We also contract for crisis beds for children with severe emotional disorders and crisis/social detox beds for adolescents with substance abuse issues. The addiction crisis beds provide an intensive level of substance abuse residential care in a family setting. Outcomes in this area have been very positive with increased school attendance, reduction in substance use, and successful reintegration into the parental home.
- Many of our clients are involved in the correctional system either at the local jail and court system or after release from prison and under the supervision of Probation and Parole. The SEHSC regional intervention staff works with the jail to triage and identify new individuals that need immediate psychiatric evaluations that are completed by SEHSC staff at the jail. SEHSC most recently completed a formal contract with Cass County Jail, who was awarded a Department of Justice grant to work with community partners in a pilot project of a post-booking diversion program for eligible offenders with mental health diagnoses. As a result of the demonstration project, called the Jail Intervention Coordinating Committee (JICC), Cass County Jail has recognized

the benefit and funded a mental health professional to work in the jail and SEHSC has an expedited process in providing case management services to offenders whose mental illness contributed to their commitment of a crime when the court feel that is an appropriate piece of their sentence. A positive unintended outcome of the project was an increase in getting individuals at the jail who were identified as having mental illness connected with services at SEHSC and with other area providers without the court ordering requirement. Both the jail and the prison work with us to plan for aftercare as much as possible with appointments made as often as possible for the day of release.

- The demand for addiction treatment services for both adults and adolescents in our region continues to grow. During this biennium, we became newly licensed to provide 3.1 American Society of Addiction Medicine (ASAM) level of residential care treatment at both our crisis residential unit and for an additional eight beds at Dakota Pioneer, which is an apartment building housing vulnerable adults. We have also expanded outreach hours in both Lisbon and Wahpeton to meet rural demand. This increased demand occurs at a time that SEHSC is experiencing a difficult time recruiting qualified licensed addiction counselors. SEHSC has implemented a "grow our own" addiction counselor program providing education support and training to current employees to help them obtain an addiction counselor license. Due to the continued expected labor shortage in this area, and expected retirement of a large number of current licensed addiction counselors in the State, this will be an on-going effort for the foreseeable future.

- The turnover rate for all employees at SEHSC during Calendar Year 2009 was 10.84%.
- We have just finished our third full year of implementing the evidence-based practice of Integrated Dual Disorder Treatment (IDDT) which has proven to improve the quality of life for individuals with co-occurring mental and chronic substance use disorders. IDDT outcomes include **reduced** rates of relapse, hospitalization, arrest, incarceration, and utilization of high cost services while **increasing** continuity of care, quality of life outcomes, stable housing, employment, and independent living. This model provides staff with very specific strategies for delivering service. Fidelity reviews led by Ohio Case Western University have been very positive and local outcomes good.
- In conjunction with the University of North Dakota Medical School, SEHSC continues to provide a psychiatric residency training site for a number of doctors each year. This has assisted with recruitment of psychiatrists both at our Center and within the State.
- SEHSC was granted a five year accreditation by the American Psychological Association (APA) in November 2009 as an approved internship site. This is the first approved APA accredited site in North Dakota to our knowledge. We believe this will assist in our recruitment efforts of psychologists for the Department, especially those completing their education at the University of North Dakota where they are required to participate in an APA approved intern site. This will provide them a North Dakota State option which has not been available to them before.

Program Trends

- The demographics of the region are shifting. Individuals 85 and older increased by 32% from 2000 to 2008. Fargo-Moorhead continues to have a culturally diverse population which requires interpreters and other special services from the center.
- Area minority groups continue to experience high levels of poverty. The largest increase in poverty since 2000 is among single mothers regardless of ethnic background.
- Seventy-six percent of children under the age of six have both parents working.
- Region V has 40% (111 individuals) of the long term homeless population in North Dakota according to the latest point in time study conducted in January 2010. "That definition is used to describe individuals or families with disabling conditions who have been homeless continuously for at least one year, or more than four times in the last three years (ND Interagency Council on Homelessness)."
- As of December 1, 2010, there were 90 children from Region V in the custody of the Department of Human Services, which is a slight increase from last biennium.
- There are between 300-350 children in foster homes in the region during a year which mirrors the State trend of declining numbers.
- There is a trend statewide and locally of placing more children with relatives instead of existing foster homes, if it can be done safely. Cass County is part of a pilot project of convening a meeting of the extended family when children are taken into custody so the family can help decide if there are family members able and willing to provide care for the children.

- There is also a trend statewide that shows children once placed with the Division of Juvenile Services are now being referred to county social services. The philosophy is that some of the children that entered the juvenile correction system were neglected and abused children and the social service system could better meet their needs.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Increase / Decrease
SEHSC	30,339,652	38,464,720	8,125,068
General Fund	14,235,049	22,185,733	7,950,684
Federal Funds	14,748,761	15,145,044	396,283
Other Funds	1,355,842	1,133,943	(221,899)
Total	30,339,652	38,464,720	8,125,068
FTE	182.35	182.15	(.20)

The salary and wages line item increased by $2,525,038 which is primarily attributed to the following:

- $1,319,916 in total funds of which $1,064,086 is general fund to fund the Governor's salary package;
- $476,950 in total funds of which $339,351 is general funds to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget;
- An increase of $115,044 to cover an underfunding of salaries from the 2009 - 2011 budget;
- A decrease of $99,079 to underfund the 2011 - 2013 pay plan;
- $70,299 to provide for the annual and sick leave lump sum payouts for 11 FTE's expected to retire;

- $92,059 in total funds of which $88,790 is general fund to maintain our current temporary employees;
- A decrease of $32,278 in the budget for overtime; and
- During the current biennium, $503,146 was transferred from the salaries – permanent budget account code to the temporary salaries budget account code to meet the increased demand for services and to prevent waiting lists. The increase is included as part of the continuing program changes in the salaries – permanent budget account code.
- The remaining increase of $78,981 in the salaries and fringe benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 182.15 FTEs and temporary employees in this area of the budget.

The operating line item increased by $65,636 and is a combination of increases and decreases expected next biennium. The majority of changes can be explained as follows:

- increased rent of $12,803 for the Off Main (dual diagnosis mental health/substance abuse) facility;
- $62,289 of federal funds, in operating fees, for vulnerable adults ombudsman program to fund local point of contact and outreach services;
- $10,981 inflation and demand increase for janitorial, drug testing and interpreter services;
- increase of $21,441 in professional service fees for the cost of the accreditation survey for our sheltered workshop during the 2011-2013 biennium;
- $7,330 decrease in motor pool costs due to removing budgets for federal part C programs from the Center budget.

- a decrease of $33,211 for staff training due to making the amount uniform for each staff in the department;
- The operating increases have a total increase of $37,857 of general fund.

Grants increased by $5,534,394 primarily based on the following:

- Inflationary increases of 3% each year for providers for a total of $265,241;
- An increase of $201,203 to continue an eight bed short term substance abuse residential facility that was established in August 2010 based upon need;
- $498,502 for an additional 24 hour contracted staff program coverage for the Cooper Apartments to ensure safety;
- $939,159 for a 15 bed substance abuse residential facility;
- $25,000 for peer support services at the Recovery Center
- A decrease of $206,339 in the medical detox contract due to the discontinuance of medical detox services for the chemically dependent population by the provider;
- $384,000 for continuing a supported employment project for individuals with mental illness;
- $3,431,017 for the increased need of inpatient hospital services for indigent HSC clients across the State. One contract for all human service centers will apply a uniform Medical Assistance equivalent rate and consistent contract specifications for all providers of the hospital service;
- These grant line increases/decreases account for $4,570,994 of general funds.

- General fund was also increased by $1,421,236 due to decreased collections and a decrease in the federal medical assistance percentage (FMAP).

In summary, the general fund request increased by $7,950,684 with 24% of that increase ($1,928,425) related to the Governor's salary package for State employees and other salary increases. The grants line accounts for $4,570,994 of the increase which is 57% of the increase. The remaining increase of $1,451,265 is associated with the increase in the operating changes and the loss of federal and other funds described above.

South Central Human Service Center (SCHSC)

SCHSC provides community services to individuals who live in Foster, Wells, Griggs, Barnes, Stutsman, LaMoure, Dickey, McIntosh and Logan counties. This region is comprised of 54,506 residents (8.4% of the state's population) as estimated by the 2009 U.S. Census Bureau and covers 10,441 square miles.

Caseload / Customer Base

- SCHSC continues to provide clinical services in Valley City, Oakes, Carrington, Cooperstown, LaMoure, Wishek and Fessenden. In addition, clinicians who work with individuals with serious mental illness, vocational rehabilitation needs and developmental disabilities travel to each of the nine counties in Region VI providing services.
- SCHSC provided behavioral health services to 3,074 individuals in SFY 2010 (2,313 adults and 761 children received services). This total includes 612 individuals within the developmental disabilities

(DD) service area. This represents close to a four percent overall increase in numbers served from last biennium.

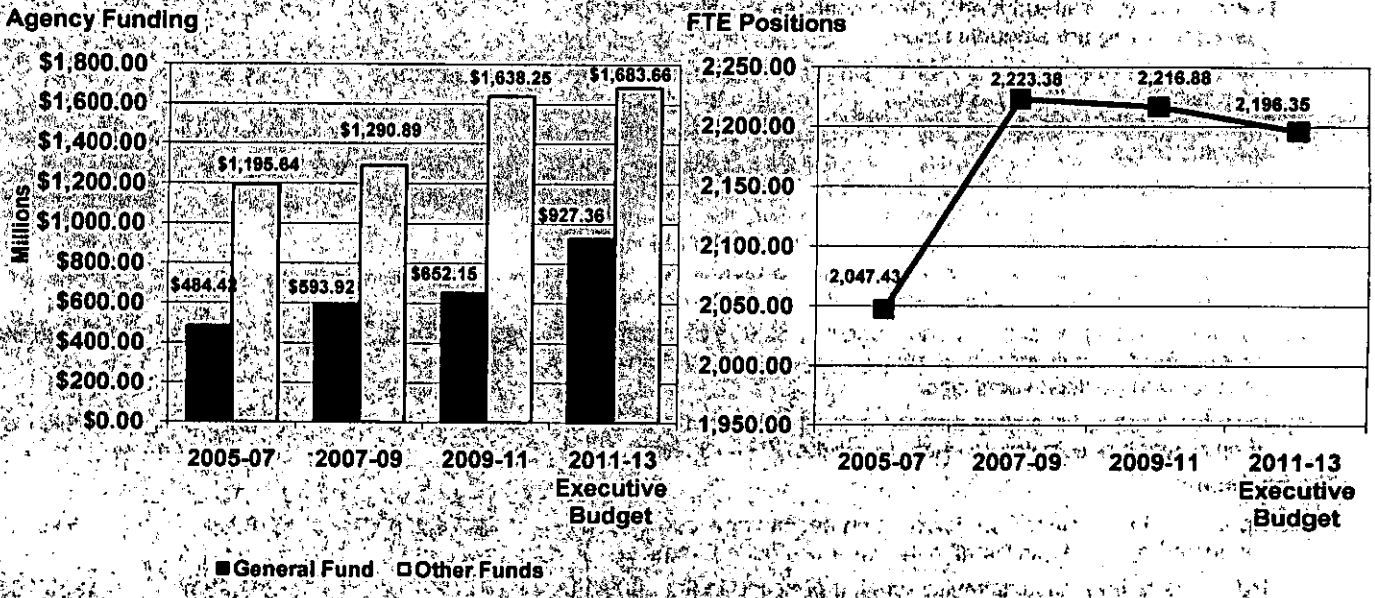
- In addition, 685 individuals received Vocational Rehabilitation Services and 124 individuals received Older Blind Services.
- Twenty-seven percent of those receiving services had no insurance. Forty-eight percent are covered by Medicare, Medicaid or other public payers.
- SCHSC has the only full-time community psychiatrist in Region VI.
- SCHSC accounted for 30% of the total admissions to the North Dakota State Hospital (NDSH) in FY 2010, averaging about 24 individuals hospitalized per month. As Region VI has no private inpatient mental health treatment facility, the NDSH is utilized for acute inpatient needs as well as for longer term hospitalization needs. Individuals from Region VI also access out-of-region private psychiatric hospitals.
- Admissions to the crisis residential unit for the past two years averaged 168 individuals per year with 66% of those admissions occurring outside of normal work hours.
- Requests for emergency service interventions continued to remain constant with SCHSC providing 510 emergent interventions in SFY 2010, which is the highest number in the State.
- Twelve percent of North Dakota's reported adult abuse and neglect incidents during FFY 2010 occurred within Region VI.
- SCHSC's Family Caregiver Support Program has consistently served the largest number of caregivers in the state, with an active caseload of 43 individuals. SCHSC utilizes both in-home and inpatient respite for our caregivers. The Family Caregiver Support Program allows families to delay transitioning of a

Prepared by the North Dakota Legislative Council staff for House Appropriations
March 2, 2011

Department 325 - Department of Human Services
Senate Bill No. 2012

	FTE Positions	General Fund	Other Funds	Total
2011-13 Executive Budget	2,196.35	$927,363,658	$1,683,661,250	$2,611,024,908
2009-11 Legislative Appropriations	2,216.88	652,145,814	1,638,250,137	2,290,395,951[1]
Increase (Decrease)	(20.53)	$275,217,844	$45,411,113	$320,628,957

[1]The 2009-11 appropriation amounts include $2.65 million, $1.5 million of which is from the general fund, for the agency's share of the $16 million funding pool appropriated to the Office of Management and Budget for special market equity adjustments for executive branch employees. The 2009-11 appropriation amounts do not include $31,704,000, of which $2,465,760 is from the general fund for carryover from the 2007-09 biennium and $11,264,771 of additional special funds authority resulting from Emergency Commission action during the 2009-11 biennium.



Ongoing and One-Time General Fund Appropriations

	Ongoing General Fund Appropriation	One-Time General Fund Appropriation	Total General Fund Appropriation
2011-13 Executive Budget	$925,563,658	$1,800,000	$927,363,658
2009-11 Legislative Appropriations	647,849,516	4,296,298	652,145,814
Increase (Decrease)	$277,714,142	($2,496,298)	$275,217,844

First House Action

Attached is a summary of first house changes.

Executive Budget Highlights (With First House Changes in Bold)

	General Fund	Other Funds	Total
Departmentwide			
1. Reflects the additional state matching funds required due to changes in the state's federal medical assistance percentage (FMAP). The FMAP determines the federal and state share of Medicaid, foster care, and other program expenditures. North Dakota's FMAP is decreasing from 60.35 percent in federal fiscal year 2011 to 55.40 percent in federal fiscal year 2012. The department anticipates North Dakota's FMAP to remain at 55.40 percent for federal fiscal year 2013. These changes are also reflected in selected program amounts below.	$104,887,387	($104,904,779)	($17,392)
2. Replaces federal fiscal stimulus funding relating to FMAP and child support enforcement appropriated for the 2009-11 biennium with funding from the general fund and removes other	$69,307,001	($99,095,205)	($29,788,204)

federal fiscal stimulus funding provided in the 2009-11 biennium. These changes are also reflected in selected program amounts below.			
3. Provides a 3 percent per year inflationary increase for human service providers. The 2009 Legislative Assembly approved a 6 percent inflationary increase for the second year of the 2009-11 biennium for rebased services (hospitals, physicians, chiropractors, and ambulances) and dentists and a 6 percent per year inflationary increase for providers of other services.	$25,516,808	$28,757,382	$54,274,190
4. Changes the funding source for medical services and long-term care services from the Bank of North Dakota loan proceeds in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$8,500,000	($8,500,000)	$0
5. Changes the funding source for breast and cervical cancer assistance from the community health trust fund in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$790,015	($790,015)	$0
6. Changes the funding source for nursing facility payments from the health care trust fund in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$4,124,506	($4,124,506)	$0
7. Removes funding from the general fund for medical services and long-term care program expenditures and allows the department to continue general fund appropriations for the 2009-11 biennium and utilize unexpended funds in the 2011-13 biennium. These changes are also reflected in selected program amounts below.	($12,800,000)		($12,800,000)
8. Reduces funding for salaries and wages by $2,935,680 from the general fund in anticipation of savings resulting from employee turnover and position vacancies.	($2,935,680)	$0	($2,935,680)
9. Includes funding for paying accrued annual leave and sick leave of employees anticipated to retire during the 2011-13 biennium.	$186,370	$305,094	$491,464
Management			
1. Adds 4 FTE positions in information technology services as requested by the department in its hold-even budget request.	$171,236	$283,803	$455,039
2. Removes federal fiscal stimulus funding provided in the 2009-11 biennium.		($307,000)	($307,000)
3. Adjusts funding for program and cost changes (detailed changes not identified).	$3,811,984	$11,591,551	$15,403,535
4. Adds funding for telepharmacy equipment over $5,000.		$138,400	$138,400
Program and Policy			
1. Provides $4,990,361, of which $3,025,754 is from the general fund and $1,964,607 is from retained funds, for **Indian county payments**.	$1,066,213	($99)	$1,066,114
2. Reduces funding for temporary assistance for needy families (TANF) costs to $16,739,250, of which $5,531,958 is from the general fund and $5,785,053 is from retained funds. The funding level is anticipated to provide services for an average monthly caseload of 2,253 and to provide an average payment of $309.57 per case.		($7,668,672)	($7,668,672)
3. Provides $20,554,852, of which $252,686 is from the general fund, $6,894,858 is from retained funds, and the remainder from federal funds, for **child care grants**. The change reflects a decrease of $97,511 from the general fund, an increase of $631,497 in retained funds, and a decrease of $2,338,968 in federal funds.	($97,511)	($1,707,471)	($1,804,982)
4. Increases federal funding for supplemental nutrition assistance program (SNAP) or **food stamp** benefits to provide a total of $241,942,496.		$30,506,121	$30,506,121
5. Decreases funding for the low-income home energy assistance program (LIHEAP) to provide a total of $39,436,277.		($13,126,445)	($13,126,445)

6. Provides $632,712,356, of which $200,203,906 is from the general fund, for **medical assistance grants** in the medical services program compared to $491,365,038 provided for the 2009-11 biennium, of which $119,205,576 was from the general fund. Major components of the additional funding are listed below:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$15,043,064	$116,988,725	$132,031,789
Adds additional general fund support as a result of FMAP changes	$35,291,452	($35,291,452)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$21,302,590	($21,302,590)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$3,954,780	$5,360,749	$9,315,529
7. Increases funding for **Healthy Steps** (children's health insurance program) to provide a total of $27,990,521, of which $8,661,586 is from the general fund, to provide health insurance coverage for an average of 4,256 children at a monthly premium of $274.03. The executive budget recommends maintaining eligibility requirements for the program at 160 percent of the federal poverty level based on net income. **The Senate added funding of $1,834,357, of which $567,367 is from the general fund, for increasing the eligibility for Healthy Steps from 160 percent to 175 percent of the federal poverty level. A section was added to the bill to provide for the related statutory change.**	$3,062,787	$3,295,198	$6,357,985
8. Includes $26,307,479, of which $25,152,575 is from the general fund and $1,154,904 is from estate collections, for making Medicare Part D prescription drug **"clawback" payments** to the federal government for the estimated prescription drug costs paid by Medicare for individuals eligible for both Medicare and Medicaid. The amount provided is an increase of $6,891,217 from the 2009-11 biennium appropriation of $19,416,262, of which $18,624,262 was from the general fund.	$6,528,313	$362,904	$6,891,217
9. Provides $459,123,033, of which $195,559,601 is from the general fund, for **nursing facility care** under the long-term care program compared to $425,713,210, of which $132,267,271 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are listed below:			
Changes the funding source from Bank of North Dakota loan proceeds in the 2009-11 biennium to the general fund	$2,692,917	($2,692,917)	$0
Changes the funding source from the health care trust fund in the 2009-11 biennium to the general fund	$4,124,506	($4,124,506)	$0
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$11,920,336	$23,364,899	$35,285,235
Adds general fund support as a result of FMAP changes	$32,078,542	($32,078,542)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$20,409,761	($20,409,761)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers and a portion of a $12.8 million general fund reduction relating to authorizing 2009-11 carryover funding in the 2011-13 biennium	($7,933,732)	$6,058,320	($1,875,412)
10. Provides $25,972,395, of which $14,812,502 is from the general fund, for **basic care services** compared to $18,113,925, of which $8,219,552 was from the general fund, for the 2009-11 biennium. Major components of the additional funding are listed below:			

Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$4,146,608	$2,575,848	$6,722,456
Adds general fund support as a result of FMAP changes	$1,169,030	($1,169,030)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$524,151	($524,151)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$753,161	$382,853	$1,136,014

11. Decreases funding for service payments for elderly and disabled (SPED) and **expanded SPED** to $14,759,712, of which $14,070,562 is from the general fund, compared to the 2009-11 biennium appropriation of $18,221,905, of which $17,347,138 was from the general fund. Major changes include:

Reduces funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	($3,890,633)	($215,669)	($4,106,302)
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$614,057	$30,052	$644,109

12. Increases funding for the **home and community-based care waiver** to $10,268,386, of which $4,538,744 is from the general fund, compared to the 2009-11 biennium appropriation of $8,707,606, of which $2,831,505 was from the general fund. Major changes include:

Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$352,436	$757,866	$1,110,302
Adds general fund support as a result of FMAP changes	$690,477	($690,477)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$464,566	($464,566)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$199,760	$250,718	$450,478

13. Decreases funding for **targeted case management** to $1,564,749, of which $690,422 is from the general fund, compared to the 2009-11 biennium appropriation of $1,957,896, of which $641,694 was from the general fund. Major changes include:

Reduces funding for cost and caseload/utilization changes including the cost to continue inflationary increases provided in the 2009-11 biennium	($152,133)	($309,333)	($461,466)
Adds general fund support as a result of FMAP changes	$74,544	($74,544)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$96,026	($96,026)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$30,291	$38,028	$68,319

14. Increases funding for the **personal care option** to $29,149,905, of which $12,886,305 is from the general fund, compared to the 2009-11 biennium appropriation of $25,044,599, of which $8,214,016 was from the general fund. Major changes include:

Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$893,104	$1,937,517	$2,830,621
Adds general fund support as a result of FMAP changes	$2,057,413	($2,057,413)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$1,156,599	($1,156,599)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$565,173	$709,512	$1,274,685

15. Provides $396,996,033, of which $174,231,307, is from the general fund, for **developmental disabilities services** under the long-term care program compared to $341,542,546, of which $110,730,341 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$13,015,970	$25,476,514	$38,492,484
Adds general fund support as a result of FMAP changes	$36,993,542	($36,993,542)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$23,091,088	($23,091,088)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$7,475,018	$9,503,377	$16,978,395
The Senate added funding of $11,364,049, of which $5,021,489 is from the general fund, for a supplemental payment to developmental disabilities providers to allow for a 50-cent per hour salary and benefit increase for employees beginning July 1, 2011.			
16. Provides $66,850,710, of which $12,122,010 is from the general fund, for **foster care services** compared to $58,089,459, of which $6,961,934 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$1,703,728	$4,119,388	$5,823,116
Adds general fund support as a result of FMAP changes	$455,959	($455,959)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$1,683,112	($1,683,112)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$1,666,421	$1,271,714	$2,938,135
17. Provides $20,208,724, of which $9,159,965 is from the general fund, for **subsidized adoption** compared to the 2009-11 biennium appropriation of $17,847,086, of which $7,003,216 was from the general fund.	$2,156,749	$204,889	$2,361,638
18. Provides funding and 7 FTE positions to perform functions necessary to comply with the provisions of federal health care reform.	$225,507	$305,588	$531,095
19. Adds funding for a grant to the Silver Haired Legislative Assembly. **The Senate removed this funding.**	$10,000		$10,000
20. Increases funding for senior service providers to assist with the costs of providing meals to the elderly.	$300,000		$300,000
21. Provides one-time federal funding for completion of vocational rehabilitation training and information technology contracts funded with federal fiscal stimulus funds in the 2011-13 biennium.		$519,175	$519,715
22. Adds 1 FTE position in medical services as requested by the department in its hold-even budget request.	$19,668	$61,236	$80,904
23. Adds 6 FTE positions in mental health and substance abuse as requested by the department in its hold-even budget request.	$23,730	$861,666	$885,396
State Hospital			
1. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund.	$337,029	($337,029)	$0
2. Reflects the additional state matching funds required due to changes in the state's FMAP.	$97,624	($97,624)	$0
3. Adds 1 FTE pharmacist position.	$190,305	$45,105	$235,410

4. Adjusts funding for program, cost, and caseload/utilization changes	$3,341,627	($2,696,650)	$644,977
5. Provides ongoing funding for extraordinary repairs	$733,650		$733,650
6. Provides one-time funding for capital projects. **The Senate increased funding for capital projects by $161,840, from $1,800,000 to $1,961,840.**	$1,800,000		$1,800,000
7. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($246,220)		($246,220)
8. Removes funding provided in the 2009-11 biennium for bond payments (The bonds were paid in full in the 2009-11 biennium.)	($437,729)		($437,729)
9. Removes one-time funding provided in the 2009-11 biennium for extraordinary repairs (The amount shown does not reflect extraordinary repair carryover funding from the 2007-09 biennium.)	($2,731,017)		($2,731,017)
Developmental Center			
1. Deletes 40.53 FTE positions not requested by the department for the Developmental Center	($1,448,609)		($1,448,609)
2. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$2,531,825	($2,531,825)	$0
3. Reflects the additional state matching funds required due to changes in the state's FMAP	$1,899,418	($1,899,418)	$0
4. Adjusts funding for program, cost, and caseload/utilization changes	($1,836,244)	$1,856,344	$20,100
5. Provides ongoing funding for extraordinary repairs	$579,469		$579,469
6. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($75,000)		($75,000)
7. Removes funding provided in the 2009-11 biennium for bond payments (The bonds were paid in full in the 2009-11 biennium.)	($501,657)		($501,657)
8. Removes one-time funding provided in the 2009-11 biennium for extraordinary repairs (The amount shown does not reflect extraordinary repair carryover funding from the 2007-09 biennium.)	($712,675)		($712,675)
Human Service Centers			
1. Adds 1 FTE position at the North Central Human Service Center as requested by the department in its hold-even budget request	$284,474	$148,977	$433,451
2. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($26,966)	($28,534)	($55,500)
3. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$2,513,432	($2,513,432)	$0
4. Reflects the additional state matching funds required due to changes in the state's FMAP	$1,372,441	($1,372,441)	$0
5. Adjusts funding for program, cost, and caseload/utilization changes	$2,131,783	($1,675,992)	$455,791
6. Provides ongoing funding for extraordinary repairs	$35,671		$35,671
7. Provides funding for equipment over $5,000	$34,372	$4,628	$39,000
8. Provides for inflationary increases of 3 percent for each year of the 2011-13 biennium	$1,093,928	$147,348	$1,241,276
9. Provides funding for contracting for beds in a crisis stabilization unit for the seriously mental ill (North Central Human Service Center)	$1,444,661		$1,444,661
10. Provides funding for increasing psychiatric inpatient hospitalization contract rates at the human service centers	$3,431,017		$3,431,017
11. Provides funding for contracting for chemical dependency residential services (Southeast Human Service Center)	$939,159		$939,159

12. Provides funding for expanding residential adult crisis bed capacity from 10 beds to 14 beds (West Central Human Service Center)	$309,128		$309,128
13. Provides funding for leasing a new office facility for nonvocational rehabilitation operations (Badlands Human Service Center)	$174,110	$16,105	$190,215

Other Sections in Bill

Transfers - Section 3 provides that the Department of Human Services may transfer appropriation authority between line items within each subdivision and between subdivisions for the 2011-13 biennium. The department is to report to the Budget Section after June 30, 2012, on any transfers made in excess of $50,000 and to the Appropriations Committees of the 63rd Legislative Assembly any transfers made.

Medicaid management information system replacement project - Section 4 provides for the continuation of the 2007-09 legislative appropriation for the Medicaid management information system replacement project in the 2011-13 biennium.

Continuation of appropriation authority - Section 5 provides for the continuation of the department's unexpended 2009-11 general fund appropriation authority to the 2011-13 biennium. The continued funding is to be used for medical assistance grants during the 2011-13 biennium. The department estimates $12.8 million of funding from the general fund will be unexpended on June 30, 2011.

Office space lease limitation - Section 6 provides that the department may not expend more than $12.50 per square foot per year for leasing office space in the Prairie Hills Plaza in Bismarck in the 2011-13 biennium.

FTE positions - Section 8 provides legislative intent that the department only fill the 7 new FTE positions relating to implementing federal health care reform after receiving applicable rules from the federal Department of Health and Human Services.

Continuing Appropriations

Child support collection and disbursement - North Dakota Century Code Section 14-09-25 - Allows the department to receive child support payments and provide the funds to the custodial parent or appropriate governmental entity for those custodial parents receiving governmental assistance.

Child support improvement account - Section 50-09-15.1 - Allows the department to receive federal child support incentive funds and spend the funds in accordance with its business plan to improve the child support collection process.

Child support cooperative agreements - Section 50-09-33 - Allows the department to accept federal funds and other income generated by the department under a cooperative agreement with an Indian tribe for child support enforcement services for hiring staff and payment of other expenses as necessary for carrying out the department's duties under the agreement.

Significant Audit Findings

There were no significant audit findings for the department.

Major Related Legislation

House Bill No. 1040 extends the moratorium on the state's licensed basic care bed capacity and the state's nursing facility bed capacity from July 31, 2011, to July 31, 2013.

House Bill No. 1152 appropriates $3,454,061, of which $1,527,802 is from the general fund, for supplemental payments to critical access hospitals.

House Bill No. 1169 increases the allowable annual education expenditures used in nursing home rates.

House Bill No. 1199 provides that the Legislative Management is to contract with a consultant to study guardianship services for vulnerable adults in the state.

House Bill No. 1320 allows a deduction from income claimed for medical assistance eligibility for real estate taxes paid on rental property for individuals screened as requiring nursing home care.

House Bill No. 1325 extends the moratorium on the state's licensed basic care bed capacity and the state's nursing facility bed capacity from July 31, 2011, to July 31, 2013, and creates a 24-month bed layaway program for up to 25 percent of a nursing facility's bed.

House Bill No. 1373 provides a $1 million general fund appropriation to the department for grants to federally designated Head Start programs.

House Bill No. 1395 requires the department to establish a substance abuse services pilot voucher payment program.

Senate Bill No. 2043 provides that the Department of Human Services is to implement a prospective or related payment system rate model for developmental disabilities service providers.

Senate Bill No. 2075 relates to excess assets in pre-need funeral service contracts.

Senate Bill No. 2121 repeals Chapter 6-09.6 relating to the developmentally disabled facility loan program and transfers the remaining loans in the program to the Bank of North Dakota.

Senate Bill No. 2163 appropriates $110,000 from the general fund to the department for traumatic brain injury services.

Senate Bill No. 2192 relates to foster care services.

Senate Bill No. 2242 increases funding in the senior citizen services and programs fund.

Senate Bill No. 2298 relates to the establishment of early childhood services inclusion support services and a grant program for licensed early childhood services providers who care for children with special needs.

ATTACH 1

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Funding Summary

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Salaries and wages	$16,513,336		$16,513,336
Operating expenses	62,408,138		62,408,138
Capital assets	138,400		138,400
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
FTE	116.10	0.00	116.10
DHS - Program/Policy			
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50
DHS - State Hospital			
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51
DHS - Developmental Center			
Developmental Center	$51,809,247		$51,809,247
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
FTE	400.76	0.00	400.76
DHS - Northwest HSC			
Northwest Human Service Center	$8,749,068		$8,749,068
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
FTE	45.75	0.00	45.75
DHS - North Central HSC			
North Central Human Service Center	$22,433,884		$22,433,884
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
FTE	117.78	0.00	117.78
DHS - Lake Region HSC			
Lake Region Human Service Center	$11,418,231		$11,418,231

Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
FTE	60.00	0.00	60.00
DHS - Northeast HSC			
Northeast Human Service Center	$28,182,609		$28,182,609
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
FTE	138.30	0.00	138.30
DHS - Southeast HSC			
Southeast Human Service Center	$38,464,720		$38,464,720
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
FTE	182.15	0.00	182.15
DHS - South Central HSC			
South Central Human Service Center	$16,953,699		$16,953,699
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
FTE	85.50	0.00	85.50
DHS - West Central HSC			
West Central Human Service Center	$26,740,493		$26,740,493
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
FTE	135.30	0.00	135.30
DHS - Badlands HSC			
Badlands Human Service Center	$11,789,654		$11,789,654
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
FTE	72.70	0.00	72.70
Bill Total			
Total all funds	$2,611,024,908	$13,350,246	$2,624,375,154
Less estimated income	1,683,661,250	7,609,550	1,691,270,800
General fund	$927,363,658	$5,740,696	$933,104,354
FTE	2196.35	0.00	2196.35

Senate Bill No. 2012 - DHS - Management - Senate Action

Other changes affecting Management programs or multiple programs of the department:

A section of legislative intent is added regarding office space leases.

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	374.50	$731,469,093	$1,510,481,136	$2,241,950,229
Program and Policy - Senate changes:				
Economic Assistance Policy Program				
No changes		$0	$0	$0
Child Support Program				
No changes		0	0	0
Medical Services Program				
Add funding relating to increase in eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		567,367	1,266,990	1,834,357
Long-Term Care Program				
Add funding for a supplemental payment to developmental disabilities providers to allow for a 50-cent salary and benefit increase for employees beginning July 1, 2011		5,021,489	6,342,560	11,364,049
Aging Services Program				
Remove funding added in the executive budget for a grant to the Silver Haired Legislative Assembly		(10,000)	0	(10,000)
Children and Family Services Program				
No changes		0	0	0
Mental Health and Substance Abuse Program				
No changes		0	0	0
Developmental Disabilities Council				
No changes		0	0	0
Developmental Disabilities Division				
No changes		0	0	0
Vocational Rehabilitation				

No changes	0	0	0
Total Senate changes - Program and Policy	0.00	$5,578,856	$7,609,550	$13,188,406
Senate version - Program and policy subdivision	374.50	$737,047,949	$1,518,090,686	$2,255,138,635

Other changes affecting Program and Policy programs:

Adds a section of legislative intent that the 7 new FTE positions included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Senate Bill No. 2012 - DHS - State Hospital - Senate Action

	Executive Budget	Senate Changes	Senate Version
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	467.51	$53,326,797	$20,146,403	$73,473,200
State Hospital - Senate changes:				
Add funding for extraordinary repairs to provide a total of $1,961,840 from the general fund		$161,840	$0	$161,840
Total Senate changes - State Hospital	0.00	$161,840	$0	$161,840
Senate version - State Hospital	467.51	$53,488,637	$20,146,403	$73,635,040

Senate Bill No. 2012 - DHS - Developmental Center - Senate Action

The Senate did not change the executive recommendation for the Developmental Center.

Senate Bill No. 2012 - DHS - Human Service Centers - Senate Action

The Senate did not change the executive recommendation for the human service centers.

11.8152.01007
Title.02000
Fiscal No. 5

Prepared by the Legislative Council staff for
Senator Fischer
February 21, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2012

Page 1, line 2, remove "and"

Page 1, line 2, after "exemption" insert "; to provide legislative intent; and to amend and reenact section 50-29-04 of the North Dakota Century Code, relating to eligibility for the children's health insurance program"

Page 1, replace line 24 with:

"Salaries and wages	$41,389,716	$8,956,495	$50,346,211"

Page 2, replace lines 3 through 7 with:

"Grants	452,990,742	34,015,295	487,006,037
Grants - Medical assistance	1,300,642,323	326,293,701	1,626,936,024
Total all funds	$1,870,492,778	$384,645,857	$2,255,138,635
Less estimated income	1,381,801,240	136,289,446	1,518,090,686
Total general fund	$488,691,538	$248,356,411	$737,047,949"

Page 2, replace line 20 with:

"State hospital	65,641,609	7,993,431	73,635,040"

Page 2, replace line 22 with:

"Total all funds	$264,143,530	$26,033,115	$290,176,645"

Page 2, replace line 24 with:

"Total general fund	$131,355,655	$33,179,288	$164,534,943"

Page 2, replace lines 29 through 31 with:

"Grand total general fund	$646,349,516	$286,754,838	$933,104,354
Grand total special funds	1,549,066,932	142,203,868	1,691,270,800
Grand total all funds	$2,195,416,448	$428,958,706	$2,624,375,154"

Page 3, replace lines 12 and 13 with:

"State hospital capital projects		0	1,961,840
Total all funds		$92,329,503	$2,481,015"

Page 3, replace line 15 with:

"Total general fund		$4,296,298	$1,961,840"

Page 4, after line 7, insert:

"**SECTION 6. OFFICE SPACE LEASE LIMITATION.** The department of human services may not expend more than twelve dollars and fifty cents per square foot per year for leasing office space in the prairie hills plaza in Bismarck for the biennium beginning July 1, 2011, and ending June 30, 2013.

SECTION 7. SUPPLEMENTAL PAYMENTS - DEVELOPMENTAL DISABILITIES SERVICE PROVIDER SALARY AND BENEFIT INCREASES. The funding appropriated in subdivision 2 of section 1 of this Act includes $11,364,049, of which $5,021,489 is from the general fund and $6,342,560 is from federal funds, for providing supplemental payments to developmental disabilities service providers to allow for a salary and benefit increase for employees beginning July 1, 2011.

SECTION 8. LEGISLATIVE INTENT - FULL-TIME EQUIVALENT POSITIONS. It is the intent of the sixty-second legislative assembly that the department of human services only fill the seven new full-time equivalent positions authorized by the legislative assembly for the 2011-13 biennium relating to implementing federal health care reform after receiving applicable rules from the federal department of health and human services.

SECTION 9. AMENDMENT. Section 50-29-04 of the North Dakota Century Code is amended and reenacted as follows:

50-29-04. Plan requirements.

The plan:

1. Must be provided through private contracts with insurance carriers;
2. Must allow conversion to another health insurance policy;
3. Must be based on an actuarial equivalent of a benchmark plan;
4. Must incorporate every state-required waiver approved by the federal government;
5. Must include community-based eligibility outreach services; and
6. Must provide:
   a. A net income eligibility limit of one hundred ~~sixty~~seventy-five percent of the poverty line;
   b. A copayment requirement for each pharmaceutical prescription and for each emergency room visit;
   c. A deductible for each inpatient hospital visit;
   d. Coverage for:
      (1) Inpatient hospital, medical, and surgical services;
      (2) Outpatient hospital and medical services;
      (3) Psychiatric and substance abuse services;

(4) Prescription medications;

(5) Preventive screening services;

(6) Preventive dental and vision services; and

(7) Prenatal services; and

e. A coverage effective date that is the first day of the month, following the date of application and determination of eligibility."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of Senate Action

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
DHS - Program/Policy			
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
DHS - State Hospital			
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
DHS - Developmental Center			
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
DHS - Northwest HSC			
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
DHS - North Central HSC			
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC			
Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
DHS - Northeast HSC			
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
DHS - Southeast HSC			

Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
DHS - South Central HSC			
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
DHS - West Central HSC			
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
DHS - Badlands HSC			
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
Bill total			
Total all funds	$2,611,024,908	$13,350,246	$2,624,375,154
Less estimated income	1,683,661,250	7,609,550	1,691,270,800
General fund	$927,363,658	$5,740,696	$933,104,354

Senate Bill No. 2012 - DHS - Management - Senate Action

Other changes affecting management programs or multiple programs of the department:
A section of legislative intent is added regarding office space leases.

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
	$2,241,950,229	$13,188,406	$2,255,138,635
Total all funds	1,510,481,136	7,609,550	1,518,090,686
Less estimated income			
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50

[1]

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	374.50	$731,469,093	$1,510,481,136	$2,241,950,229
Program and Policy - Senate changes:				
Economic Assistance Policy Program				
No changes			$0	

Child Support Program			
No changes		0	
Medical Services Program			
Add funding relating to increase in eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level	567,367	1,266,990	1,834,357
Long-Term Care Program			
Add funding for a supplemental payment to developmental disabilities providers to allow for a 50-cent salary and benefit increase for employees beginning July 1, 2011	5,021,489	6,342,560	11,364,049
Aging Services Program			
Remove funding added in the executive budget for a grant to the Silver Haired Legislative Assembly	(10,000)	0	(10,000)
Children and Family Services Program			
No changes		0	
Mental Health and Substance Abuse Program			
No changes		0	
Developmental Disabilities Council			
No changes		0	
Developmental Disabilities Division			
No changes		0	
Vocational Rehabilitation			
No changes		0	
Total Senate changes - Program and Policy	0.00	$5,578,856	$7,609,550	$13,188,406
Senate version - Program and policy subdivision	374.50	$737,047,949	$1,518,090,686	$2,255,138,635

Other changes affecting program and policy programs:

Adds a section of legislative intent that the 7 new FTE positions included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Senate Bill No. 2012 - DHS - State Hospital - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51

1

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	467.51	$53,326,797	$20,146,403	$73,473,200
State Hospital - Senate changes:				
Add funding for extraordinary repairs to provide a total of $1,961,840 from the general fund		$161,840	$0	$161,840
Total Senate changes - State Hospital	0.00	$161,840	$0	$161,840
Senate version - State Hospital	467.51	$53,488,637	$20,146,403	$73,635,040

11.8152.02002
Title.

Prepared by the Legislative Council staff for
Senator Mathern
February 22, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	328,874,163	1,629,516,486
Total all funds	$1,870,492,778	$387,226,319	$2,257,719,097
Less estimated income	1,381,801,240	138,299,755	1,520,100,995
Total general fund	$488,691,538	$248,926,564	$737,618,102"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$287,324,991	$933,674,507
Grand total special funds	1,549,066,932	144,214,177	1,693,281,109
Grand total all funds	$2,195,416,448	$431,539,168	$2,626,955,616"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment adds funding of $2,580,462, of which $570,153 is from the general fund, $570,153 is from special funds, and $1,440,156 is from federal funds, for a competitive institution for mental disease demonstration grant available through federal health care reform.

SB 2012
March 2, 2011
Attachment 1

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations Committee
Representative Delzer, Chairman
March 2, 2011

Chairman Delzer, members of the House Appropriations Committee, I am Carol Olson, Executive Director of the North Dakota Department of Human Services. Thank you for the opportunity to introduce the Department's budget request for the 2011-2013 biennium. Brenda Weisz, the Chief Financial Officer for the Department will cover the changes made by the Senate.

The Department's budget request is $2.6 billion total, which is a $277.7 million increase in total funds (11.9% increase)

- $927.4 million general funds
  - $272.8 million general fund increase (41.67% increase)
- $1.57 billion federal funds
- $114 million other funds

- *2009-2011 Biennium Budget History*
  - *$2.3 billion budget total*
    - *$654.6 million general funds*
    - *$1.56 billion federal funds*
    - *$118 million other funds*

This budget also includes a reduction in 20.5 Full Time Equivalents (FTE).

The significant general fund increase ($272.8 million) is due to these

reasons:

- The **decrease in the Federal Medical Assistance Percentage** (federal match rate for Medicaid that is referred to as FMAP) = $171.4 million,
- **Cost and caseload increases in major grant areas** (especially Medicaid) = $46 million,
- Annual **inflationary increases of 3% for Medicaid providers and other providers** during the biennium = $25.5 million, and
- The **cost to continue the employee second-year salary increase** from the 2009-2011 biennium = $3.8 million.

While the FMAP has fallen, the Medicaid caseload and health care costs and utilization in general have gone up, which compounds the Medicaid funding situation. Together, these areas represent about 80% of the general fund increase in the Department's budget.

I would like to expand on the cost and caseload growth in the major grants area, which again is responsible for a $46 million increase in general funds. Most of this grant area increase is in Medicaid – the federal and state funded health coverage program for qualifying individuals – and much of it is in the Traditional Medicaid Grants area of the budget.

These funds go to thousands of health care providers and other providers of covered services. Without Medicaid, many of these services could be uncompensated.

These services include inpatient hospital care, outpatient surgery, clinic visits, prescription medications, and other health-related services.

Traditional Medicaid grants also pay for preventive health screenings of children.

Caseload and utilization increases are also driving up costs in the long-term care area of Department's budget. This area includes support services that help the elderly and people with developmental and other disabilities to remain living in their homes and community settings, as well as 24-hour skilled nursing home care. Medicaid pays for the care of about half of the nursing facility residents in North Dakota.

Medicaid supports the quality of life of thousands of individuals who rely on Medicaid-funded services. It also compensates thousands of doctors, dentists, chiropractors, therapists, and ambulance service providers.

In this budget, there is only one significant policy change. This budget includes a **$6.1 million increase for behavioral health services to address psychiatric inpatient hospitalization** needs in the regions and other capacity concerns. Most of this increase ($3.43 million) is for about 4,900 contracted inpatient psychiatric hospital days to be paid at the Medicaid equivalent rate for regional human service center clients who do not qualify for Medicaid.

The other behavioral health capacity increases are as follows:

- An added 10-bed crisis residential unit in Minot for people with serious mental illness who need emergency shelter and care, but not hospitalization ($1.4 million),
- Expands the adult crisis bed capacity in Bismarck by four additional beds ($309,000),
- A 15-bed long-term residential facility in the Fargo region for people

affected by chronic and serious addiction ($940,000).

I want to stress that aside from the highlighted areas, this budget holds other existing Department programs and services pretty even. Again, most of this budget is passed directly out-the-door to pay for health-related and other services in communities across the state and to provide benefits to qualifying vulnerable North Dakotans.

We take our mission very seriously and strive "to provide quality, efficient, and effective human services, which improve the lives of people." I am very proud of the fact that the Department can perform its responsibilities and also hold the line on administrative costs. For the past three biennia, the Department has held its administrative costs at six percent.

Before I close I would like to provide you with an update on our Medicaid Systems Project. ACS has informed us that they are currently tracking for a completion date of June 1, 2012 and that the project is scheduled to be on budget.

Thank you for this opportunity. Allow me to introduce the Department's Chief Financial Officer, Brenda Weisz who will provide a detailed overview of the Department's 2011-2013 budget.

SB 2012
March 2, 2011
Attachment 2

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations Committee
Representative Delzer, Chairman
March 2, 2011

Chairman Delzer, members of the House Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide an overview of the Department's 2011 – 2013 Executive Budget request included in SB 2012, fiscal related information, along with the Senate amendments to the Executive Budget.

2009 – 2011 Appropriation and Estimated Spending

When comparing the current biennium expenditures in the major program areas to the amount of general fund appropriated, the Department is expecting the following:

- Long Term Care area of the Department's budget (including developmental disability grants) – we are estimating the overall spending to be under budget by $26.9 million in total with $13.2 million of that amount from the general fund. Nursing Facilities and the SPED program are experiencing lower utilization than budgeted while Basic Care services are being utilized in excess of the amounts budgeted.
- Medicaid traditional grants and Healthy Steps – we are estimating the overall shortfall to be $19.6 million in total with a $5.8 million shortfall in general fund. The general fund shortfall in this area is offset by a general fund savings in the Medicare Part D clawback payment of $2.8 million – all from the general fund. The net general fund shortfall amounts to $3.0 million.
- Human Services Centers - we are estimating the overall general fund spending to be under budget by $1.6 million.

- Institutions - we are estimating the overall general fund spending to be under budget by $800,000 at the State Hospital and on budget at the Developmental Center.
- Central Office - we are estimating the overall general fund spending to be under budget by $200,000.

When considering all areas of the budget, the Department is expecting to have an unexpended general fund appropriation of approximately $12.8 million at June 30, 2011. It is this estimated $12.8 million for which an exemption is being made in Section 5 of SB 2012 for the purpose of funding the medical assistance grants portion of our 2011 – 2013 Executive Budget.

Major Policy Changes in Developing the 2011 – 2013 Budget In developing the budget for **Inpatient Hospitalization at the Human Service Centers,** the Department continued contracts for inpatient hospital services for those who are not eligible for Medicaid but are clients of the Department in the following regions: North Central, Northeast, Southeast, West Central and Badlands in the amount of $829,243. The Executive Budget includes an additional $3.43 million for a total budget of $4.26 million. This will allow the Department to provide approximately 4,900 inpatient hospital days across the state to be paid at the Medicaid equivalent rate. The Department also plans to move forward with a centralized contract allowing for consistent contract terms statewide and allowing flexibility for amounts to be moved from region to region based upon need.

Current Budget / Executive Budget / Senate Amendments

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	59,416,844	7,442,703	66,859,547		66,859,547
Operating	124,195,067	29,063,434	153,258,501		153,258,501
Capital Assets	1,206,747	(1,068,347)	138,400		138,400
Capital Construction Carryover	30,234,275	(30,234,275)	0		0
Grants	483,066,261	3,949,776	487,016,037	(10,000)	487,006,037
HSCs and Institutions	270,150,215	19,864,590	290,014,805	161,840	290,176,645
Grants-Medical Assistance	1,365,095,313	248,642,305	1,613,737,618	13,198,406	1,626,936,024
Total	2,333,364,722	277,660,186	2,611,024,908	13,350,246	2,624,375,154
General Funds	654,611,574	272,752,084	927,363,658	5,740,696	933,104,354
Federal Funds	1,560,552,211	8,805,392	1,569,357,603	7,609,550	1,576,967,153
Other Funds	118,200,937	(3,897,290)	114,303,647		114,303,647
[redacted]al	2,333,364,722	277,660,186	2,611,024,908	13,350,246	2,624,375,154
FTE	2,216.88	(20.53)	2,196.35		2,196.35

Explanation of Major Budget Changes - Current Budget to Executive Budget - General Fund Only - Increase of $272.8 million

$171.4 million – increase in state funds as a result of the decrease in the Federal Medical Assistance Percentage (FMAP). First, we need to replace the discontinuation of the enhanced FMAP as a result of the federal stimulus funding. The enhanced FMAP during this time period was 69.95%. This enhanced FMAP was to have expired December 31, 2010, however, as a result of federal legislation it was extended through June 30, 2011 at "stepped down" intervals. For North Dakota those rates are 66.95% for the period of January 2011 – March 2011 and 64.95% for April 2011 – June 2011. Also impacting the FMAP is the per capita

income of North Dakota in relation to other states and the strength of North Dakota's economy compared to that of the Nation. The FMAP rates for the upcoming biennium are as follows:

- FFY 2011 (July 2011 – Sept 2011) 60.35% Final
- FFY 2012 55.40% Final
- FFY 2013 55.40% Estimated

$25.5 million – 3% inflationary increase extended to providers each year of the biennium.

$24.4 million – net cost changes in the grant programs of the Department including traditional Medicaid grants, nursing facilities, developmental disability grants, extended services, home and community based services, child welfare grants, Indian County allocation payments to counties. Changes are the result of several factors such as rate setting rules, federal mandates, continuation of the year two 6% inflationary increase granted during the current biennium, along with costs that cannot be controlled by the Department (drugs, premiums – Medicare and Healthy Steps.)

$21.6 million – net increase in caseload / utilization. The largest impact of change in this area is an increase of $12.2 million in traditional Medicaid grants followed by a $5.6 million increase in the nursing home area.

$16.2 million – to replace with general fund, the other funding sources no longer available as follows: the ability to use child support incentive funds for match as allowed by stimulus legislation ($2.8 million); Bank of North Dakota loan ($8.5 million); Health Care Trust Fund ($4.1); and the use of the Community Health Trust Fund, which was used as match for

the allowable treatment and other medical costs for clients qualifying through the Women's Way Program ($800,000).

$14.3 million – increase ($10.3 million) attributed to the Governor's salary and benefit package, the cost to continue this biennium's year two salary increase ($3.8 million) for just under 2,200 employees; and ($200,000) for the seven Full Time Equivalents (FTE) associated with Health Care Reform.

$6.5 million – increase in the Medicare Part D clawback payment as a result of increased required payments and increased dual eligibles – those eligible for both Medicare and Medicaid.

$6.1 million – increase to address behavioral health needs at the Human Service Centers to 1) allow for consistent payment of psychiatric inpatient hospitalization statewide at the Medicaid equivalent rate for Human Service Center clients who are not eligible for Medicaid ($3.43 million); and 2) address the capacity issues in the Regions by: adding a ten bed crisis residential facility in Minot for those with serious mental illness ($1.44 million); adding four beds to the current ten bed adult crisis residential facility in Bismarck ($300,000); and adding a 15 bed long term residential facility for those with an addiction in Fargo ($940,000).

$3.1 million – to fund extraordinary repairs ($1.3 million) and capital improvements at the State Hospital ($1.8 million).

$2.6 million – increased information technology costs in both the rates charged by the Information Technology Department and ongoing operational costs of the new systems developed under the Medicaid Systems Project.

($7.2) million – decrease in one-time funding for extraordinary repairs, equipment over $5,000 and bond payments ($6.2 million) and funding for the Medicaid Systems Project ($1.0 million).

($12.8) million – reduction to the overall budget submitted by the Department and anticipated amount of general fund turnback at June 30, 2011 as explained earlier in my testimony.

The remaining **$1.1 million** or 0.4% of the general fund increase is tied to miscellaneous net increases throughout the Department, which will be addressed by each division as they present their overview testimony.

FTE Changes

The Executive Budget includes a **net decrease of 20.53 FTE.** As the Department developed its budget we arrived at that reduction incrementally. First, we began with an overall decrease of 40.53 at the Developmental Center resulting from the decreased need of staff as we have transitioned clients to the community. Our current budget was built on a population of 115 clients with a goal of 95 clients by June 30, 2011. As we developed the budget for the 2011 – 2013 biennium, we analyzed the FTE needs Department-wide and within our authorized FTE count we addressed internal needs offsetting this decrease as follows:

- Information Technology Services – we added 1 FTE for Health Information Technology and 3 FTE for individuals who have worked in the Department full time as temporary staff for over four years without benefits on data entry of primarily Medicaid claims.
- Medical Services – we added 1 FTE for the conversion of a claims analyst who has been a temporary employee working for the Department full time over four years without benefits.

- Mental Health / Substance Abuse Division – we added 6 FTE for work that was previously accomplished under contract. The federal funding was moved from the operating line item to the salaries line item for this change.
- NCHSC – we added a staff psychiatrist, who will serve both Northwest Human Service Center and North Central Human Service Center.
- State Hospital – we added a pharmacist to provide telepharmacy services to the eight Human Service Centers, which provide medication monitoring on a routine basis. This will be more efficient than adding a pharmacist at each location.

After our internal work, the Department's budget request submitted to OMB included a net decrease of 27.53 FTE.

The Executive Budget then added seven FTE to address the policy changes that will be needed to implement Health Care Reform. Health Care Reform is scheduled to go into effect January 2014, should there be no changes with this legislation at the federal level. The seven include one FTE each in the area of Economic Assistance Policy and Child Support and the remaining five in Medical Services. The FTE have a staggered employment date ranging from as early as July 1, 2011 to as late as April 1, 2013. This brings the net reduction in FTE to **20.53.**

Key Points in Developing the Budget

Traditional Medicaid Grants – The traditional Medicaid grants budget is built on utilization and cost data by service. However, the utilization is often driven by the number of individuals on the program. The number of eligibles in May 2010, when we began preparing the 2011 – 2013 budget

was 62,257. This compares to 51,308 eligibles in April 2008 when we began preparing our current budget.

Healthy Steps Program – The Executive Budget maintains coverage at 160% of poverty (net). The budget is built on providing coverage to an estimated 4,256 children per month at a monthly premium of $274.03 per child. The premium increase this biennium is 19.82%. The Senate did amend this area of the budget to provide coverage at 175% of poverty (net) which will serve an estimated 445 more children.

Institutions – The Executive Budget for the State Hospital is based on a total capacity of 298 beds. The breakdown by program includes 132 beds for inpatient psychiatric services, 90 beds for the Tompkins Program, and 76 beds for the civilly committed sex offender program. The Executive Budget for the Developmental Center is based on a population of 95 individuals at the Center.

Home and Community Based Services – Please refer to **Attachment A** for a breakdown among Long Term Care services in the Executive Budget with the Senate amendments.

As in past presentations, I have included in **Attachment B**, a breakdown of "Where the Money Goes" in the Executive Budget with the Senate amendments. 84% of the Department's budget goes directly "out the door" to providers or grant recipients. This compares to 83% of the budget for the 2009 – 2011 Legislatively Approved Budget. Another 10% is expended on direct client services at our Human Service Centers and the Institutions, which is down from 11% in the 2009 – 2011 budget. The administrative costs have been held to 6%.

Attachment C provides a one page presentation of our $2.6 billion budget with Senate Amendments. I would like to point out that 62% of this budget is Medicaid and that equates to Health care.

Senate Amendments

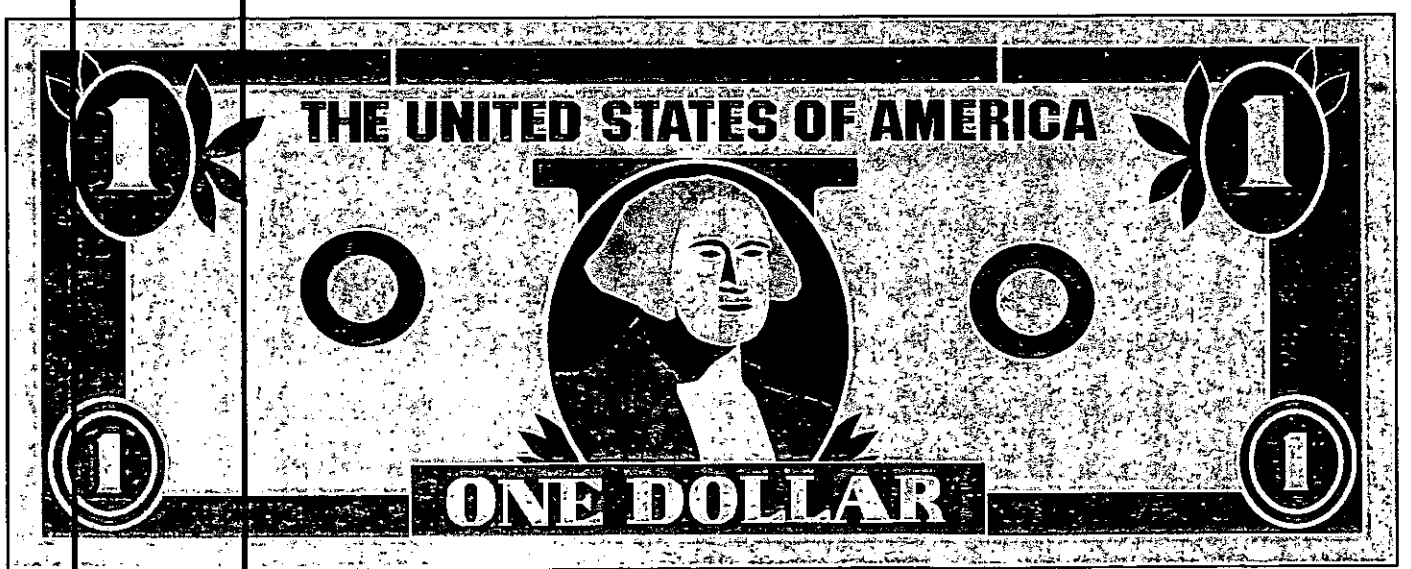
- Removes $10,000 for the Silver Haired Assembly within the Aging Services Division.
- Adds $1.8 million total funds, of which $567,000 is from the general fund to increase the eligibility level for the Healthy Steps program from 160% of poverty (net) to 175%.
- Adds $11.4 million total funds, of which $5.0 million is from the general fund to provide a $.50 per hour wage increase to Developmental Disability Provider staff on July 1, 2011.
- Adds $161,840 to the State Hospital to fully fund the remainder of the OAR request submitted to OMB.
- Includes intent language that the Department may not exceed more than $12.50 per square foot for leasing office space at Prairie Hills Plaza for the 2011 – 2013 biennium.
- Includes intent language that the Department only fill the seven full-time equivalent positions authorized for implementing federal health care reform after receiving applicable rules from the federal department of Health and Human Services.

Finally for your future reference, I have included **Attachment D**, a summary of the general fund increases in Engrossed SB 2012.

This concludes my overview testimony and I would be happy to address your questions.

Thank you.

Department of Human Services
2011 - 2013 Budget to House
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $552,798,506



.05
Basic Care

.12
Home & Community Based Services

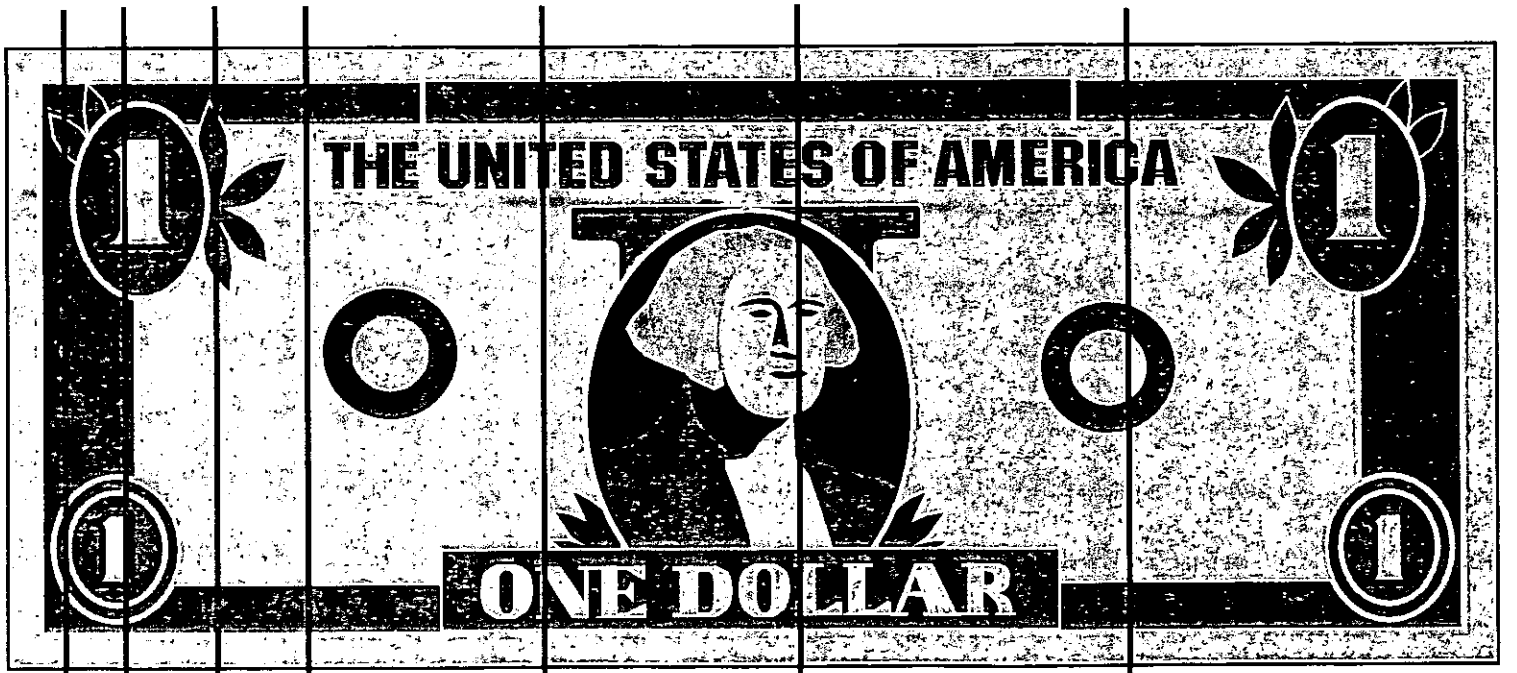
.83
Nursing Homes

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

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Attachment A

Department of Human Services
2011 - 2013 Budget to House
Where Does the Money Go?
Department-Wide
Total Funds $2,624,375,154



.04 HCBS & Basic Care	.04 Insti-tu-tions	.06 Admin-istration	.06 Human Service Centers	.16 Developmental Disabilities Grants	.17 Nursing Homes	.22 Direct Client Services *	.25 Traditional Medical Grants & Healthy Steps

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

* Includes TANF, JOBS, Child Care, SNAP, Heating Assistance, IV-D Tribal, IV-D Judicial, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, and Non-Medicaid Developmental Disability grants and services.

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Attachment B

Department of Human Services 2011 - 2013 Budget to the House (SB 2012)

Subdivision	FTEs (Full Time Equivalents) 32501	Salaries and Wages 32510	Operating Expenses 32530	Capital Assets 32550	Grants 32560	HSCs and Institutions 32570	Grants-Medical Assistance 32573	Total 32590	General 32591	Federal 32592	Other 32593
100-15 ADMINISTRATION - SUPPORT	74.60	$10,351,992	$5,683,423					$16,035,415	$7,775,396	$7,090,067	$1,169,952
100-20 INFORMATION TECHNOLOGY SRVCS	41.50	$6,161,344	$56,724,715	$138,400				$63,024,459	$23,746,066	$37,243,950	$2,034,443
100 MANAGEMENT Total	**116.10**	**$16,513,336**	**$62,408,138**	**$138,400**				**$79,059,874**	**$31,521,462**	**$44,334,017**	**$3,204,395**
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	39.80	$5,516,945	$11,703,561		$331,251,570			$348,472,076	$11,439,272	$318,286,921	$18,745,883
300-02 CHILD SUPPORT ENFORCEMENT	165.20	$20,858,604	$4,182,317					$25,040,921	$6,874,824	$15,175,197	$2,990,900
300-03 MEDICAL SERVICES	73.50	$10,139,971	$34,236,842				$665,549,436	$709,926,249	$240,545,012	$434,510,018	$34,871,219
300-10 LONG TERM CARE							$961,386,588	$961,386,588	$427,330,132	$530,781,396	$3,275,060
300-42 DD COUNCIL	1.00	$162,095	$132,652		$621,142			$915,889		$915,889	
300-43 AGING SERVICES	10.00	$1,461,314	$13,762,611		$2,896,942			$18,120,867	$4,666,276	$13,174,591	$280,000
300-46 CHILDREN AND FAMILY SERVICES	17.00	$2,555,408	$5,744,630		$126,793,961			$135,093,999	$31,053,237	$82,978,058	$21,062,704
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	24.00	$3,592,202	$11,687,985		$4,445,584			$19,725,771	$7,128,641	$12,026,270	$570,860
300-51 VOC REHAB	35.00	$4,672,532	$2,049,230		$20,558,631			$27,280,393	$4,859,126	$22,326,268	$94,999
300-52 DEVELOPMENTAL DISABILITIES DIVISION	9.00	$1,387,140	$7,350,535		$438,207			$9,175,882	$3,151,429	$5,874,450	$150,003
300 PROGRAM AND POLICY Total	**374.50**	**$50,346,211**	**$90,850,363**		**$487,006,037**		**$1,626,936,024**	**$2,255,138,635**	**$737,047,949**	**$1,436,049,058**	**$82,041,628**
410-71 NORTHWEST HSC	45.75					$8,749,068		$8,749,068	$4,958,832	$3,321,230	$469,006
410-72 NORTH CENTRAL HSC	117.78					$22,433,884		$22,433,884	$13,410,027	$8,104,420	$919,437
410-73 LAKE REGION HSC	60.00					$11,418,231		$11,418,231	$6,882,190	$4,063,599	$472,442
410-74 NORTHEAST HSC	138.30					$28,182,609		$28,182,609	$13,209,723	$12,967,908	$2,004,978
410-75 SOUTHEAST HSC	182.15					$38,464,720		$38,464,720	$22,185,733	$15,145,044	$1,133,943
410-76 SOUTH CENTRAL HSC	85.50					$16,953,699		$16,953,699	$9,343,547	$6,691,551	$918,601
410-77 WEST CENTRAL HSC	135.30					$26,740,493		$26,740,493	$14,109,532	$11,430,961	$1,200,000
410-78 BADLANDS HSC	72.70					$11,789,654		$11,789,654	$6,529,292	$4,426,122	$834,240
410 HUMAN SERVICE CENTERS Total	**837.48**					**$164,732,358**		**$164,732,358**	**$90,628,876**	**$66,150,835**	**$7,952,647**
420-00 STATE HOSPITAL	381.45					$62,370,125		$62,370,125	$42,223,722	$2,609,783	$17,536,620
421-00 SH SECURED SERVICES	86.06					$11,264,915		$11,264,915	$11,264,915		
430-00 DEVELOPMENTAL CENTER	400.76					$51,809,247		$51,809,247	$20,417,430	$27,823,460	$3,568,357
4xx INSTITUTIONS Total	**868.27**					**$125,444,287**		**$125,444,287**	**$73,906,067**	**$30,433,243**	**$21,104,977**
Grand Total	**2,196.35**	**$66,859,547**	**$153,258,501**	**$138,400**	**$487,006,037**	**$290,176,645**	**$1,626,936,024**	**$2,624,375,154**	**$933,104,354**	**$1,576,967,153**	**$114,303,647**

Attachment C

Department of Human Services
SB 2012
Summary of General Fund Increases

		Expressed in Millions
FMAP changes		$ 171.4
Loss of Stimulus FMAP	*66.5*	
Decrease to 55.40%	*104.9*	
3% Inflationary Increase each year to Providers		$ 25.5
Net Cost Changes for programs that we cannot control		$ 24.4
Caseload / Utilization for programs that we cannot control		$ 21.6
82% of increase is Traditional Medicaid grants ($12.2 m) and Nursing Homes ($5.6 m)		
Replace Funding Sources no longer Available		$ 16.2
Child Support Stimulus	*2.8*	
Bank of ND Loan	*8.5*	
Health Care Trust Fund	*4.1*	
Community Health Trust Fund	*0.8*	
Increase in Governor's Salary & Benefit Package & Continuing Yr 2 salary increase		$ 14.3
Increase in Medicare Part D Clawback payment		$ 6.5
Increase to address Behavioral Health Care Needs at Human Service Centers		$ 6.1
Fund Extraordinary Repairs and capital improvements		$ 3.1
Technology Rate Increases by ITD and other technology increases		$ 2.6
Decrease of One-Time Funding		$ (7.2)
Extraordinary repairs, equipment over $5,000 and bond payments	*(6.2)*	
Funding for Medicaid Systems Project	*(1.0)*	
Reduction to overall budget submitted by Department based on anticipated turn back at June 30, 2011		$ (12.8)
Miscellaneous or 0.4%		$ 1.1
Overall Costs to Continue before increases		**$ 272.8**
SENATE INCREASES		
Removed funding for Silver Haired Assembly $10,000		$ -
Increase CHIP from 160% net to 175% net		$ 0.6
Provide $.50 hourly increase to DD providers		$ 5.0
Additional funds for extraordinary repairs for State Hospital		$ 0.1
Total General Fund Increase - Engrossed SB 2012		**$ 278.5**

Attachment ONE
March 3, 2011

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations Committee
Representative Delzer, Chairman
March 2, 2011

Chairman Delzer, members of the House Appropriations Committee, I am Carol Olson, Executive Director of the North Dakota Department of Human Services. Thank you for the opportunity to introduce the Department's budget request for the 2011-2013 biennium. Brenda Weisz, the Chief Financial Officer for the Department will cover the changes made by the Senate.

The Department's budget request is $2.6 billion total, which is a $277.7 million increase in total funds (11.9% increase)

- $927.4 million general funds
  - $272.8 million general fund increase (41.67% increase)
- $1.57 billion federal funds
- $114 million other funds

- *2009-2011 Biennium Budget History*
  - *$2.3 billion budget total*
    - *$654.6 million general funds*
    - *$1.56 billion federal funds*
    - *$118 million other funds*

This budget also includes a reduction in 20.5 Full Time Equivalents (FTE).

The significant general fund increase ($272.8 million) is due to these

reasons:

- The **decrease in the Federal Medical Assistance Percentage** (federal match rate for Medicaid that is referred to as FMAP) = $171.4 million,
- **Cost and caseload increases in major grant areas** (especially Medicaid) = $46 million,
- Annual **inflationary increases of 3% for Medicaid providers and other providers** during the biennium = $25.5 million, and
- The **cost to continue the employee second-year salary increase** from the 2009-2011 biennium = $3.8 million.

While the FMAP has fallen, the Medicaid caseload and health care costs and utilization in general have gone up, which compounds the Medicaid funding situation. Together, these areas represent about 80% of the general fund increase in the Department's budget.

I would like to expand on the cost and caseload growth in the major grants area, which again is responsible for a $46 million increase in general funds. Most of this grant area increase is in Medicaid – the federal and state funded health coverage program for qualifying individuals – and much of it is in the Traditional Medicaid Grants area of the budget.

These funds go to thousands of health care providers and other providers of covered services. Without Medicaid, many of these services could be uncompensated.

These services include inpatient hospital care, outpatient surgery, clinic visits, prescription medications, and other health-related services.

Traditional Medicaid grants also pay for preventive health screenings of children.

Caseload and utilization increases are also driving up costs in the long-term care area of Department's budget. This area includes support services that help the elderly and people with developmental and other disabilities to remain living in their homes and community settings, as well as 24-hour skilled nursing home care. Medicaid pays for the care of about half of the nursing facility residents in North Dakota.

Medicaid supports the quality of life of thousands of individuals who rely on Medicaid-funded services. It also compensates thousands of doctors, dentists, chiropractors, therapists, and ambulance service providers.

In this budget, there is only one significant policy change. This budget includes a $6.1 million increase for behavioral health services to address psychiatric inpatient hospitalization needs in the regions and other capacity concerns. Most of this increase ($3.43 million) is for about 4,900 contracted inpatient psychiatric hospital days to be paid at the Medicaid equivalent rate for regional human service center clients who do not qualify for Medicaid.

The other behavioral health capacity increases are as follows:

- An added 10-bed crisis residential unit in Minot for people with serious mental illness who need emergency shelter and care, but not hospitalization ($1.4 million),
- Expands the adult crisis bed capacity in Bismarck by four additional beds ($309,000),
- A 15-bed long-term residential facility in the Fargo region for people

affected by chronic and serious addiction ($940,000).

I want to stress that aside from the highlighted areas, this budget holds other existing Department programs and services pretty even. Again, most of this budget is passed directly out-the-door to pay for health-related and other services in communities across the state and to provide benefits to qualifying vulnerable North Dakotans.

We take our mission very seriously and strive "to provide quality, efficient, and effective human services, which improve the lives of people." I am very proud of the fact that the Department can perform its responsibilities and also hold the line on administrative costs. For the past three biennia, the Department has held its administrative costs at six percent.

Before I close I would like to provide you with an update on our Medicaid Systems Project. ACS has informed us that they are currently tracking for a completion date of June 1, 2012 and that the project is scheduled to be on budget.

Thank you for this opportunity. Allow me to introduce the Department's Chief Financial Officer, Brenda Weisz who will provide a detailed overview of the Department's 2011-2013 budget.

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations Committee
Representative Delzer, Chairman
March 2, 2011

Chairman Delzer, members of the House Appropriations Committee, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide an overview of the Department's 2011 – 2013 Executive Budget request included in SB 2012, fiscal related information, along with the Senate amendments to the Executive Budget.

2009 – 2011 Appropriation and Estimated Spending

When comparing the current biennium expenditures in the major program areas to the amount of general fund appropriated, the Department is expecting the following:

- Long Term Care area of the Department's budget (including developmental disability grants) – we are estimating the overall spending to be under budget by $26.9 million in total with $13.2 million of that amount from the general fund. Nursing Facilities and the SPED program are experiencing lower utilization than budgeted while Basic Care services are being utilized in excess of the amounts budgeted.
- Medicaid traditional grants and Healthy Steps – we are estimating the overall shortfall to be $19.6 million in total with a $5.8 million shortfall in general fund. The general fund shortfall in this area is offset by a general fund savings in the Medicare Part D clawback payment of $2.8 million – all from the general fund. The net general fund shortfall amounts to $3.0 million.
- Human Services Centers - we are estimating the overall general fund spending to be under budget by $1.6 million.

- Institutions - we are estimating the overall general fund spending to be under budget by $800,000 at the State Hospital and on budget at the Developmental Center.
- Central Office - we are estimating the overall general fund spending to be under budget by $200,000.

When considering all areas of the budget, the Department is expecting to have an unexpended general fund appropriation of approximately $12.8 million at June 30, 2011. It is this estimated $12.8 million for which an exemption is being made in Section 5 of SB 2012 for the purpose of funding the medical assistance grants portion of our 2011 – 2013 Executive Budget.

Major Policy Changes in Developing the 2011 – 2013 Budget In developing the budget for **Inpatient Hospitalization at the Human Service Centers,** the Department continued contracts for inpatient hospital services for those who are not eligible for Medicaid but are clients of the Department in the following regions: North Central, Northeast, Southeast, West Central and Badlands in the amount of $829,243. The Executive Budget includes an additional $3.43 million for a total budget of $4.26 million. This will allow the Department to provide approximately 4,900 inpatient hospital days across the state to be paid at the Medicaid equivalent rate. The Department also plans to move forward with a centralized contract allowing for consistent contract terms statewide and allowing flexibility for amounts to be moved from region to region based upon need.

Current Budget / Executive Budget / Senate Amendments

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	59,416,844	7,442,703	66,859,547		66,859,547
Operating	124,195,067	29,063,434	153,258,501		153,258,501
Capital Assets	1,206,747	(1,068,347)	138,400		138,400
Capital Construction Carryover	30,234,275	(30,234,275)	0		0
Grants	483,066,261	3,949,776	487,016,037	(10,000)	487,006,037
HSCs and Institutions	270,150,215	19,864,590	290,014,805	161,840	290,176,645
Grants-Medical Assistance	1,365,095,313	248,642,305	1,613,737,618	13,198,406	1,626,936,024
Total	2,333,364,722	277,660,186	2,611,024,908	13,350,246	2,624,375,154
General Funds	654,611,574	272,752,084	927,363,658	5,740,696	933,104,354
Federal Funds	1,560,552,211	8,805,392	1,569,357,603	7,609,550	1,576,967,153
Other Funds	118,200,937	(3,897,290)	114,303,647		114,303,647
[illegible]tal	2,333,364,722	277,660,186	2,611,024,908	13,350,246	2,624,375,154
FTE	2,216.88	(20.53)	2,196.35		2,196.35

Explanation of Major Budget Changes - Current Budget to Executive Budget - General Fund Only - Increase of $272.8 million

$171.4 million – increase in state funds as a result of the decrease in the Federal Medical Assistance Percentage (FMAP). First, we need to replace the discontinuation of the enhanced FMAP as a result of the federal stimulus funding. The enhanced FMAP during this time period was 69.95%. This enhanced FMAP was to have expired December 31, 2010, however, as a result of federal legislation it was extended through June 30, 2011 at "stepped down" intervals. For North Dakota those rates are 66.95% for the period of January 2011 – March 2011 and 64.95% for April 2011 – June 2011. Also impacting the FMAP is the per capita

income of North Dakota in relation to other states and the strength of North Dakota's economy compared to that of the Nation. The FMAP rates for the upcoming biennium are as follows:

- FFY 2011 (July 2011 – Sept 2011) 60.35% Final
- FFY 2012 55.40% Final
- FFY 2013 55.40% Estimated

$25.5 million – 3% inflationary increase extended to providers each year of the biennium.

$24.4 million – net cost changes in the grant programs of the Department including traditional Medicaid grants, nursing facilities, developmental disability grants, extended services, home and community based services, child welfare grants, Indian County allocation payments to counties. Changes are the result of several factors such as rate setting rules, federal mandates, continuation of the year two 6% inflationary increase granted during the current biennium, along with costs that cannot be controlled by the Department (drugs, premiums – Medicare and Healthy Steps.)

$21.6 million – net increase in caseload / utilization. The largest impact of change in this area is an increase of $12.2 million in traditional Medicaid grants followed by a $5.6 million increase in the nursing home area.

$16.2 million – to replace with general fund, the other funding sources no longer available as follows: the ability to use child support incentive funds for match as allowed by stimulus legislation ($2.8 million); Bank of North Dakota loan ($8.5 million); Health Care Trust Fund ($4.1); and the use of the Community Health Trust Fund, which was used as match for

the allowable treatment and other medical costs for clients qualifying through the Women's Way Program ($800,000).

$14.3 million – increase ($10.3 million) attributed to the Governor's salary and benefit package, the cost to continue this biennium's year two salary increase ($3.8 million) for just under 2,200 employees; and ($200,000) for the seven Full Time Equivalents (FTE) associated with Health Care Reform.

$6.5 million – increase in the Medicare Part D clawback payment as a result of increased required payments and increased dual eligibles – those eligible for both Medicare and Medicaid.

$6.1 million – increase to address behavioral health needs at the Human Service Centers to 1) allow for consistent payment of psychiatric inpatient hospitalization statewide at the Medicaid equivalent rate for Human Service Center clients who are not eligible for Medicaid ($3.43 million); and 2) address the capacity issues in the Regions by: adding a ten bed crisis residential facility in Minot for those with serious mental illness ($1.44 million); adding four beds to the current ten bed adult crisis residential facility in Bismarck ($300,000); and adding a 15 bed long term residential facility for those with an addiction in Fargo ($940,000).

$3.1 million – to fund extraordinary repairs ($1.3 million) and capital improvements at the State Hospital ($1.8 million).

$2.6 million – increased information technology costs in both the rates charged by the Information Technology Department and ongoing operational costs of the new systems developed under the Medicaid Systems Project.

($7.2) million – decrease in one-time funding for extraordinary repairs, equipment over $5,000 and bond payments ($6.2 million) and funding for the Medicaid Systems Project ($1.0 million).

($12.8) million – reduction to the overall budget submitted by the Department and anticipated amount of general fund turnback at June 30, 2011 as explained earlier in my testimony.

The remaining **$1.1 million** or 0.4% of the general fund increase is tied to miscellaneous net increases throughout the Department, which will be addressed by each division as they present their overview testimony.

FTE Changes

The Executive Budget includes a **net decrease of 20.53 FTE.** As the Department developed its budget we arrived at that reduction incrementally. First, we began with an overall decrease of 40.53 at the Developmental Center resulting from the decreased need of staff as we have transitioned clients to the community. Our current budget was built on a population of 115 clients with a goal of 95 clients by June 30, 2011. As we developed the budget for the 2011 – 2013 biennium, we analyzed the FTE needs Department-wide and within our authorized FTE count we addressed internal needs offsetting this decrease as follows:

- Information Technology Services – we added 1 FTE for Health Information Technology and 3 FTE for individuals who have worked in the Department full time as temporary staff for over four years without benefits on data entry of primarily Medicaid claims.
- Medical Services – we added 1 FTE for the conversion of a claims analyst who has been a temporary employee working for the Department full time over four years without benefits.

- Mental Health / Substance Abuse Division – we added 6 FTE for work that was previously accomplished under contract. The federal funding was moved from the operating line item to the salaries line item for this change.
- NCHSC – we added a staff psychiatrist, who will serve both Northwest Human Service Center and North Central Human Service Center.
- State Hospital – we added a pharmacist to provide telepharmacy services to the eight Human Service Centers, which provide medication monitoring on a routine basis. This will be more efficient than adding a pharmacist at each location.

After our internal work, the Department's budget request submitted to OMB included a net decrease of 27.53 FTE.

The Executive Budget then added seven FTE to address the policy changes that will be needed to implement Health Care Reform. Health Care Reform is scheduled to go into effect January 2014, should there be no changes with this legislation at the federal level. The seven include one FTE each in the area of Economic Assistance Policy and Child Support and the remaining five in Medical Services. The FTE have a staggered employment date ranging from as early as July 1, 2011 to as late as April 1, 2013. This brings the net reduction in FTE to **20.53.**

Key Points in Developing the Budget

Traditional Medicaid Grants – The traditional Medicaid grants budget is built on utilization and cost data by service. However, the utilization is often driven by the number of individuals on the program. The number of eligibles in May 2010, when we began preparing the 2011 – 2013 budget

was 62,257. This compares to 51,308 eligibles in April 2008 when we began preparing our current budget.

Healthy Steps Program – The Executive Budget maintains coverage at 160% of poverty (net). The budget is built on providing coverage to an estimated 4,256 children per month at a monthly premium of $274.03 per child. The premium increase this biennium is 19.82%. The Senate did amend this area of the budget to provide coverage at 175% of poverty (net) which will serve an estimated 445 more children.

Institutions – The Executive Budget for the State Hospital is based on a total capacity of 298 beds. The breakdown by program includes 132 beds for inpatient psychiatric services, 90 beds for the Tompkins Program, and 76 beds for the civilly committed sex offender program. The Executive Budget for the Developmental Center is based on a population of 95 individuals at the Center.

Home and Community Based Services – Please refer to **Attachment A** for a breakdown among Long Term Care services in the Executive Budget with the Senate amendments.

As in past presentations, I have included in **Attachment B**, a breakdown of "Where the Money Goes" in the Executive Budget with the Senate amendments. 84% of the Department's budget goes directly "out the door" to providers or grant recipients. This compares to 83% of the budget for the 2009 – 2011 Legislatively Approved Budget. Another 10% is expended on direct client services at our Human Service Centers and the Institutions, which is down from 11% in the 2009 – 2011 budget. The administrative costs have been held to 6%.

Attachment C provides a one page presentation of our $2.6 billion budget with Senate Amendments. I would like to point out that 62% of this budget is Medicaid and that equates to Health care.

Senate Amendments

- Removes $10,000 for the Silver Haired Assembly within the Aging Services Division.
- Adds $1.8 million total funds, of which $567,000 is from the general fund to increase the eligibility level for the Healthy Steps program from 160% of poverty (net) to 175%.
- Adds $11.4 million total funds, of which $5.0 million is from the general fund to provide a $.50 per hour wage increase to Developmental Disability Provider staff on July 1, 2011.
- Adds $161,840 to the State Hospital to fully fund the remainder of the OAR request submitted to OMB.
- Includes intent language that the Department may not exceed more than $12.50 per square foot for leasing office space at Prairie Hills Plaza for the 2011 – 2013 biennium.
- Includes intent language that the Department only fill the seven full-time equivalent positions authorized for implementing federal health care reform after receiving applicable rules from the federal department of Health and Human Services.

Finally for your future reference, I have included **Attachment D**, a summary of the general fund increases in Engrossed SB 2012.

This concludes my overview testimony and I would be happy to address your questions.

Thank you.

Department of Human Services
2011 - 2013 Budget to House
Where Does the Money Go?
Long Term Care Continuum (Excluding DD Grants)
Total Funds $552,798,506



.05
Basic Care

.12
Home & Community Based Services

.83
Nursing Homes

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

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Attachment A

Department of Human Services
2011 - 2013 Budget to House
Where Does the Money Go?
Department-Wide
Total Funds $2,624,375,154



.04 HCBS & Basic Care

.04 Institutions

.06 Administration

.06 Human Service Centers

.16 Developmental Disabilities Grants

.17 Nursing Homes

.22 Direct Client Services *

.25 Traditional Medical Grants & Healthy Steps

NOTE: Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

* Includes TANF, JOBS, Child Care, SNAP, Heating Assistance, IV-D Tribal, IV-D Judicial, Child Welfare, Aging, Mental Health, Substance Abuse, Vocational Rehabilitation, and Non-Medicaid Developmental Disabilit and services.

FA-2/28/11-ci\1113leniat

Attachment B

Department of Human Services 2011 - 2013 Budget to the House (SB 2012)

Subdivision	FTEs (Full Time Equivalents) 32501	Salaries and Wages 32510	Operating Expenses 32530	Capital Assets 32550	Grants 32560	HSCs and Institutions 32570	Grants-Medical Assistance 32573	Total 32590	General 32591	Federal 32592	Other 32593
100-15 ADMINISTRATION - SUPPORT	74.60	$10,351,992	$5,683,423					$16,035,415	$7,775,396	$7,090,067	$1,169,952
100-20 INFORMATION TECHNOLOGY SRVCS	41.50	$6,161,344	$56,724,715	$138,400				$63,024,459	$23,746,066	$37,243,950	$2,034,443
100 MANAGEMENT Total	**116.10**	**$16,513,336**	**$62,408,138**	**$138,400**				**$79,059,874**	**$31,521,462**	**$44,334,017**	**$3,204,395**
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	39.80	$5,516,945	$11,703,561		$331,251,570			$348,472,076	$11,439,272	$318,286,921	$18,745,883
300-02 CHILD SUPPORT ENFORCEMENT	165.20	$20,858,604	$4,182,317					$25,040,921	$6,874,824	$15,175,197	$2,990,900
300-03 MEDICAL SERVICES	73.50	$10,139,971	$34,236,842				$665,549,436	$709,926,249	$240,545,012	$434,510,018	$34,871,219
300-10 LONG TERM CARE							$961,386,588	$961,386,588	$427,330,132	$530,781,396	$3,275,060
300-42 DD COUNCIL	1.00	$162,095	$132,652		$621,142			$915,889		$915,889	
300-43 AGING SERVICES	10.00	$1,461,314	$13,762,611		$2,896,942			$18,120,867	$4,666,276	$13,174,591	$280,000
300-46 CHILDREN AND FAMILY SERVICES	17.00	$2,555,408	$5,744,630		$126,793,961			$135,093,999	$31,053,237	$82,978,058	$21,062,704
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE	24.00	$3,592,202	$11,687,985		$4,445,584			$19,725,771	$7,128,641	$12,026,270	$570,860
300-51 VOC REHAB	35.00	$4,672,532	$2,049,230		$20,558,631			$27,280,393	$4,859,126	$22,326,268	$94,999
300-52 DEVELOPMENTAL DISABILITIES DIVISION	9.00	$1,387,140	$7,350,535		$438,207			$9,175,882	$3,151,429	$5,874,450	$150,003
300 PROGRAM AND POLICY Total	**374.50**	**$50,346,211**	**$90,850,363**		**$487,006,037**		**$1,626,936,024**	**$2,255,138,635**	**$737,047,949**	**$1,436,049,058**	**$82,041,628**
410-71 NORTHWEST HSC	45.75					$8,749,068		$8,749,068	$4,958,832	$3,321,230	$469,006
410-72 NORTH CENTRAL HSC	117.78					$22,433,884		$22,433,884	$13,410,027	$8,104,420	$919,437
410-73 LAKE REGION HSC	60.00					$11,418,231		$11,418,231	$6,882,190	$4,063,599	$472,442
410-74 NORTHEAST HSC	138.30					$28,182,609		$28,182,609	$13,209,723	$12,967,908	$2,004,978
410-75 SOUTHEAST HSC	182.15					$38,464,720		$38,464,720	$22,185,733	$15,145,044	$1,133,943
410-76 SOUTH CENTRAL HSC	85.50					$16,953,699		$16,953,699	$9,343,547	$6,691,551	$918,601
410-77 WEST CENTRAL HSC	135.30					$26,740,493		$26,740,493	$14,109,532	$11,430,961	$1,200,000
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SB 2012
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Increase in Governor's Salary & Benefit Package & Continuing Yr 2 salary increase		$ 14.3
Increase in Medicare Part D Clawback payment		$ 6.5
Increase to address Behavioral Health Care Needs at Human Service Centers		$ 6.1
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Technology Rate Increases by ITD and other technology increases		$ 2.6
Decrease of One-Time Funding		$ (7.2)
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Miscellaneous or 0.4%		$ 1.1
Overall Costs to Continue before increases		**$ 272.8**

SENATE INCREASES

Removed funding for Silver Haired Assembly $10,000	$ -
Increase CHIP from 160% net to 175% net	$ 0.6
Provide $.50 hourly increase to DD providers	$ 5.0
Additional funds for extraordinary repairs for State Hospital	$ 0.1
Total General Fund Increase - Engrossed SB 2012	**$ 278.5**

- Attachment TWO
- Debra McDermott, DHS

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide an overview of the Administration / Support area.

Programs

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. Each of these areas provides the needed support for the divisions within the Department to carry out their programs. This budget area includes centralized costs for department-wide expenditures such as program appeals, audit fees charged by the State Auditor's Office, and the legal work provided by the Attorney General's Office. Also included are the centralized costs for the Central Office divisions such as motor pool expenses, postage for routine mailings such as federally required client TANF notices, along with the telephone services provided by the Information Technology Department. Finally, this area of the budget reflects the Insurance and Risk Management Fees for the Central Office and Human Service Centers.

Major Program Changes

There have not been any program changes in this area.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	9,346,006	1,005,986	10,351,992		10,351,992
Operating	4,913,798	769,625	5,683,423		5,683,423
Total	14,259,804	1,775,611	16,035,415		16,035,415
General Funds	6,727,982	1,047,414	7,775,396		7,775,396
Federal Funds	6,468,144	621,923	7,090,067		7,090,067
Other Funds	1,063,678	106,274	1,169,952	-	1,169,952
Total	14,259,804	1,775,611	16,035,415		16,035,415

FTE	74.60	0.00	74.60		74.60

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item increased by $1,005,986 and can be attributed to the following:

- $553,938 in total funds of which $356,700 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $91,753 to cover an underfunding of salaries from the 2009-2011 budget.
- $206,867 in total funds of which $166,092 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- During the biennium the Department recognized an increased need in assistance from the Legal Advisory Unit and moved an FTE internally to accommodate this priority. Increased appeals, administrative rules and federal requirements especially from the Centers of Medicare and Medicaid have required additional legal expertise within the Department. The additional attorney hired resulted in additional need of $121,237 for salary and fringes.

- The remaining $32,191 is a combination of increases and decreases needed to sustain the salary of the 74.60 FTE in this area of the budget.

The Operating line item increased by $769,625 (15.7%) and is a combination of the increases and decreases expected next biennium. Outlined below are the significant areas of change:

- $602,146 increase in Professional Fees. $298,481 is a result of increased utilization of the services provided by the Attorney General's office coupled with their rate increase of 4.63% - $73.81 per hour to $77.23 per hour. $267,258 is attributed to services provided by the Office of Administrative Hearings. Our utilization in this area has increased along with a rate increase of 33.99% - $93.29 per hour to $125.00 per hour. The remainder of the increase is attributed to the expected increase in audit fees of $36,407.
- $53,737 is attributable to the increase in the Travel category of the budget. $49,025 is related to an increase in state fleet usage partially offset by a rate decrease established by DOT - $0.40 per mile to $0.37 per mile. The remainder of the increase is related to additional travel required by staff for training and to audit cost reports of the additional basic care facilities across the state.
- $52,867 increase in Insurance the majority being a result of a rate increase by OMB for the Department's Central Office and Human Service Center risk management premium, offset by decreases in property and foster care liability insurance.
- $35,120 increase in Building Leases. $26,298 is attributable to rate increases established by OMB – office space from $8.97 to $10.21 (13.8%) per square foot and storage space $1.36 to $1.42 (4.4%) per square foot. The payment to OMB is federal/other funds and contains no general funds. $3,189 is due to a $1 per square foot

rate increase ($13.50 to $14.50) established by Workforce Safety and Insurance for staff located in the Century Center. The remainder of the increase is essentially due to an oversight, as our current budget did not include two years of rent for staff located at the North Central Human Service Center.

- $21,780 increase in Printing costs as a result of a rate increase by OMB of 3% each year of the biennium, and an anticipated 7% increase each year of the biennium for envelopes based upon information provided by current vendor.
- $10,313 increase in the Postage budget due to a 4% postal rate increase anticipated in October 2011 and October 2012.
- A decrease of $16,235 in IT Communications is primarily due to the reduced long distance rates from $0.09 to $0.07 a minute and reduced utilization of blackberry services and rates.

The general fund request increased by $1,047,414 with 58% of the increase ($608,683) associated with the salary changes as indicated above. The remaining increase of $438,731 is associated with the increase in the operating changes described above.

The net change of the federal and other funds is a result of the increases above and the approved cost allocation plan which is the basis for the majority of the funding in this area of the budget.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for Administration / Support area of the Department. I would be happy to answer any questions.

Attachment THREE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Jenny Witham, Director of Information Technology Services, of the Department of Human Services. I am here today to provide you an overview of Information Technology Services Division, for the Department of Human Services.

Programs

The Department's Information Technology Services Division staff is responsible for information technology strategic planning and budgeting, business analysis, project management, procurement, software development and maintenance, technology standards and policy enforcement, and data entry services.

Customer Base

The Department's Information Technology Services Division (ITS) provides technology services to support the business needs of the central office divisions, the eight Human Service Centers, the State Hospital, the Developmental Center, and the county social service boards across North Dakota.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	5,219,112	942,232	6,161,344	-	6,161,344
Operating	41,773,438	14,951,277	56,724,715	-	56,724,715
IT Equipment over $5,000	7,022	131,378	138,400	-	138,400
Capital Construction Carryover	30,234,275	(30,234,275)	-	-	-
Total	77,233,847	(14,209,388)	63,024,459	-	63,024,459
General Funds	20,703,546	3,042,520	23,746,066	-	23,746,066
Federal Funds	52,180,431	(14,936,481)	37,243,950	-	37,243,950
Other Funds	4,349,870	(2,315,427)	2,034,443	-	2,034,443
Total	77,233,847	(14,209,388)	63,024,459	-	63,024,459
FTE	37.5	4.0	41.5	-	41.5

Budget Changes from Current Budget to the Executive Budget:

The Salaries line item increased by $942,232 and can be attributed to the following changes:

- $319,219 in total funds of which $211,811 is general fund needed to fund the Governor's salary package for state employees.
- $140,063 in total funds of which $122,442 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- The Budget includes an increase of 4 FTE in the 2011- 2013 biennium as follows: (All four FTE are derived from the FTE no longer needed at the Developmental Center and were reduced in their budget request.)

- A Health Information Technology Coordinator position to work closely with the Information Technology Department as requirements must be met as the State continues moving forward in sharing health information electronically. Total budget need $214,819, with $21,482 being general fund.
- The conversion of three data entry staff who process primarily Medicaid claims who have been temporary employees working for the Department full time for over four years without benefits. Total budget need for adding benefits - $82,965, with $25,528 being general fund.

- During the biennium the Department recognized an increased need in provider outreach and information system training and moved an FTE internally to accommodate this priority. This represents an increase of $181,601 in total funds of which $118,222 is general fund.
- There was an increase of $3,565 which is a combination of increases and decreases needed to sustain the salary of the 41.5 FTE in this area of the budget.

The Operating line item increased by $14,951,277 major changes including:

- $11,092,427 of which $3,338,800 is general fund to support Information Technology Department services due to increased rates and utilization.
- $1,065,881 of which $317,262 is general fund to support vendor contracts for the ongoing operations of the new Medicaid Management Information Systems, the Pharmacy Point of Sale system and Medicaid Decision Support system.

- $2,500,000 of all federal funds for the replacement of the Vocational Rehabilitation case management system, which is a commercial off the shelf software.
- $112,118 of which $65,221 is general fund for increases in central printing costs and other desktop hardware and software license fees and maintenance.

IT Equipment over $5,000 had a federal funds increase of $131,378 to purchase telemedicine equipment at each of the Human Service Centers to implement Telepharmacy at the State Hospital. The entire project cost is $140,259 of which $138,400 is in IT Equipment over $5,000. The remaining $1,859 is reflected in various accounts contained in the operating line.

Capital Construction Carryover had a decrease of $30,234,275 in total funds of which $996,035 is general fund for the Medicaid System Project. However, section 4 of SB 2012 will be requesting any unexpended funds be made available for the completion of the Medicaid System Project during the 2011-2013 biennium.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the Information Technology Services Division of the Department. I would be happy to answer any questions.

Attachment FOUR

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Tove Mandigo, Economic Assistance Policy Division Director, with the Department of Human Services. I am here today to provide an overview of the Economic Assistance Policy Division.

Programs
Economic Assistance Policy (EAP) is responsible for eligibility policy for Basic Care Assistance, Child Care Assistance, Low Income Heating and Energy Assistance Program (LIHEAP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). This includes:

- Distribution of benefits to recipients and payments to providers;
- Direction, supervision, and training of county social service board administration of EAP programs;
- Implementation of applicable state and federal law;
- Operation of electronic eligibility determination and reporting systems; and
- Preparation of required state and federal reports.

Economic Assistance Policy also performs Quality Control reviews of SNAP, Healthy Steps, Medicaid and TANF.

Caseload / Customer Base

EAP will direct and supervise county social services' determination of eligibility for the following:

Basic Care Assistance: An average of 489 residents of licensed Basic Care facilities, compared to the 2009-2011 biennium budget which was based on an average of 455 residents.

Child Care Assistance: An average of 3,915 cases per month, and pays about 3,055 qualified child care providers an average monthly benefit per case of $219, compared to the 2009-2011 biennium budget which was based on an average of 4,164 cases per month receiving an average monthly benefit of $224.

SNAP: An average of 33,890 cases each month, and pays about 450 grocers in North Dakota an average monthly benefit per case of $297, compared to the 2009-2011 biennium budget which was based on an average of 30,848 cases per month receiving an average monthly benefit of $286.

LIHEAP: Approximately 16,000 cases each heating season, and pays about 400 energy providers an average monthly benefit per case of $222 for regular cases, compared to the 2009-2011 biennium budget which was based on approximately 15,500 cases per heating season receiving an average monthly benefit of $296.

TANF: An average of 2,241 cases each month receiving an average monthly benefit of $301. Job Opportunities and Basic Skills (JOBS) program will work with 1,221 cases to find jobs and promote family self-sufficiency at an average monthly cost of $246, compared to the 2009-2011 biennium budget which was based on an average of 2,851 cases per month receiving an average monthly benefit of $343 and JOBS working with 1,425 cases at an average monthly cost of $210.

Kinship Care: An average of 29 cases each month receiving an average monthly benefit of $614. These children would otherwise be in Foster Care. The limit on child care assistance benefits to those providing Kinship Care has been removed and the Department now pays actual costs of child care.

Program Trends / Major Program Changes

Child Care Assistance: The child care caseloads are lower due to less cases qualifying for benefits as a result of increased wages in North Dakota. Some cases are qualifying at lower benefit amounts due to the increased wages in North Dakota.

SNAP: The SNAP program is the cornerstone of USDA nutrition programs and is the safety net that helps people buy food to help them meet their nutrition needs. The caseload during the 2011-2013 biennium

continues to increase. A major factor contributing to the growth in the caseload is the policy change to implement simplified reporting. Outreach has been formalized ensuring that people are aware of the program and can access it. The Department launched the online Application for Assistance early last fall as a way to make it easier for people to apply for and remain on the program.

LIHEAP: The LIHEAP caseload has remained fairly stable but the fuel costs have steadily increased. This is a 100% federally funded program. In the past two Federal Fiscal Years (FFY), the federal government funded $5.1 billion per year nationwide, so states could meet the fiscal demands of increasing fuel costs. With this funding, trends would indicate that North Dakota will meet the heating needs of the LIHEAP clients in the 2011-2013 biennium, although FFY 2011 funding is not yet final.

TANF: North Dakota continues to exceed the federally required 50% work participation rate without the addition of the caseload reduction credit. In order to meet the federally required work participation rate, the Department contracts with Job Service, Community Options and Tribal Employment and Training. As a result of case management by employment contractors, pay after performance, and job opportunities in North Dakota, the TANF caseload remains below 3,000 per month.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	5,236,318	280,627	5,516,945		5,516,945
Operating	11,711,891	(8,330)	11,703,561		11,703,561
Grants	334,441,734	(3,190,164)	331,251,570		331,251,570
Total	351,389,943	(2,917,867)	348,472,076		348,472,076
General Funds	10,676,487	762,785	11,439,272		11,439,272
Federal Funds	322,674,475	(4,387,554)	318,286,921		318,286,921
Other Funds	18,038,981	706,902	18,745,883		18,745,883
Total	351,389,943	(2,917,867)	348,472,076		348,472,076

FTE	38.80	1.00	39.80		39.80

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item increased by $280,627 and can be attributed to the following:

- $288,487 in total funds of which $123,401 is general fund needed to fund the Governor's salary package for state employees.
- $101,942 in total funds of which $64,213 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $17,058 of which all is general fund to fund the cost of the Training FTE added for Health Care Reform. The FTE is projected to be hired April 2013.
- The remaining $126,860 decrease is a combination of increases and decreases needed to sustain the salary of the 39.80 FTE in this area of the budget.

The Operating line item decreased by ($8,330) and is a combination of the increases expected next biennium which are offset by decreases as follows:

- $190,091 decrease in purchased services, $106,261 general fund, related to federally required estate collection activities. The duties will now be handled by the Legal Advisory Unit.
- $478,261 decrease in Supportive Services, all federal funds, due to decreased JOBS clients and JOBS clients needing less of these supportive services.
- $280,455 increase in the Payment Error Rate Measurement contract, $74,321 general fund, due to the cyclical nature of the three-year federal eligibility review requirements.
- $32,545 increase, all federal funds, due to increased costs to serve JOBS clients.
- $37,273 increase in Parental Responsibility Initiative for the Development of Employment (PRIDE), all federal funds, due to the program being expanded to additional locations in the state.
- $173,091 increase in SNAP, all federal funds, for outreach programs.
- $101,947 increase to SNAP EBT (Electronic Benefit Transfer), $6,117 general fund, due to increased SNAP caseload.
- $10,000 increase in Non-Employee Travel, all federal funds, related to the TANF Work Group assisting with additional projects such as TANF Next Steps and the development of an education program for approximately 40 TANF clients to help move them towards self sufficiency and off of public assistance.
- $23,000 increase in LIHEAP Printing, all federal funds, due to increased printing demands.

The Grants line item decreased by $3,190,164 and is a combination of the increases and decreases expected next biennium. Some of the significant changes are noted below:

- $9,474,333 decrease to the TANF Subsidized Employment Program, all federal TANF ARRA funds, which expired September 30, 2010.
- $606,593 decrease in the SNAP Food Nutrition contracted with NDSU, all federal funds, as the amount of match provided by NDSU decreased.
- $365,408 decrease in the SNAP Charitable Food Program created by SB 2231 from the 2009 Legislative Session, $350,000 general fund, expires 6/30/2011.
- $13,126,445 decrease in LIHEAP benefits, all federal funds, which were built on weather and fuel price trends that did not reach the levels budgeted in the 2009-2011 biennium.
- $478,261 decrease in Supportive Services, all federal funds, due to decreased JOBS clients and JOBS clients needing less of these supportive services.
- $2,759,339 decrease in SNAP Administration, all federal funds, due to removal of one-time ARRA funds.
- $1,804,982 decrease in Child Care benefits, all federal funds, due to decreased caseloads and costs.
- $2,081,766 decrease in TANF Regular Benefits, all federal funds, due to decreased caseload and costs.
- $5,589,191 decrease in TANF Diversion Benefits, all federal funds, due to changes in Federal Regulations, very few individuals qualify for this benefit now.

- $1,066,213 increase in Indian County Allocation, all general fund, based upon the statutory funding formula in HB 1540 from the 2009 Legislative Session.
- $1,407,975 increase in JOBS Transportation benefits, all federal funds, due to increased clients working and in need of transportation assistance. Higher gas prices caused an increase in the amount of the maximum monthly benefit.
- $30,506,121 increase in SNAP benefits, all federal funds, based on federal outreach on a national level.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the Economic Assistance Policy Division of the Department. I would be happy to answer any questions.

Attachment FIVE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Committee, I am James Fleming, Director of the Child Support Enforcement Division of the Department of Human Services. I am here today to provide an overview of the child support enforcement (CSE) program for the Department of Human Services.

Programs

The CSE program is designed to enhance the well-being of children and reduce the demands on public treasuries by securing child support and medical support from legally responsible parents and by encouraging positive relationships between children and their parents.

The budget includes the staff and operating expenses for nine offices, consisting of the central office in Bismarck and the eight regional child support enforcement units (RCSEUs).

Caseload / Customer Base

The CSE caseload consists of cases receiving full services under Title IV-D of the Social Security Act (IV-D cases) and cases in which CSE only issues income withholding orders and maintains payment records (nonIV-D cases).

A child support case can become a IV-D case:

- Upon application from either parent,
- Upon referral from Foster Care, TANF, or Medical Assistance, or
- Upon request from another state or Tribe.

As shown in the chart below, the total IV-D caseload was 40,399 in December 2010. The nonIV-D portion of the caseload was 11,072. These cases include roughly 62,800 children and 75,600 parents.

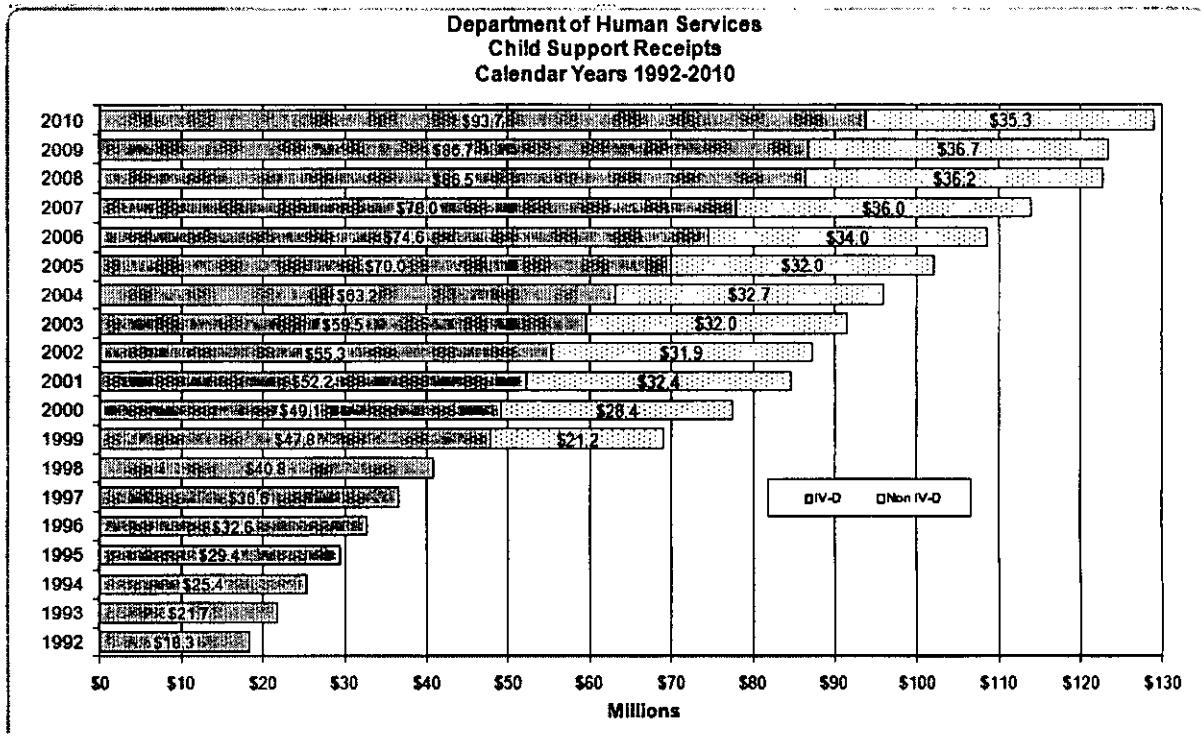
Department of Human Services
Child Support Cases
December 2001 through December 2010

Case Type	12/2001	12/2002	12/2003	12/2004	12/2005	12/2006	12/2007	12/2008	12/2009	12/2010
Non IV-D	13,131	11,872	9,474	9,802	9,771	10,314	10,161	9,971	10,410	11,072
IV-D	39,047	39,236	40,180	41,385	41,886	42,323	42,540	42,108	42,241	40,399
Total	52,178	51,108	49,654	51,187	51,657	52,637	52,701	52,079	52,651	51,471

The decline in the last year is primarily due to changes in the type of Medicaid cases that are referred to CSE.

Program Trends

Collections For calendar year 2010, total collections reached a new record of $129 million. The collections in IV-D cases increased 8.1% to $93.7 million. The collections in nonIV-D cases dropped slightly to $35.3 million. Of the estimated $260 million we expect to collect in the next biennium, about 90% is sent to families, with the balance sent to another jurisdiction for further distribution or retained to reimburse the taxpayers for expenditures from the TANF and Foster Care programs.



Receivables During the last biennium, a key point was reached where our total receivables in IV-D cases stopped growing and started to decrease. At the end of December 2009, our total IV-D receivables, including interest, were $221.1 million, compared to $224.8 million in 2008. This amount rose slightly at the end of 2010 to $223.54 million, which is still less than the total two years ago. With the nonIV-D receivables added, the statewide total at the end of 2010 was $285 million, compared to $282.6 million at the end of 2009 and $279.7 million at the end of 2008.

Performance The CSE program, including the clerks of court and other partners, continues to rank as one of the best programs nationally. Nevertheless, we are committed to achieving our goal of offering a World Class program. Using the most recent federal fiscal year measurements:

- Percent of children in IV-D cases born out of wedlock with paternity established or acknowledged: 108.14% (this formula compares the

children born out of wedlock in this year's IV-D cases with the number of children born out of wedlock in last year's IV-D caseload), improving on 106.33% in FFY 2009 and 103.99% in FFY 2008.

- Percent of cases with court orders for child support: 89.78%, up from 88.68% in FFY 2009 and 87.14% in FFY 2008.
- Percent of current support owed in IV-D cases that is collected: 74.21%, down slightly from 75.05% in FFY 2009 and 75.85% in FFY 2008.
- Amount collected for each $1 spent: $5.61, compared to $5.86 in FFY 2009 and $5.81 in FFY 2008.
- Medical support measurements are still under development at the national level at this time.

Medical Support Establishment and enforcement of medical support has long been a core service of the CSE program. To date, our program focus has been on locating coverage that is available to the custodial parent at no or nominal cost, if any, or else any coverage that is available to the noncustodial parent at reasonable cost. Under federal healthcare reform, we anticipate being expected to conduct a more in-depth analysis of the health insurance or other medical support options available to each parent, considering cost, accessibility, and comprehensiveness of coverage. The largest portion of the increases in time and expense are not expected until January 2014. However, contingent on clarification from the federal government of our program requirements, in the next biennium, we may need to study and re-engineer our program functions and legal practices to provide medical support services that do not unnecessarily disrupt the families we serve or jeopardize children's health coverage. With over 40,000 IV-D cases in our caseload, this will be a

significant undertaking, and one that would need to begin long before the January 2014 implementation date of federal healthcare reform.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	19,170,611	1,687,993	20,858,604		20,858,604
Operating	4,794,376	(612,059)	4,182,317		4,182,317
Total	23,964,987	1,075,934	25,040,921		25,040,921
General Funds	3,585,371	3,289,453	6,874,824		6,874,824
Federal Funds	17,591,107	(2,415,910)	15,175,197		15,175,197
Other Funds	2,788,509	202,391	2,990,900		2,990,900
Total	23,964,987	1,075,934	25,040,921		25,040,921

FTE	164.20	1.00	165.20		165.20

Budget Changes from Current Budget to the Executive Budget

The Salary and Wages line item increased by $1,687,993 and can be attributed to the following:

- $1,116,411 in total funds of which $372,793 is general fund needed to fund the Governor's salary package for state employees.
- $258,062 in total funds of which $97,289 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $48,151 of which all is general fund to fund an underfunding of salaries from the 2009-2011 biennium.
- An increase of $174,612 of which $59,368 is general fund to fund the cost of the attorney added for Health Care Reform.

- The remaining $90,757 increase is a combination of increases and decreases needed to sustain the salary of the 165.20 FTEs in this area of the budget.

The Operating line item decreased by $612,059 and is a combination of the increases and decreases expected in the next biennium. Some of the significant changes are noted below:

- $200,000 decrease to remove the funding for a receivables study.
- $159,579 decrease to remove the funding for a collaboration grant that has been completed.
- $436,918 decrease to remove ARRA one-time funding.
- $167,000 increase in federal funds for judicial services obtained from the ND judicial system.

Eligible IV-D expenditures are matched with 66% federal funds and 34% state funds. The other funds contained in the budget include the State's share of fee revenue ($319,566) and $2.6 million in federal incentive funds which must be reinvested in the program. Incentive funds are no longer eligible for federal match, so you will note a corresponding increase in general funds.

Senate Changes

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the Child Support Enforcement Division of the Department. I would be happy to answer any questions.

Attachment 5(X

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs; they are Medicaid and the Children's Health Insurance Program (Healthy Steps). This area of the budget for Medicaid and Healthy Steps provides health care coverage for qualifying families and children, pregnant women, the elderly, and disabled citizens of North Dakota. Attachment A lists the Medicaid Mandatory and Optional Services, and Attachment B lists the current services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last twenty-four months.

The 2009-2011 appropriation included funding to increase the income level for Healthy Steps to 160 percent of the federal poverty level (net).

This increase was implemented July 1, 2009. The Executive Budget for Healthy Steps was built on an average caseload of 4,256 children. Attachment D shows the number of children enrolled each month in Healthy Steps for the last twenty-four months, and also provides the number of children enrolled in Medicaid for the same time period.

Currently, children eligible for either Healthy Steps or Medicaid coverage are approved for twelve months of coverage; and the twelve-month continuous coverage is included as part of the Executive Budget. When Medicaid continuous eligibility was implemented in June 2008, there were 25,914 children enrolled in this coverage. For June 2009, the enrollment was 31,780 and for June 2010, it was 33,921. The average amount paid by Medicaid per child per month prior to June 2008 was $205.65; the average from July 2008-June 2009 was $221.01; and the average from July 2009 – June 2010 was $233.75. The averages include the increases to provider reimbursement rates.

Program Trends / Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- The **funeral set aside** for Medicaid was increased to $6,000 on July 1, 2009.

- The **Medically Needy income levels** were increased to 83% of poverty, effective July 1, 2009.

- The first payment under the **critical access hospital supplemental payment** was made in March 2010. The second payment will be made in April 2011. This was one-time funding, and the funding to continue the payments was not included in the Executive Budget.

Medicare Savings Programs

The Medicare Improvements for Patients and Providers Act of 2008, which was signed into law on July 15, 2008, increases the federal asset allowance for individuals who apply for coverage under the Medicare Savings Programs (QMBs, SLMBs, and QIs), to be equal to the asset allowance for LIS (low income subsidy) recipients of Medicare Part D. These new asset levels were effective January 1, 2010. In 2010, the asset allowance level for a one person household increased from $4,000 to $6,600 and is increasing to $6,680 in 2011; and from $6,000 for a couple to $9,910 in 2010 and is increasing to $10,020 in 2011. This allows current recipients to save more assets and allows additional individuals to qualify for coverage. The expected increased enrollment was accounted for in the 2011-2013 Executive Budget request. We do not know the exact levels yet for 2012 and 2013 as they are increased each year by the Consumer Price Index (CPI). The above Act also prohibits estate recovery collections for Medicare Savings Programs costs paid by Medicaid after January 1, 2010. This will reduce estate recovery collections over time; however, the impact is unknown at this time.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Demonstration Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions

QMB - Qualified Medicare Beneficiaries

that serve individuals with developmental disabilities in transitioning to home and community-based settings. The passage of the Affordable Care Act extended the grant through 2020. CMS has authorized 100 percent federal administrative funding to address housing barriers, nurse quality assurance, increase awareness of Home and Community-Based Services (HCBS), and transition coordination capacity. Three Requests for Proposal have been issued for:

1. Housing Assistance: to assist MFP Grant consumers in securing safe, affordable, and accessible housing opportunities through such activities as helping them assess and update their current housing plan and options, working with community agencies to eliminate systemic barriers and to create improved pathways to appropriate housing, helping consumers and their families access income such as housing subsidies, and working with housing providers to improve consumer access.
2. Nurse Quality Assurance: to provide nursing input, assessment and recommendations to the Centers for Independent Living in all four quadrants of the state as they transition individuals from nursing facilities or other designated institutional settings to assure all health related aspects of services that will be needed in the community are addressed.
3. HCBS Marketing: to develop and implement a marketing plan to promote awareness of Home and Community Based Services in North Dakota.

Six additional transition coordinators will be hired by the Centers for Independent Living to enhance the efforts for outreach and transition coordination activities for individuals choosing to move from institutions to their communities.

I will provide additional information on the transitions in the Long-Term Care Services overview.

Health Care Reform

As I cover the Administrative Budget portion of this testimony, you will see there are five new full-time equivalents (FTE) that were included in the Executive Budget. These five FTE will assist the Division in the implementation and operation of the Medicaid provisions related to health care reform, and I will provide the details for each position later in my testimony.

The Affordable Care Act (ACA), or "health care reform" includes a significant expansion to the Medicaid program. This expansion would require Medicaid programs to cover the population often referred to as "childless adults." The Medicaid coverage would extend to all individuals under the age of 65 below 133% of the Federal Poverty Level (plus a 5% income disregard); and would be **effective January 1, 2014**. To date, there has been little guidance from the Centers for Medicare and Medicaid Services (CMS) about the details states need to move forward with the implementation; however, based on feedback received from CMS, we expect to receive some of the needed guidance in 2011.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	8,416,259	1,723,712	10,139,971	-	10,139,971
Operating	23,813,704	10,423,138	34,236,842	-	34,236,842
Grants	515,394,985	148,320,094	663,715,079	1,834,357	665,549,436
Total	547,624,948	160,466,944	708,091,892	1,834,357	709,926,249
General Funds	148,519,693	91,457,952	239,977,645	567,367	240,545,012
Federal Funds	365,011,673	68,231,355	433,243,028	1,266,990	434,510,018
Other Funds	34,093,582	777,637	34,871,219	-	34,871,219
Total	547,624,948	160,466,944	708,091,892	1,834,357	709,926,249
FTE	67.5	6.0	73.5	-	73.50

Budget Changes from Current Budget to the Executive Budget

The Salaries line item increased by $1,723,712 and can be attributed to the following changes:

- $496,027 in total funds, of which $217,159 is general fund, is due to the Governor's salary package for state employees.
- $168,882 in total funds, of which $115,447 is general fund, is needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $30,807 to cover an underfunding of salaries from the 2009-2011 budget.
- $293,010 in total funds, of which $99,395 is general fund for an increase in temporary salaries for additional claims staff needed to

ensure timely processing of provider payments. The Department expects to retain the temporary staff until implementation of the new Medicaid Management Information System, scheduled for June 2012.

- $123,341 in total funds, of which $63,322 is general fund, for temporary salaries to assist with the review of service limits requests, administrative support, and primary care provider questions and oversight.
- During the interim, the Department recognized a need for an additional FTE to assist with the volume of management duties within the Division. An FTE was transferred from within the Department to the Medical Services Division. The new position serves as the Deputy Director of Medical Assistance. The transfer of this position represents an increased need of $59,554.
- $16,724 in total funds, of which $4,066 is general fund, to provide for the annual and sick leave lump sum payouts for three FTE expected to retire.
- The Budget includes a new FTE in the 2011 – 2013 biennium for the conversion of a claims analyst who has been a temporary employee working for the Department full time for over four years without benefits. This FTE was derived from the FTE no longer needed at the Developmental Center and was reduced in their budget request. Total budget need for adding benefits - $23,533, with $7,559 being general fund.
- The Executive Budget also added five FTE for Health Care Reform, totaling $312,609 of which $137,697 is general fund. The addition of the positions would be staggered based on our estimates of when the additional assistance would be needed.

Position	Start Date	Total Funds	General Funds
Eligibility Policy	July 1, 2011	$ 110,919	$ 55,460
Program Integrity	January 1 2012	$ 103,961	$ 51,980
Nurse	October 1, 2012	$ 52,896	$ 13,224
SURS Analyst	January 1, 2013	$ 24,221	$ 5,888
Administrative Support	January 1 2013	$ 20,612	$ 11,145

Eligibility Policy – This position would help develop policy for the rules surrounding Medicaid expansion. This position would also develop training for county staff and assist with defining business rules for the design of the eligibility system needed to convert from the current "net" income rules to the "modified adjusted gross income" rules required by the health care law.

Program Integrity – The expectations for Medicaid program integrity are increasing significantly and with an expanded number of individuals enrolled in the program, additional staff are needed to ensure all program integrity efforts can keep up with the increased Medicaid enrollment

Nurse – This position will be responsible for managing the increased prior authorization requests expected with an expansion of Medicaid.

Surveillance and Utilization Review System (SURS) Analyst – as the Medicaid enrollment increases, so does the need to analyze recipient "use" information and ensure services are being utilized appropriately.

Administrative Support – This position would provide administrative support for the new positions as well as assist in answering an increased volume of telephone and paper correspondence, which is expected because of an increased Medicaid enrollment.

- The remaining $199,225 is a combination of increases and decreases needed to sustain the salary of the 73.5 FTE in this area of the budget.

The Executive Budget for Operating Expenses is $34.2 million which is an increase of $10.4 million.

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $26.3 million for 2011-2013. This is an **increase of $6.9 million** over the current budget of $19.4 million, and was built based on an average of 10,825 individuals at an average payment of $101.26 per person per month. The Clawback payment is funded with 96 percent general fund and 4 percent estate collections.
- The Money Follows the Person (MFP) Demonstration Grant **increased $2.5 million**. This increase is primarily funded by Federal MFP Funds.
- Operating expenses also include contracts for services, such as: utilization review and prior authorization; drug pricing; Medicaid identification cards; nursing facility screenings; actuary services; and third party liability identification.

The Executive Budget for Grants is $663.7 million, which is an increase of $148.3 million.

Senate Changes

The Senate included language and funding to increase the income eligibility level of the Children's Health Insurance Program from 160%

(net) to 175% (net) of the federal poverty level. This increase is estimated to provide coverage for an additional 445 children in the 2011-2013 Biennium.

Attachment E shows the changes in the Traditional Medicaid Grants Budget from 2009-2011 Appropriation to the 2011-2013 Budget to the House.

Attachment F is a cost and caseload comparison of the 2009-2011 Traditional Medical Grants Appropriation to the 2011-2013 Executive Budget request to the Senate for the top thirteen services. These services represent 94% of the Traditional Medicaid Grants.

Attachment G shows each Traditional Medicaid Service comparing the 2009-2011 Budget; 2009-2011 Projected Need; the 2011-2013 Executive Budget request; and the Budget to the House.

This concludes my testimony on the 2011-2013 budget request for the Traditional Medicaid and Children's Health Insurance Programs. I would happy to answer any questions.

Attachment A

North Dakota Department of Human Services
Medical Services Division

MEDICAID MANDATORY AND OPTIONAL SERVICES

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services 65 and older in IMD
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services for MR
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services & Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy Related Services and services for other conditions that might complicate pregnancy	Dental & Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy & Occupational Therapy	Nursing Facility Services Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

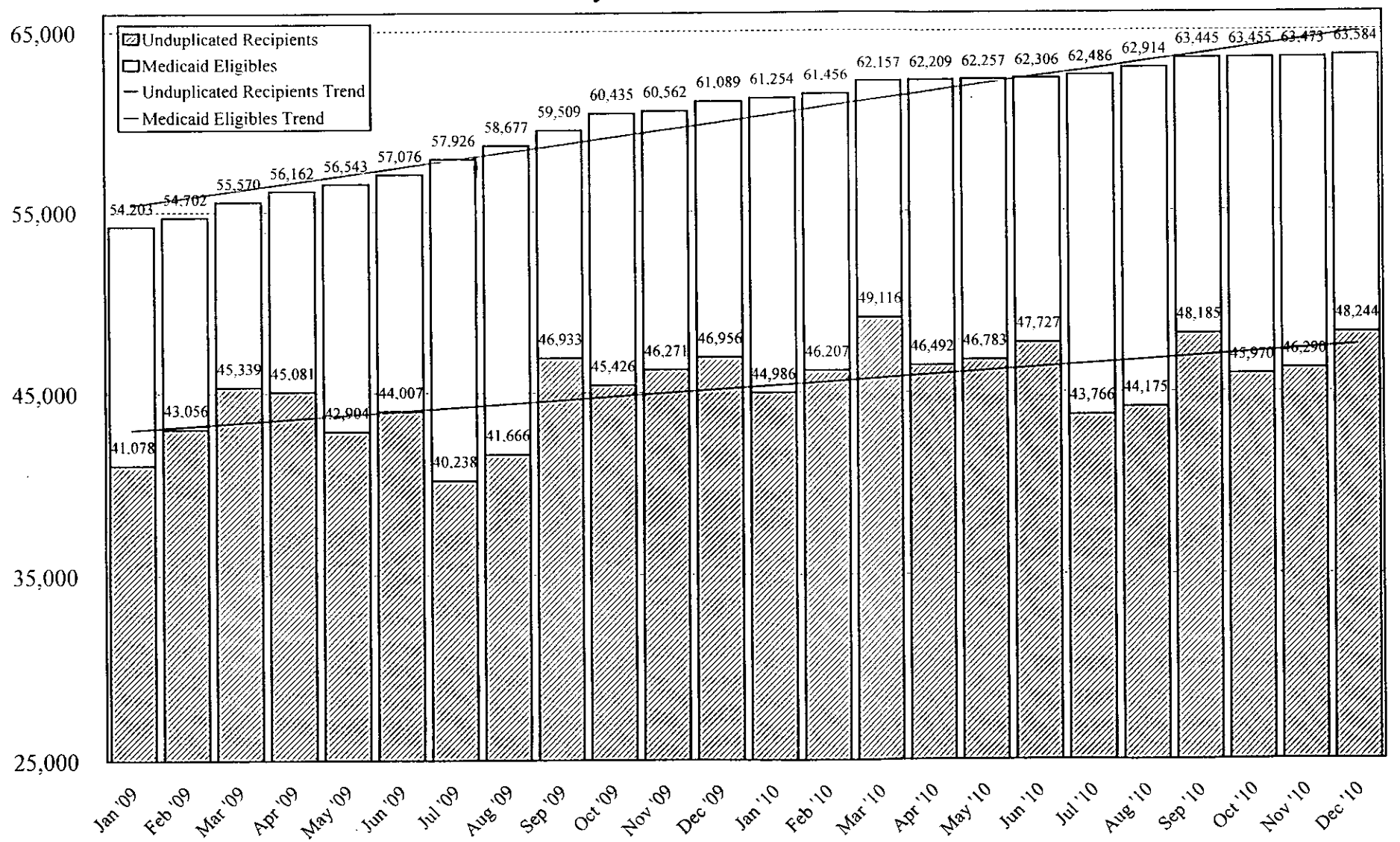
North Dakota Department of Human Services
Medical Services Division

CURRENT MEDICAID SERVICE LIMITS AND COPAYMENTS

SERVICE LIMITS	COPAYMENTS
Chiropractic Manipulations 12/year	$2 Occupational Therapy
Chiropractic X-rays 2/year	$2 Optometry Service
Physical / Occupational / Speech Therapy Evaluation 1/year	$2 Psychological Service
Occupational Therapy 20 visits/year	$1 Speech Therapy
Psychological Testing 4 hours/year	$2 Physical Therapy
Psychological Therapy 40 visits/year	$3 Podiatry Service
Speech Therapy 30 visits/year	$2 Hearing Test
Physical Therapy 15 visits/year	$3 Hearing Aid
Eyeglasses for Individuals 21 & Older once every 2 years	$75 Inpatient Hospital
Eye exams for Individuals 21 & Older once every 2 years	$3 non-emergent use of Emergency Room
Ambulatory Behavioral Health – limited based on level of care	$2 Physician Visit
Inpatient Psychiatric – 21 days per admission, not to exceed 45 days per year	$3 Federally Qualified Health Center / Rural Health Center Visit
Inpatient Rehabilitation Services – 30 days per admission	$3 Brand Prescriptions
Nursing facilities – 15 days hospital leave; 24 therapeutic leave days per year	$1 Chiropractic Services
Wheelchairs – limited to once every 5 years	$2 Dental Services
Nebulizers limited to once every 5 years	
Dentures – limited to once every 5 years	
Dietitian – 4 visits per year	
Biofeedback – 6 visits per year	

Attachment C

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients
January 2009 - December 2010



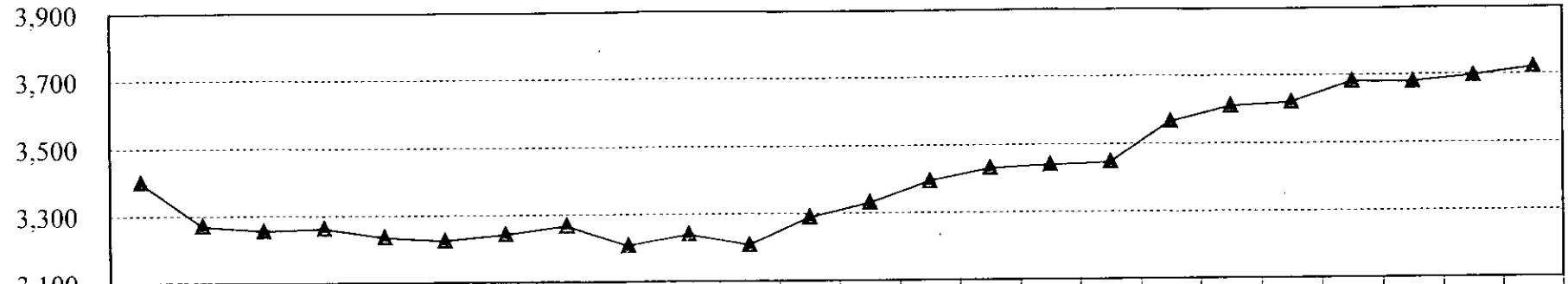
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North Dakota Department of Human Services

Attachment D

Healthy Steps Premiums Paid by Month

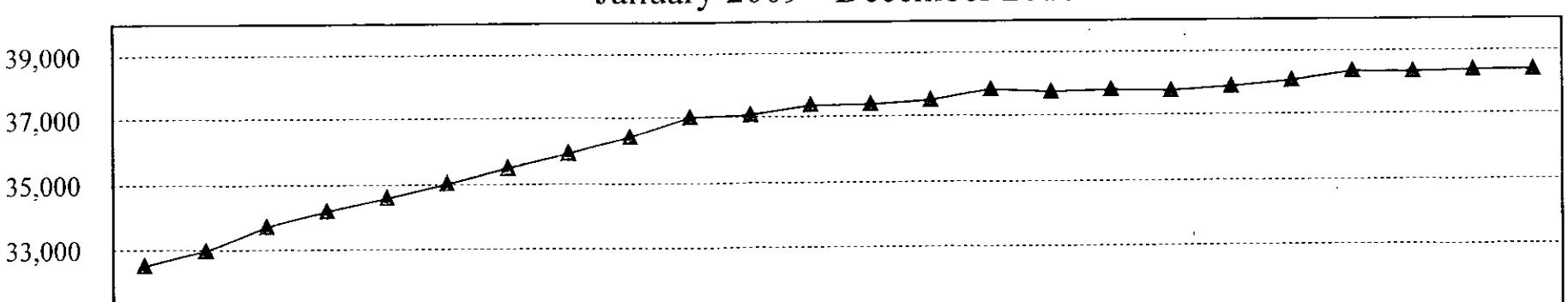
January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
3,399	3,270	3,255	3,262	3,235	3,224	3,242	3,267	3,207	3,239	3,207	3,288	3,330	3,393	3,431	3,439	3,446	3,565	3,609	3,620	3,680	3,678	3,696	3,721

Children Enrolled in Medicaid by Month

January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
32,504	32,964	33,694	34,168	34,577	35,012	35,480	35,916	36,399	37,002	37,058	37,358	37,385	37,499	37,824	37,739	37,797	37,761	37,876	38,056	38,337	38,313	38,375	38,375

North Dakota Department of Human Services
Changes in Medical Assistance Services from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP Changes	Decrease in Premium Rates	3/3 Inflation	Total Changes	2011-2013 Budget To Senate	Increase CHIP from 160% to 175% (445 Children)	2009-2011 Budget To House
Inpatient Hospital	136,073,409		21,714,395	1,190,244			6,579,444	29,484,083	165,557,492		165,557,492
Outpatient Hospital	61,913,737		(11,417,821)	23,004,432			2,368,572	13,955,183	75,868,920		75,868,920
Supplemental Rural Critical Access Hospitals	400,000		(400,000)	0				(400,000)	0		0
Physician Services	99,606,658		(8,933,002)	14,061,208			4,700,204	9,828,410	109,435,068		109,435,068
Drugs - NET (Includes Rebates)	50,911,883		11,993,334	(12,391,662)				(398,328)	50,513,555		50,513,555
Premiums	24,089,464		11,951,650	504,322		(7,361,653)		5,094,319	29,183,783		29,183,783
Dental Services	17,026,199		962,593	4,995,320			1,045,408	7,003,321	24,029,520		24,029,520
Psychiatric Residential Treatment Facilities	25,112,375		(514,340)	(1,716,413)				(2,230,753)	22,881,622		22,881,622
Durable Medical Equipment	6,682,391		(149,984)	1,257,457			357,592	1,465,065	8,147,456		8,147,456
Psychological Services	3,795,618		1,791,598	900,672			295,160	2,987,430	6,783,048		6,783,048
Ambulance Services	5,649,154		31,774	(431,728)			238,616	(161,338)	5,487,816		5,487,816
Indian Health Services ^	26,845,632		13,378,602	(10,744,022)				2,634,580	29,480,212		29,480,212
Electronic Health Records Incentive Payment ^			64,895,312					64,895,312	64,895,312		64,895,312
Other Services	33,258,518		215,617	5,882,531	0	0	41,092,186	47,190,034	40,448,552	0	40,448,552
Chiropractic Services	878,852		155,645	188,303			55,700	399,648	1,278,500		1,278,500
Disease Management	2,891,208		(183,948)	(39,384)				(223,332)	2,667,876		2,667,876
Federally Qualified Health Centers	2,939,309		816,901	1,413,258				2,230,159	5,169,468		5,169,468
Foster Care Family Support	713,976		52,504	281,216			47,676	381,396	1,095,372		1,095,372
Home Health Services	3,104,835		(435,675)	437,320			93,934	95,579	3,200,414		3,200,414
Hospice Services	746,991		(28,221)	0				(28,221)	718,770		718,770
Laboratory & Radiology	1,806,074		(43,842)	231,544			91,148	278,850	2,084,924		2,084,924
ND Health Tracks - EPSDT Screenings	4,978,635		(235,195)	468,880			236,540	470,225	5,448,860		5,448,860
Occupational Therapy	746,001		64,399	372,776			53,372	490,547	1,236,548		1,236,548
Optometry Services	3,375,527		751,203	741,394			145,360	1,637,957	5,013,484		5,013,484
Physical Therapy	1,196,429		112,203	6,920			59,924	179,047	1,375,476		1,375,476
Rural Health Clinics	3,990,120		333,784	(303,752)				30,032	4,020,152		4,020,152
Special Education ^^	2,060,004		(172,020)	1,564,848			156,516	1,549,344	3,609,348		3,609,348
Speech & Hearing Services	1,049,817		(11,073)	287,336			60,152	336,415	1,386,232		1,386,232
Targeted Case Mgt - DJS Alt Care ^^	0		0	536,960			21,520	558,480	558,480		558,480
Targeted Case Mgt - Pregnant Women	81,732		(1,404)	(29,936)			2,308	(29,032)	52,700		52,700
Transportation Services	2,699,008		(959,944)	(275,152)			68,036	(1,167,060)	1,531,948		1,531,948
Total (Excluding Healthy Steps)	**491,365,038**	**0**	**105,519,428**	**26,512,361**	**0**	**(7,361,653)**	**16,677,182**	**141,347,318**	**632,712,356**	**0**	**632,712,356**
Healthy Steps	21,632,536		4,286,590	2,071,395				6,357,985	27,990,521	1,834,357	29,824,878
Total Medical Assistance	**512,997,574**	**0**	**109,806,018**	**28,583,756**	**0**	**(7,361,653)**	**16,677,182**	**147,705,303**	**660,702,877**	**1,834,357**	**662,537,234**
General Funds	**124,804,375**	**5,406,444 ***	**3,993,111**	**12,695,390**	**58,011,392**	**(3,049,336)**	**7,004,116**	**84,061,117**	**208,865,492**	**567,367**	**209,432,859**

* BND Loan Funds of $4,616,429 and Tobacco Money of $790,015 were replaced with General Funds.

^ Indian Health Services & Electronic Health Records Incentive Payments are 100% federally funded.

^^ Only federal funds are in the DHS budget. The matching funds are in other state agency budgets.

Attachment E

Cost and Caseload Comparison

2011-2013 Executive Budget To the Senate

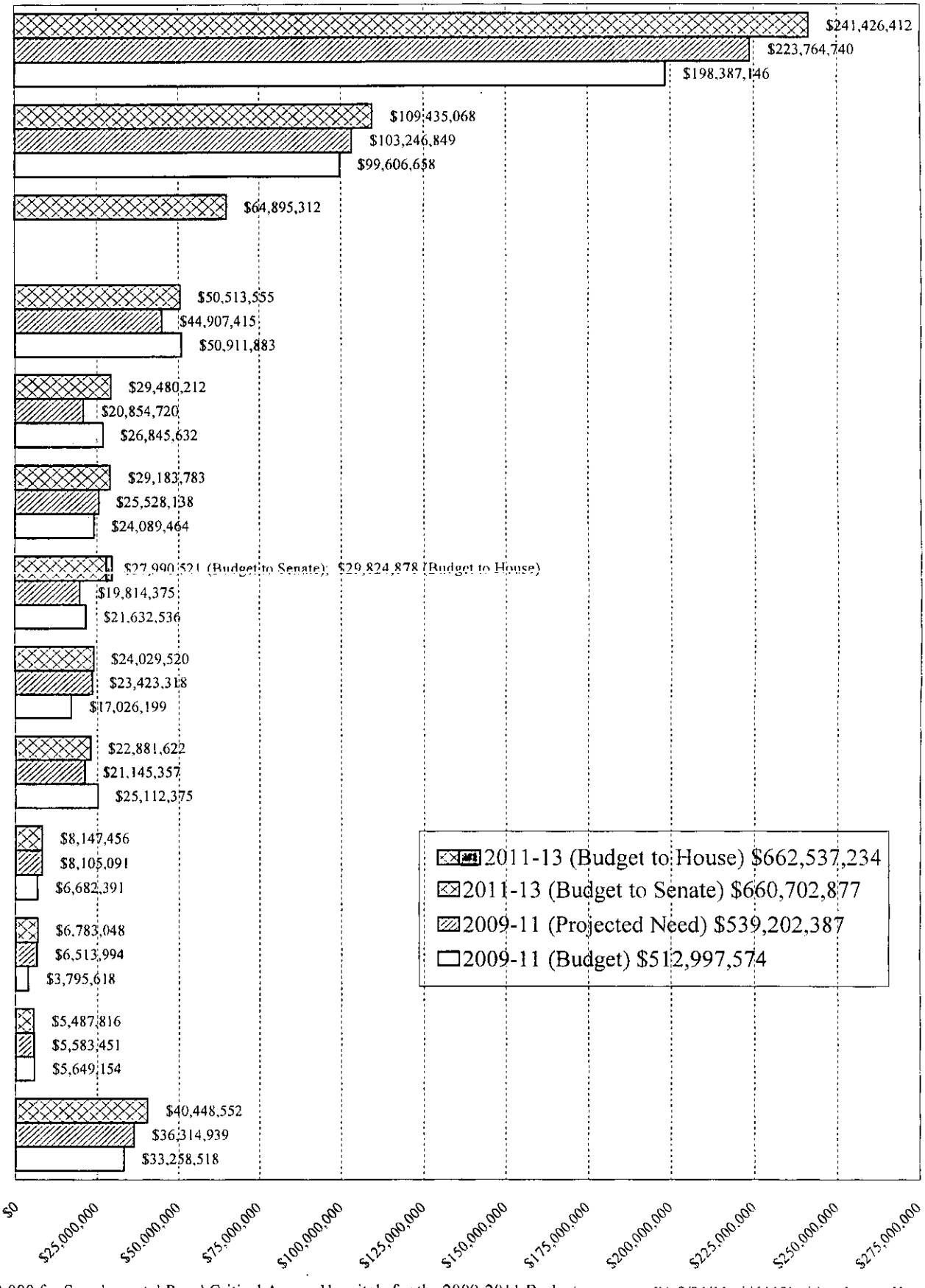
Compared to 2009 - 2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case	2011-2013 Budgeted Avg Monthly Cost per Case	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference: Increase (Decrease)
Inpatient Hospital	902.17	1,216.82	314.65	6,294	5,669	(625)
Outpatient Hospital	19.41	16.87	(2.54)	133,029	187,412	54,383
Physician Services	24.73	19.63	(5.10)	168,224	232,254	64,030
Net Drugs (Includes Rebates)	45.33	39.09	(6.24)	46,800	53,840	7,040
Premiums	111.54	133.36	21.82	8,987	9,118	131
Dental Services	60.86	65.94	5.08	11,657	15,183	3,526
Psychiatric Residential Treatment Facilities	382.38	372.64	(9.74)	90	84	(6)
Durable Medical Equipment	1.94	1.99	0.05	143,221	170,877	27,656
Psychological Services	67.88	103.98	36.10	2,331	2,718	387
Ambulance Services	14.01	14.74	0.73	16,809	15,513	(1,296)
Indian Health Services	661.87	148.02	(513.85)	1,690	8,298	6,608
EHR Incentive Payment Program	-	-	-	-	-	-
Healthy Steps	228.71	274.03	45.32	3,941	4,256	315

Attachment F

Attachment G

North Dakota Department of Human Services
Medical Services
2009-11 and 2011-13 Biennium Comparisons
Senate Bill 2012 to House (2011 - 2013 Biennium)



1/ Includes $400,000 for Supplemental Rural Critical Access Hospitals for the 2009-2011 Budget.

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Attachment ONE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs; they are Medicaid and the Children's Health Insurance Program (Healthy Steps). This area of the budget for Medicaid and Healthy Steps provides health care coverage for qualifying families and children, pregnant women, the elderly, and disabled citizens of North Dakota. Attachment A lists the Medicaid Mandatory and Optional Services, and Attachment B lists the current services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last twenty-four months.

The 2009-2011 appropriation included funding to increase the income level for Healthy Steps to 160 percent of the federal poverty level (net).

This increase was implemented July 1, 2009. The Executive Budget for Healthy Steps was built on an average caseload of 4,256 children. Attachment D shows the number of children enrolled each month in Healthy Steps for the last twenty-four months, and also provides the number of children enrolled in Medicaid for the same time period.

Currently, children eligible for either Healthy Steps or Medicaid coverage are approved for twelve months of coverage; and the twelve-month continuous coverage is included as part of the Executive Budget. When Medicaid continuous eligibility was implemented in June 2008, there were 25,914 children enrolled in this coverage. For June 2009, the enrollment was 31,780 and for June 2010, it was 33,921. The average amount paid by Medicaid per child per month prior to June 2008 was $205.65; the average from July 2008-June 2009 was $221.01; and the average from July 2009 – June 2010 was $233.75. The averages include the increases to provider reimbursement rates.

Program Trends / Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- The **funeral set aside** for Medicaid was increased to $6,000 on July 1, 2009.

- The **Medically Needy income levels** were increased to 83% of poverty, effective July 1, 2009.

- The first payment under the **critical access hospital supplemental payment** was made in March 2010. The second payment will be made in April 2011. This was one-time funding, and the funding to continue the payments was not included in the Executive Budget.

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QMB - Qualified Medicare Beneficiaries

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3. HCBS Marketing: to develop and implement a marketing plan to promote awareness of Home and Community Based Services in North Dakota.

Six additional transition coordinators will be hired by the Centers for Independent Living to enhance the efforts for outreach and transition coordination activities for individuals choosing to move from institutions to their communities.

I will provide additional information on the transitions in the Long-Term Care Services overview.

Health Care Reform

As I cover the Administrative Budget portion of this testimony, you will see there are five new full-time equivalents (FTE) that were included in the Executive Budget. These five FTE will assist the Division in the implementation and operation of the Medicaid provisions related to health care reform, and I will provide the details for each position later in my testimony.

The Affordable Care Act (ACA), or "health care reform" includes a significant expansion to the Medicaid program. This expansion would require Medicaid programs to cover the population often referred to as "childless adults." The Medicaid coverage would extend to all individuals under the age of 65 below 133% of the Federal Poverty Level (plus a 5% income disregard); and would be **effective January 1, 2014**. To date, there has been little guidance from the Centers for Medicare and Medicaid Services (CMS) about the details states need to move forward with the implementation; however, based on feedback received from CMS, we expect to receive some of the needed guidance in 2011.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	8,416,259	1,723,712	10,139,971	-	10,139,971
Operating	23,813,704	10,423,138	34,236,842	-	34,236,842
Grants	515,394,985	148,320,094	663,715,079	1,834,357	665,549,436
Total	547,624,948	160,466,944	708,091,892	1,834,357	709,926,249
General Funds	148,519,693	91,457,952	239,977,645	567,367	240,545,012
Federal Funds	365,011,673	68,231,355	433,243,028	1,266,990	434,510,018
Other Funds	34,093,582	777,637	34,871,219	-	34,871,219
Total	547,624,948	160,466,944	708,091,892	1,834,357	709,926,249
FTE	67.5	6.0	73.5	-	73.50

Budget Changes from Current Budget to the Executive Budget

The Salaries line item increased by $1,723,712 and can be attributed to the following changes:

- $496,027 in total funds, of which $217,159 is general fund, is due to the Governor's salary package for state employees.
- $168,882 in total funds, of which $115,447 is general fund, is needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $30,807 to cover an underfunding of salaries from the 2009-2011 budget.
- $293,010 in total funds, of which $99,395 is general fund for an increase in temporary salaries for additional claims staff needed to

ensure timely processing of provider payments. The Department expects to retain the temporary staff until implementation of the new Medicaid Management Information System, scheduled for June 2012.

- $123,341 in total funds, of which $63,322 is general fund, for temporary salaries to assist with the review of service limits requests, administrative support, and primary care provider questions and oversight.
- During the interim, the Department recognized a need for an additional FTE to assist with the volume of management duties within the Division. An FTE was transferred from within the Department to the Medical Services Division. The new position serves as the Deputy Director of Medical Assistance. The transfer of this position represents an increased need of $59,554.
- $16,724 in total funds, of which $4,066 is general fund, to provide for the annual and sick leave lump sum payouts for three FTE expected to retire.
- The Budget includes a new FTE in the 2011 – 2013 biennium for the conversion of a claims analyst who has been a temporary employee working for the Department full time for over four years without benefits. This FTE was derived from the FTE no longer needed at the Developmental Center and was reduced in their budget request. Total budget need for adding benefits - $23,533, with $7,559 being general fund.
- The Executive Budget also added five FTE for Health Care Reform, totaling $312,609 of which $137,697 is general fund. The addition of the positions would be staggered based on our estimates of when the additional assistance would be needed.

Position	Start Date	Total Funds	General Funds
Eligibility Policy	July 1, 2011	$ 110,919	$ 55,460
Program Integrity	January 1 2012	$ 103,961	$ 51,980
Nurse	October 1, 2012	$ 52,896	$ 13,224
SURS Analyst	January 1, 2013	$ 24,221	$ 5,888
Administrative Support	January 1 2013	$ 20,612	$ 11,145

Eligibility Policy – This position would help develop policy for the rules surrounding Medicaid expansion. This position would also develop training for county staff and assist with defining business rules for the design of the eligibility system needed to convert from the current "net" income rules to the "modified adjusted gross income" rules required by the health care law.

Program Integrity – The expectations for Medicaid program integrity are increasing significantly and with an expanded number of individuals enrolled in the program, additional staff are needed to ensure all program integrity efforts can keep up with the increased Medicaid enrollment

Nurse – This position will be responsible for managing the increased prior authorization requests expected with an expansion of Medicaid.

Surveillance and Utilization Review System (SURS) Analyst – as the Medicaid enrollment increases, so does the need to analyze recipient "use" information and ensure services are being utilized appropriately.

Administrative Support – This position would provide administrative support for the new positions as well as assist in answering an increased volume of telephone and paper correspondence, which is expected because of an increased Medicaid enrollment.

- The remaining $199,225 is a combination of increases and decreases needed to sustain the salary of the 73.5 FTE in this area of the budget.

The Executive Budget for Operating Expenses is $34.2 million which is an increase of $10.4 million.

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $26.3 million for 2011-2013. This is an **increase of $6.9 million** over the current budget of $19.4 million, and was built based on an average of 10,825 individuals at an average payment of $101.26 per person per month. The Clawback payment is funded with 96 percent general fund and 4 percent estate collections.
- The Money Follows the Person (MFP) Demonstration Grant **increased $2.5 million**. This increase is primarily funded by Federal MFP Funds.
- Operating expenses also include contracts for services, such as: utilization review and prior authorization; drug pricing; Medicaid identification cards; nursing facility screenings; actuary services; and third party liability identification.

The Executive Budget for Grants is $663.7 million, which is an increase of $148.3 million.

Senate Changes

The Senate included language and funding to increase the income eligibility level of the Children's Health Insurance Program from 160%

(net) to 175% (net) of the federal poverty level. This increase is estimated to provide coverage for an additional 445 children in the 2011-2013 Biennium.

Attachment E shows the changes in the Traditional Medicaid Grants Budget from 2009-2011 Appropriation to the 2011-2013 Budget to the House.

Attachment F is a cost and caseload comparison of the 2009-2011 Traditional Medical Grants Appropriation to the 2011-2013 Executive Budget request to the Senate for the top thirteen services. These services represent 94% of the Traditional Medicaid Grants.

Attachment G shows each Traditional Medicaid Service comparing the 2009-2011 Budget; 2009-2011 Projected Need; the 2011-2013 Executive Budget request; and the Budget to the House.

This concludes my testimony on the 2011-2013 budget request for the Traditional Medicaid and Children's Health Insurance Programs. I would happy to answer any questions.

Attachment A

North Dakota Department of Human Services
Medical Services Division

MEDICAID MANDATORY AND OPTIONAL SERVICES

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services 65 and older in IMD
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services for MR
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services & Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy Related Services and services for other conditions that might complicate pregnancy	Dental & Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy & Occupational Therapy	Nursing Facility Services Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

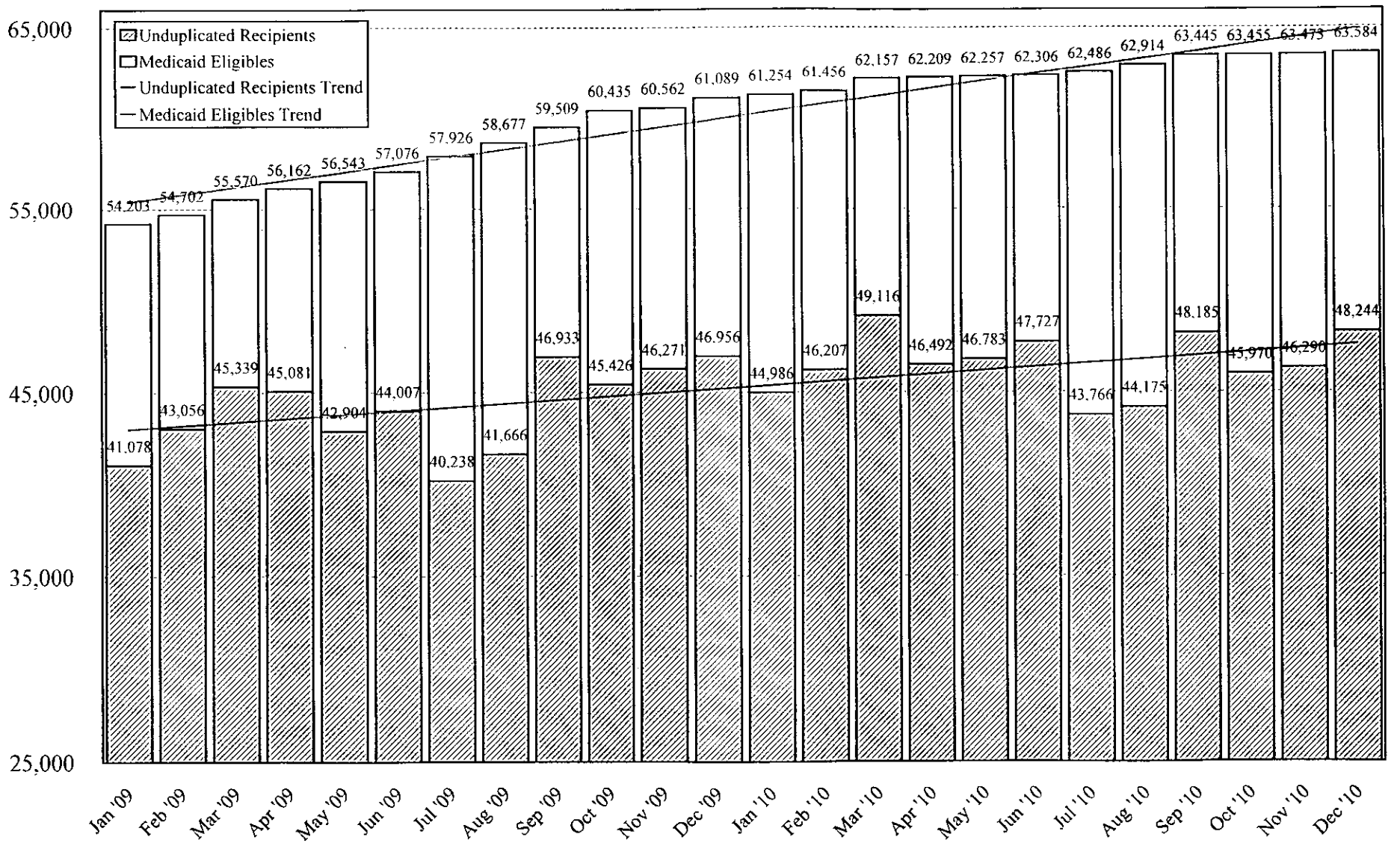
North Dakota Department of Human Services
Medical Services Division

CURRENT MEDICAID SERVICE LIMITS AND COPAYMENTS

SERVICE LIMITS	COPAYMENTS
Chiropractic Manipulations 12/year	$2 Occupational Therapy
Chiropractic X-rays 2/year	$2 Optometry Service
Physical / Occupational / Speech Therapy Evaluation 1/year	$2 Psychological Service
Occupational Therapy 20 visits/year	$1 Speech Therapy
Psychological Testing 4 hours/year	$2 Physical Therapy
Psychological Therapy 40 visits/year	$3 Podiatry Service
Speech Therapy 30 visits/year	$2 Hearing Test
Physical Therapy 15 visits/year	$3 Hearing Aid
Eyeglasses for Individuals 21 & Older once every 2 years	$75 Inpatient Hospital
Eye exams for Individuals 21 & Older once every 2 years	$3 non-emergent use of Emergency Room
Ambulatory Behavioral Health – limited based on level of care	$2 Physician Visit
Inpatient Psychiatric – 21 days per admission, not to exceed 45 days per year	$3 Federally Qualified Health Center / Rural Health Center Visit
Inpatient Rehabilitation Services – 30 days per admission	$3 Brand Prescriptions
Nursing facilities – 15 days hospital leave; 24 therapeutic leave days per year	$1 Chiropractic Services
Wheelchairs – limited to once every 5 years	$2 Dental Services
Nebulizers limited to once every 5 years	
Dentures – limited to once every 5 years	
Dietitian – 4 visits per year	
Biofeedback – 6 visits per year	

Attachment C

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients
January 2009 - December 2010

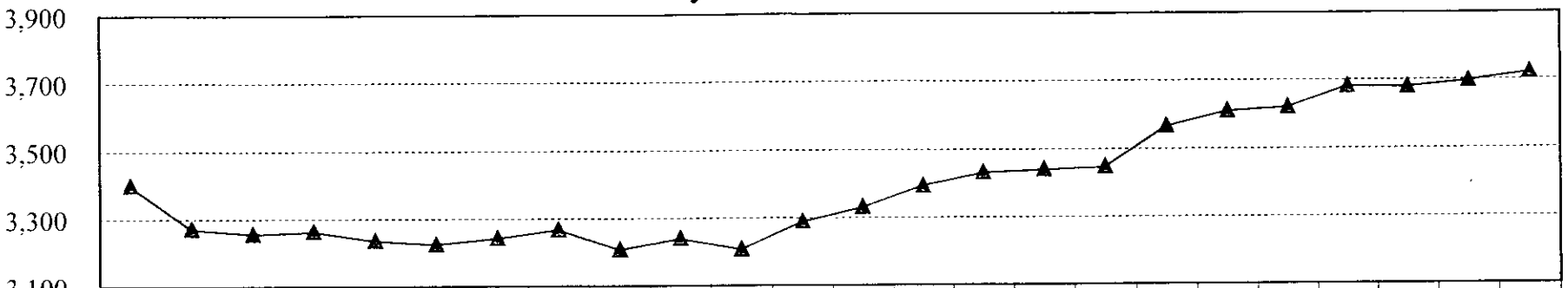


North Dakota Department of Human Services

Attachment D

Healthy Steps Premiums Paid by Month

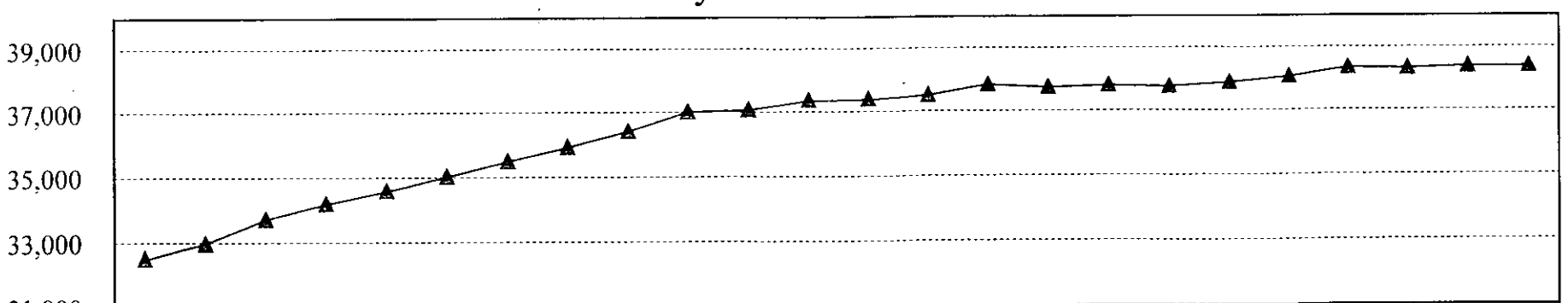
January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
3,399	3,270	3,255	3,262	3,235	3,224	3,242	3,267	3,207	3,239	3,207	3,288	3,330	3,393	3,431	3,439	3,446	3,565	3,609	3,620	3,680	3,678	3,696	3,721

Children Enrolled in Medicaid by Month

January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
32,504	32,964	33,694	34,168	34,577	35,012	35,480	35,916	36,399	37,002	37,058	37,358	37,385	37,499	37,824	37,739	37,797	37,761	37,876	38,056	38,337	38,313	38,375	38,375

North Dakota Department of Human Services
Changes in Medical Assistance Services from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation -	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP Changes	Decrease in Premium Rates	3/3 Inflation	Total Changes	2011-2013 Budget To Senate	Increase CHIP from 160% to 175% (445 Children)	2009-2011 Budget To House
Inpatient Hospital	136,073,409		21,714,395	1,190,244			6,579,444	29,484,083	165,557,492		165,557,492
Outpatient Hospital	61,913,737		(11,417,821)	23,004,432			2,368,572	13,955,183	75,868,920		75,868,920
Supplemental Rural Critical Access Hospitals	400,000		(400,000)	0				(400,000)	0		0
Physician Services	99,606,658		(8,933,002)	14,061,208			4,700,204	9,828,410	109,435,068		109,435,068
Drugs - NET (Includes Rebates)	50,911,883		11,993,334	(12,391,662)				(398,328)	50,513,555		50,513,555
Premiums	24,089,464		11,951,650	504,322		(7,361,653)		5,094,319	29,183,783		29,183,783
Dental Services	17,026,199		962,593	4,995,320			1,045,408	7,003,321	24,029,520		24,029,520
Psychiatric Residential Treatment Facilities	25,112,375		(514,340)	(1,716,413)				(2,230,753)	22,881,622		22,881,622
Durable Medical Equipment	6,682,391		(149,984)	1,257,457			357,592	1,465,065	8,147,456		8,147,456
Psychological Services	3,795,618		1,791,598	900,672			295,160	2,987,430	6,783,048		6,783,048
Ambulance Services	5,649,154		31,774	(431,728)			238,616	(161,338)	5,487,816		5,487,816
Indian Health Services ^	26,845,632		13,378,602	(10,744,022)				2,634,580	29,480,212		29,480,212
Electronic Health Records Incentive Payment ^			64,895,312					64,895,312	64,895,312		64,895,312
Other Services	33,258,518		215,317	5,882,531	0	0	1,092,186	7,190,034	40,448,552	0	40,448,552
Chiropractic Services	878,852		155,645	188,303			55,700	399,648	1,278,500		1,278,500
Disease Management	2,891,208		(183,948)	(39,384)				(223,332)	2,667,876		2,667,876
Federally Qualified Health Centers	2,939,309		816,901	1,413,258				2,230,159	5,169,468		5,169,468
Foster Care Family Support	713,976		52,504	281,216			47,676	381,396	1,095,372		1,095,372
Home Health Services	3,104,835		(435,675)	437,320			93,934	95,579	3,200,414		3,200,414
Hospice Services	746,991		(28,221)	0				(28,221)	718,770		718,770
Laboratory & Radiology	1,806,074		(43,842)	231,544			91,148	278,850	2,084,924		2,084,924
ND Health Tracks - EPSDT Screenings	4,978,635		(235,195)	468,880			236,540	470,225	5,448,860		5,448,860
Occupational Therapy	746,001		64,399	372,776			53,372	490,547	1,236,548		1,236,548
Optometry Services	3,375,527		751,203	741,394			145,360	1,637,957	5,013,484		5,013,484
Physical Therapy	1,196,429		112,203	6,920			59,924	179,047	1,375,476		1,375,476
Rural Health Clinics	3,990,120		333,784	(303,752)				30,032	4,020,152		4,020,152
Special Education ^^	2,060,004		(172,020)	1,564,848			156,516	1,549,344	3,609,348		3,609,348
Speech & Hearing Services	1,049,817		(11,073)	287,336			60,152	336,415	1,386,232		1,386,232
Targeted Case Mgt - DJS Alt Care ^^	0		0	536,960			21,520	558,480	558,480		558,480
Targeted Case Mgt - Pregnant Women	81,732		(1,404)	(29,936)			2,308	(29,032)	52,700		52,700
Transportation Services	2,699,008		(959,944)	(275,152)			68,036	(1,167,060)	1,531,948		1,531,948
Total (Excluding Healthy Steps)	**491,365,038**	**0**	**105,519,428**	**26,512,361**	**0**	**(7,361,653)**	**16,677,182**	**141,347,318**	**632,712,356**	**0**	**632,712,356**
Healthy Steps	21,632,536		4,286,590	2,071,395				6,357,985	27,990,521	1,834,357	29,824,878
Total Medical Assistance	**512,997,574**	**0**	**109,806,018**	**28,583,756**	**0**	**(7,361,653)**	**16,677,182**	**147,705,303**	**660,702,877**	**1,834,357**	**662,537,234**
General Funds	**124,804,375**	**5,406,444 ***	**3,993,111**	**12,695,390**	**58,011,392**	**(3,049,336)**	**7,004,116**	**84,061,117**	**208,865,492**	**567,367**	**209,432,859**

* BND Loan Funds of $4,616,429 and Tobacco Money of $790,015 were replaced with General Funds.

^ Indian Health Services & Electronic Health Records Incentive Payments are 100% federally funded.

^^ Only federal funds are in the DHS budget. The matching funds are in other state agency budgets.

Attachment E

Cost and Caseload Comparison

2011-2013 Executive Budget To the Senate

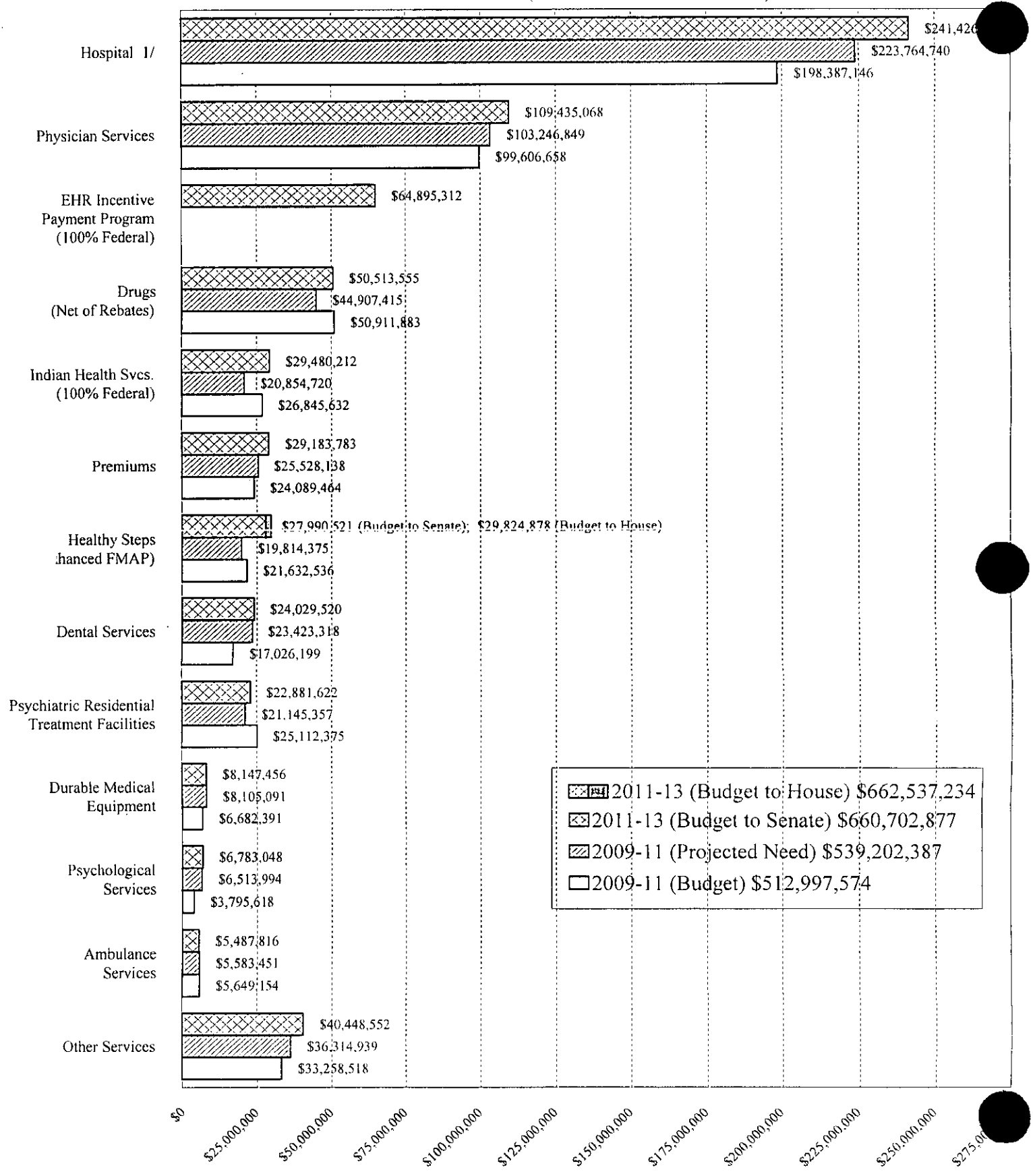
Compared to 2009 - 2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case	2011-2013 Budgeted Avg Monthly Cost per Case	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference: Increase (Decrease)
Inpatient Hospital	902.17	1,216.82	314.65	6,294	5,669	(625)
Outpatient Hospital	19.41	16.87	(2.54)	133,029	187,412	54,383
Physician Services	24.73	19.63	(5.10)	168,224	232,254	64,030
Net Drugs (Includes Rebates)	45.33	39.09	(6.24)	46,800	53,840	7,040
Premiums	111.54	133.36	21.82	8,987	9,118	131
Dental Services	60.86	65.94	5.08	11,657	15,183	3,526
Psychiatric Residential Treatment Facilities	382.38	372.64	(9.74)	90	84	(6)
Durable Medical Equipment	1.94	1.99	0.05	143,221	170,877	27,656
Psychological Services	67.88	103.98	36.10	2,331	2,718	387
Ambulance Services	14.01	14.74	0.73	16,809	15,513	(1,296)
Indian Health Services	661.87	148.02	(513.85)	1,690	8,298	6,608
EHR Incentive Payment Program	-	-	-	-	-	-
Healthy Steps	228.71	274.03	45.32	3,941	4,256	315

Attachment F

Attachment G

North Dakota Department of Human Services
Medical Services
2009-11 and 2011-13 Biennium Comparisons
Senate Bill 2012 to House (2011 - 2013 Biennium)



1/ Includes $400,000 for Supplemental Rural Critical Access Hospitals for the 2009-2011 Budget.

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Attachment TWO

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Long-Term Care Continuum budget.

Programs

The long-term care services included in this area of the budget are the Developmentally Disabled Community-Based Care grants; Nursing Facilities, Basic Care Facilities, and the Home and Community-Based Services Programs which have the following funding sources: (Service Payments for the Elderly and Disabled (SPED); Expanded SPED; the Medicaid Technology-Dependant Waiver; Personal Care; the Program for All-Inclusive Care of the Elderly (PACE); Targeted Case Management; Children's Medically Fragile Waiver, Children's Hospice Waiver, and the Medicaid Home and Community-Based Services Waiver).

The Long-Term Care Continuum encompasses a wide range of medical and support services for individuals who lack some capacity for self-care, and are expected to need care for an extended period of time.

I will provide an overview of the long-term care continuum budget, with the exception of the Developmental Disabilities grants, which will be provided by Tina Bay, Director of the Developmental Disabilities Division.

Program Trends

Nursing Facilities

As of September 30, 2010, the percentage of Medicaid-eligible individuals in nursing facilities was 52 percent. Attachment A shows the Licensed and Occupied Nursing Facility Beds since October 2008, and Attachment B shows the Medicaid occupied beds. Based on the September 30, 2010 occupancy reports, 24 facilities were below 90 percent occupancy. The average occupancy for these 24 facilities is 78 percent. The Department continues to believe that a moratorium on the number of nursing facility beds should remain. During the 2009-10 and the 2007-08 interims, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the nursing facility beds that are being shifted through the state. The Department's 2011-2013 Budget takes the "bed shifting" into account and is predicated on the moratorium continuing.

Basic Care

The Department continues to believe that a moratorium on the number of basic care beds should also remain. The process in place for requested exceptions to come before the Department of Health and the Department of Human Services continues to work well to manage the number of Basic Care beds. Similar to Nursing Facility beds, the Department has worked with the North Dakota Long Term Care Association for the purpose of tracking the basic care beds that are being shifted and added throughout the state.

Home and Community-Based Services

Home and Community-Based Services (HCBS) continue to provide an array of services determined to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care. HCBS staff work closely with county case managers and providers to ensure clients have the services they need in a timely and efficient manner. Ongoing collaboration occurs between HCBS staff and the Centers for Medicare and Medicaid (CMS) to identify changes in federal requirements and to continually enhance quality measures to assure clients and families are receiving the appropriate services to meet their needs.

Major Program Changes

The following items were authorized by the 2009 Legislature and were implemented during the 2009-2010 Interim:

- Increased the **home delivered meals** offered in the HCBS waiver from 3 meals per week to 7 meals per week; effective January 1, 2010.

- 2009 House Bill 1433 authorized a **supplemental payment for at-risk nursing facilities.** No facility has requested reimbursement under this provision.

- 2009 House Bill 1327 authorized funding to **convert a nursing facility** into a basic care/assisted living facility. Funds to **operate**

a rent-subsidy pilot project were also included. The funding will expire June 30, 2011.

- Implemented **non-medical transportation** in SPED and ExSPED; effective January 1, 2010.

- The **SPED fee schedule** was updated, based on actual cost of living adjustments. This change was effective July 1, 2009.

- The **Adult Family Foster Care Point Split** was removed effective January 1, 2010.

- The **Hospice for Children Waiver** was implemented July 1, 2010, after receiving approval from the Centers for Medicare and Medicaid Services.

- The **third tier of Personal Care** was implemented January 1, 2010.

- The $20 **Personal Needs Allowance** for SSI only individuals was implemented January 1, 2010.

Money Follows the Person Demonstration Grant

As noted in the Traditional Medicaid testimony, the passage of the Affordable Care Act extended the Money Follows the Person (MFP) grant through 2020. The grant is now expected to transition 87 individuals with a developmental disability and 265 individuals who reside in a nursing facility to the community. To accomplish the new transition expectations,

CMS has authorized 100 percent federal administrative funding discussed previously.

The primary barriers to transition identified to date include the limited availability of affordable and accessible housing, shortage of qualified service providers in rural North Dakota, limited public awareness of the types of home and community based services offered in the home, varied availability of home health/hospice services across the state, and rural transportation capacity. Through December 2010, forty- four individuals were transitioned to the community. The transition goal for Calendar Year 2011 is thirty-nine individuals. Included with this testimony are two MFP brochures (one for each transition population) to provide additional information and detail.

Minimum Data Set (MDS) 3.0

On October 1, 2010, North Dakota, as well as other states began using Version 3.0 of the Minimum Data Set (MDS). MDS is part of the federally mandated process for clinical assessment of all residents in nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are completed for all residents in certified nursing homes, regardless of individual's source of payment. MDS assessments are required for residents on admission to the nursing facility and periodically thereafter, within specific guidelines and time frames. MDS information is transmitted electronically by nursing homes to the state Medicaid office, and is used as the cornerstone for establishing the resident's per day cost of care.

With the implementation of MDS 3.0, one of the modifications the Department made to the classification logic was to recognize a distinct classification period for therapies when the initiation or discontinuation of therapies results in a change in a resident's classification. A resident's classification period will remain as a 3-month period; however, during that 3-month period, if a resident was classified in a rehab category and therapies are discontinued the resident's classification will be changed as of the date all therapies were discontinued to the classification that would otherwise have been in effect at the beginning of the classification period had there been no therapies. Likewise, if therapies are started during the 3-month classification period, a resident's classification may be changed as of the start date of therapies.

Overall, the implementation of MDS 3.0 went smoothly. We continue to answer questions from providers and work on individual issues as needed.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Budget	Senate Changes	To House
Nursing Homes	425,713,210	33,409,823	459,123,033	-	459,123,033
Basic Care	18,113,925	7,858,470	25,972,395	-	25,972,395
SPED	17,495,327	(3,712,339)	13,782,988	-	13,782,988
Ex-SPED	726,578	250,146	976,724	-	976,724
Personal Care Services	25,044,599	4,105,306	29,149,905	-	29,149,905
Targeted Case Management	1,957,896	(393,147)	1,564,749	-	1,564,749
HCBS Waiver	8,707,606	1,560,780	10,268,386	-	10,268,386
Children's Medically Fragile Waiver	1,147,844	(829,064)	318,780	-	318,780
Technology Dependent Waiver	532,608	(32,472)	500,136	-	500,136
PACE	7,393,711	1,977,269	9,370,980	-	9,370,980
Children's Hospice Waiver	856,410	914,020	1,770,430	-	1,770,430
Total	507,689,714	45,108,792	552,798,506	-	552,798,506
General Fund	172,803,502	75,045,834	247,849,336	-	247,849,336
Federal Funds	324,704,819	(23,030,709)	301,674,110	-	301,674,110
Other Funds	10,181,393	(6,906,333)	3,275,060	-	3,275,060
Total	507,689,714	45,108,792	552,798,506	-	552,798,506

FTE	-	-	-	-	-

Budget Changes from Current Budget to the Executive Budget

Nursing Homes

The Executive Budget was based on Medicaid nursing home days paid. The monthly average days are projected to be:

97,832	–	Nursing Facility
449	–	Dakota Alpha
975	–	Geropsych Unit
1,310	–	Swing Bed
2,650	–	Hospice Room and Board
1,888	–	Out of State
105,104		Total

A "day" is the unit of service for nursing facilities. Basing the nursing facility budget on bed days more closely mirrors how claims are reimbursed by Medicaid. For example, if an individual enters the nursing home on the 20th of January. The facility may chose to bill Medicaid for January and February at the same time. This results in the "bed" only being counted once, even though the days are greater than 30.

Attachment C shows historical information on expenditures and average daily Nursing Facility Rates.

Upper Payment Limit

The Medicaid regulations contain a requirement that Medicaid payments to institutional providers, including nursing facilities, in the aggregate, cannot exceed what Medicare would pay, in the aggregate, for the same care. This is known as the Upper Payment Limit (UPL). The Upper Payment Limit must be calculated yearly for each type of facility: private; state-government owned, and non-state government owned.

Historically, the gap between the Medicaid payments and the Upper Payment Limit has been large enough, where this has not been an issue or something the Department needed to bring to your attention. However, the increases provided by the 2009 Legislature, have resulted in North Dakota approaching the Upper Payment Limit for the private facilities, and actually, for 2011, exceeding the Upper Payment Limit for the non-state government owned facilities. The Department is working with the non-state government owned facilities to ensure their rates for 2011 are in compliance with the Upper Payment Limit.

During session, when there are requests for fiscal impact related to nursing facility rates, the Department will be providing information on the estimated impact the proposed change will have on the upper payment limit and whether the proposed change will be able to be implemented by the Department under the Medicaid regulations.

Senate Changes

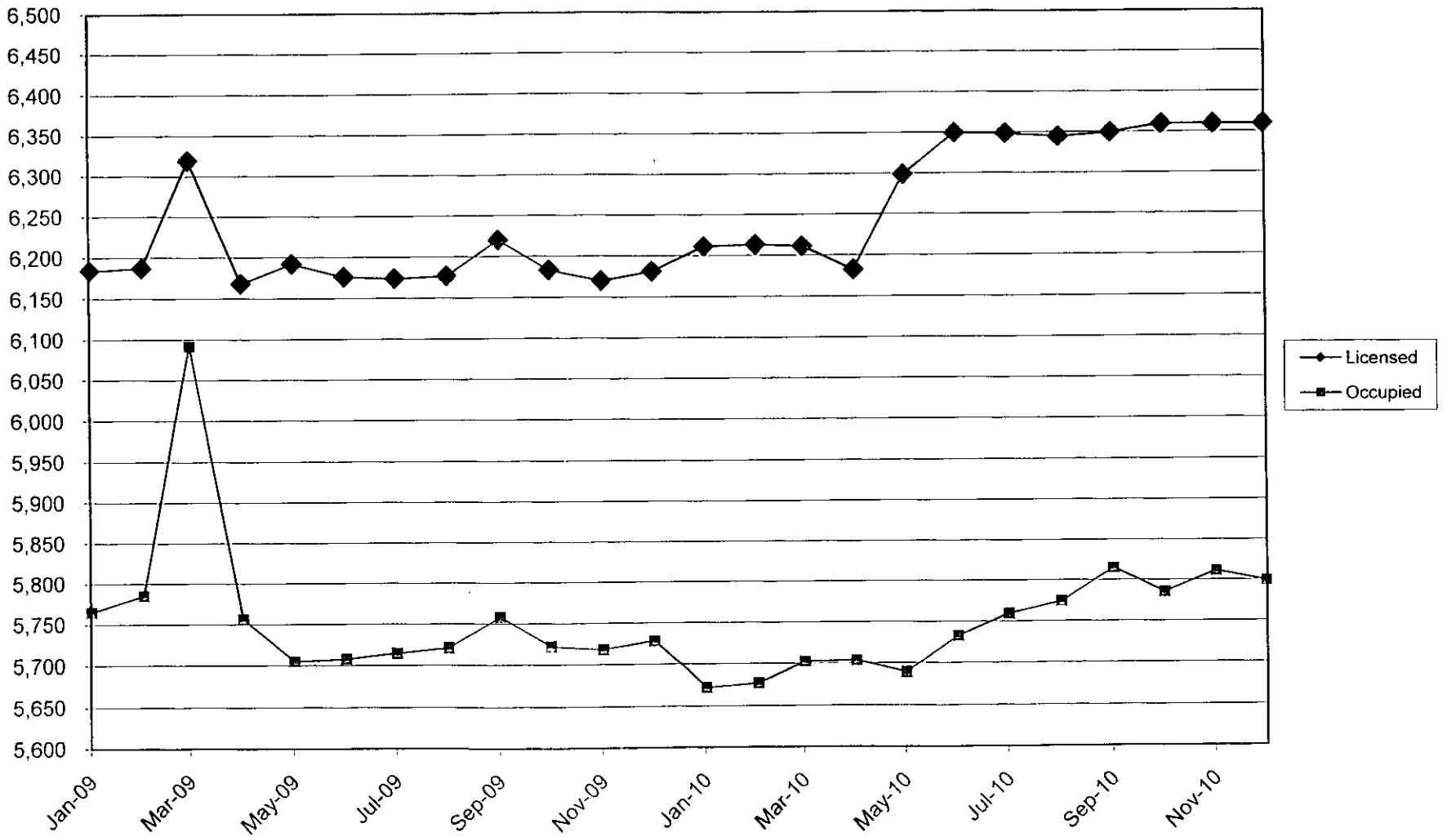
The Senate made no changes to this section of the Department's Budget.

Attachment D shows the changes in the Long Term Care Continuum Budget from 2009-2011 Appropriation to the 2011-2013 Executive Budget request; to the Budget to the House.

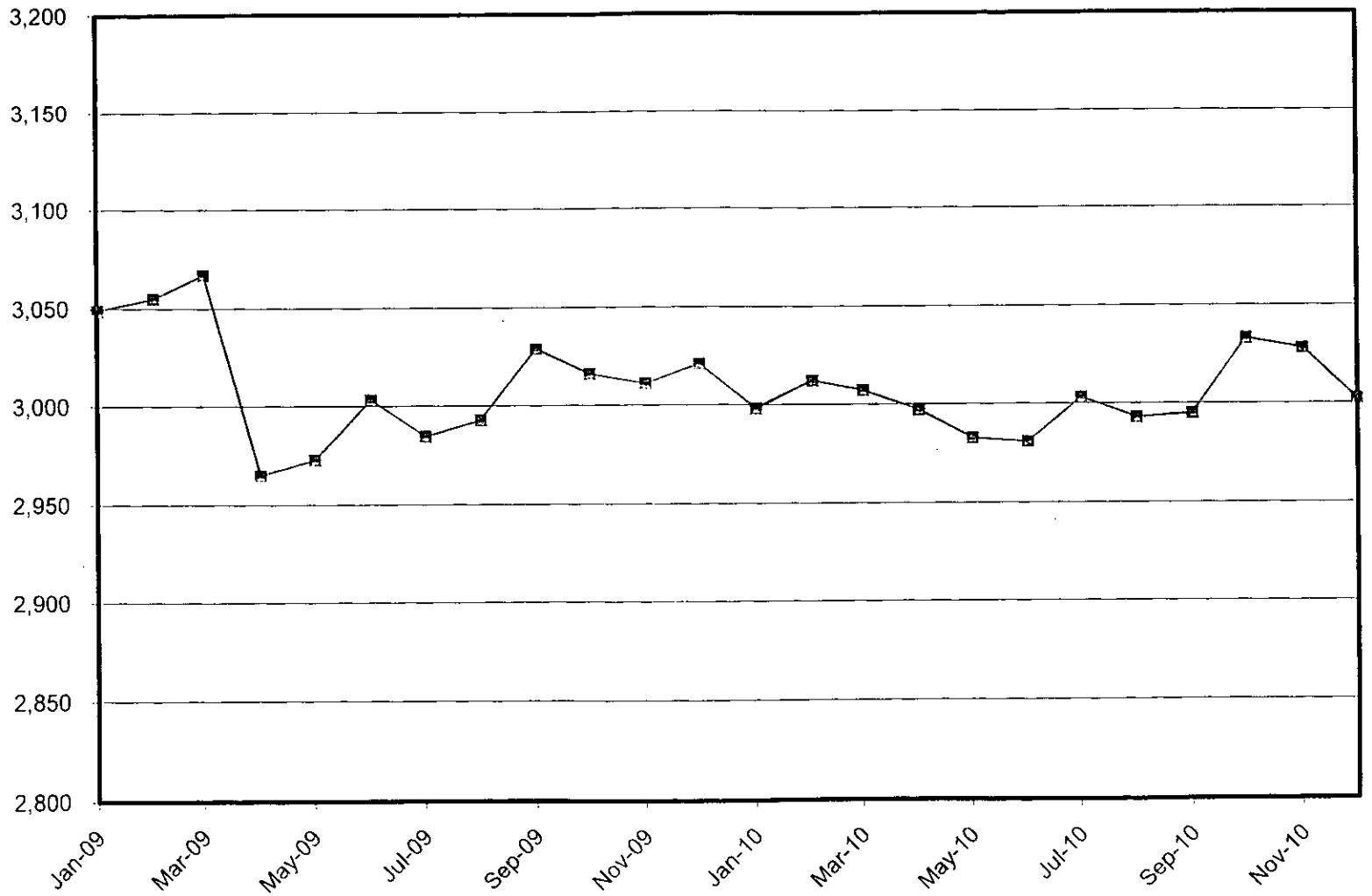
Attachment E is a cost and caseload comparison of the 2009-2011 Appropriation to the 2011-2013 Budget to the Senate.

This concludes my testimony on the 2011 – 2013 budget request for Long-Term Care Continuum. I would be happy to answer any questions.

NF Occupancy at Month End

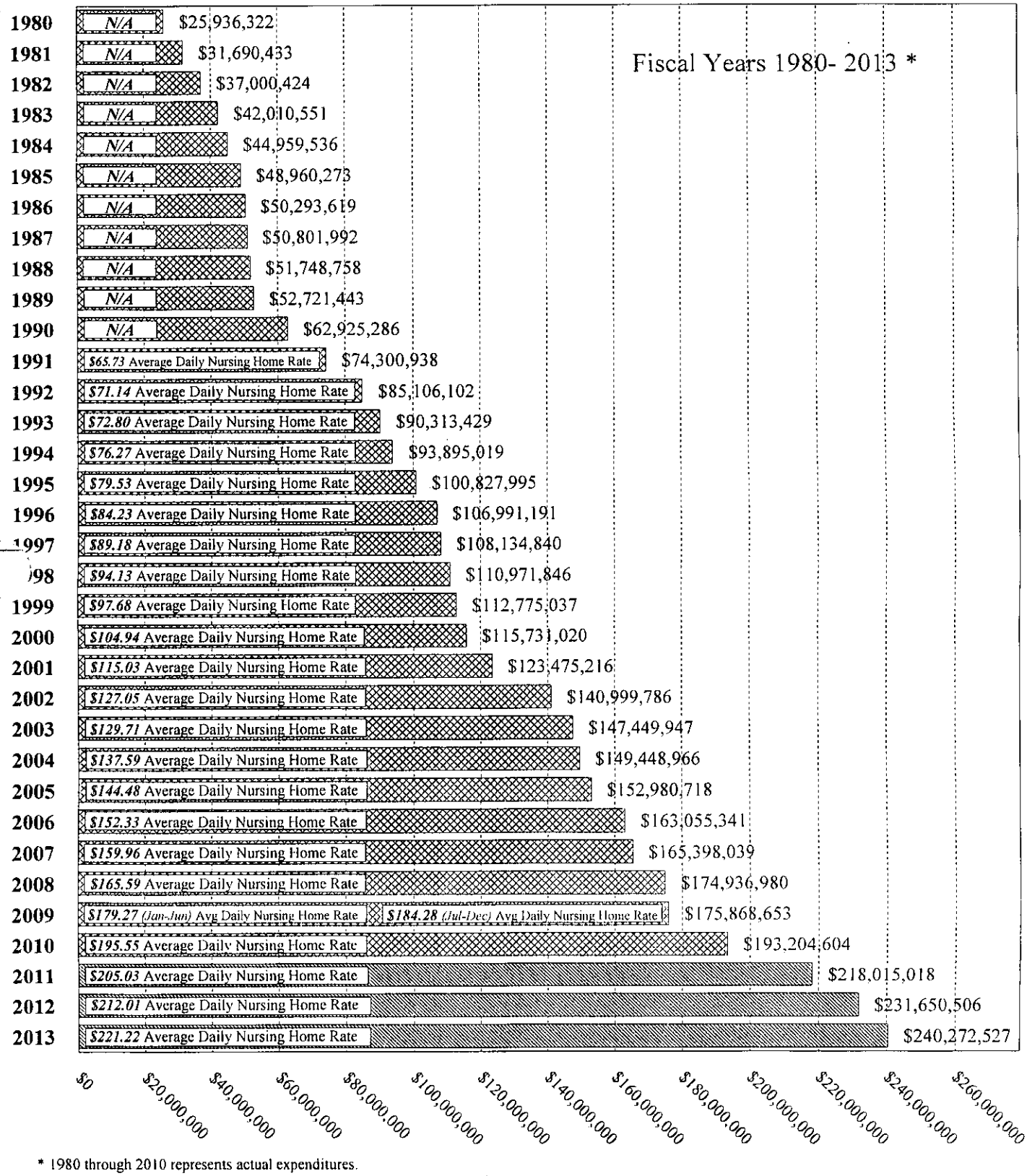


NF Occupancy at Month End Medicaid ONLY



Attachment C

North Dakota Department of Human Services
Nursing Home Facilities
Senate Bill 2012 to House
2011 - 2013 Biennium



* 1980 through 2010 represents actual expenditures.
2011 represents one month actual and eleven months estimated expenditures.
2012 and 2013 represents estimated expenditures included in the Governor's budget.
The average daily nursing home rate is effective January 1 of each year as indicated.
NOTE: Budget amount for 2012 and 2013 reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

FA-2/24/11-cj-1113legis\ltc H

North Dakota Department of Human Services
Changes in Long Term Care from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Offset for General Fund Carryover **	Total Changes	2011-2013 Budget To Senate	Total Changes	2009-2011 Budget To House
Nursing Homes	425,713,210		18,306,125	16,979,110		10,924,588	(12,800,000)	33,409,823	459,123,033		459,123,033
Basic Care ^	18,113,925		2,995,658	3,726,798		1,136,014		7,858,470	25,972,395		25,972,395
Home & Community Based Services	363,862,579		1,538,520	(248,688)		2,550,667		3,840,499	67,703,078	0	67,703,078
SPED ^^	17,495,327		(1,901,567)	(2,411,820)		601,048		(3,712,339)	13,782,988		13,782,988
Ex-SPED ^^^	726,578		121,856	85,229		43,061		250,146	976,724		976,724
Personal Care Services	25,044,599		2,830,627	(6)		1,274,685		4,105,306	29,149,905		29,149,905
Targeted Case Management	1,957,896		(552,024)	90,558		68,319		(393,147)	1,564,749		1,564,749
Home & Community Based Services Waiver	8,707,606		705,502	404,800		450,478		1,560,780	10,268,386		10,268,386
Children's Medically Fragile Waiver	1,147,844		(771,555)	(71,873)		14,364		(829,064)	318,780		318,780
Technology Dependent Waiver	532,608		65,376	(119,592)		21,744		(32,472)	500,136		500,136
PACE	7,393,711		1,049,983	927,286				1,977,269	9,370,980		9,370,980
Children's Hospice Waiver	856,410		(9,678)	846,730		76,968		914,020	1,770,430		1,770,430
Total	**507,689,714**		**22,840,303**	**20,457,220**	**0**	**14,611,269**	**(12,800,000)**	**45,108,792**	**552,798,506**	**0**	**552,798,506**
General Funds	**172,803,502**	**6,817,423 ***	**7,702,004**	**6,162,907**	**60,084,630**	**7,078,870**	**(12,800,000)**	**75,045,834**	**247,849,336**	**-**	**247,849,336**

Other Areas:

Community of Care Funds $120,000 for both the 09-11 and 11-13 Biennium- 100% General funds

Personal Care Needs Allowance SSI $148,068 for the 09-11 Biennium and 108,000 for the 11-13 Biennium - 100% General Funds

Assisted Living Rent Subsidy $200,000 for the 09-11 Biennium and $0 for the 11-13 Biennium - IGT Funds

* BND Loan Funds of $2,692,917 and IGT Funds of $4,124,506 were replaced with General Funds.

** Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

^ Room & board costs are funded with general funds and retained funds.

^^ SPED is funded with 95% general funds and 5% county funds.

^^^ Expanded SPED is funded with 100% general funds.

Attachment D

Cost and Caseload Comparison

2011 - 2013 Executive Budget To the Senate

Compared to 2009 - 2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case ^	2011-2013 Budgeted Avg Monthly Cost per Case ^	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload *	2011-2013 Budgeted Avg Monthly Caseload *	Difference: Increase (Decrease)
Nursing Homes (Daily Rates)	175.55	187.09 ^^	11.54	101,072	105,104	4,032
Basic Care (Daily Rates)	27.23	33.14	5.91	27,706	32,651	4,945
Personal Care	1,551.83	1,810.10	258.27	671	671	-
Technology Dependent Waiver	8,825.30	10,419.32	1,594.02	3	2	(1)
Children's Medically Fragile Waiver	4,276.19	1,473.38	(2,802.81)	11	9	(2)
SPED	456.02	425.40	(30.62)	1,597	1,350	(247)
Expanded SPED	235.13	287.61	52.48	129	142	13
PACE	4,053.57	4,620.80	567.23	76	85	9
Targeted Case Management	178.12	133.74	(44.38)	458	488	30.00
HCBS Waiver	1,084.98	1,215.48	130.50	334	352	18.00
Children's Hospice Waiver	2,378.91	2,458.93	80.02	30**	30	-

^ With the exception of Nursing Homes and Basic Care which are daily rates all other categories are average monthly cost per case.

^^ 11-13 Nursing Home rate above reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

* Nursing Homes and Basic Care caseload represents the number of "Days" paid in a month for recipients. All other categories represent the number of recipients paid for in a month.

** The Children's Hospice was budgeted to begin in the 2nd year of the 09-11 biennium at 30 persons per month. The average shown is for the 12 months of SFY 2011.

Attachment E

Developmental Disabilities
Case Management Service Providers

Human Service Center Contact Information

Bismarck – 701-328-8888
888-328-2662

Devils Lake – 701-665-2200
888-607-8610

Dickinson – 701-227-7500
888-227-7525

Fargo – 701-298-4500
888-342-4900

Grand Forks – 701-795-3000
888-256-6742

Jamestown – 701-253-6300
800-260-1310

Minot – 701-857-8500
888-470-6968

Williston – 701-774-4600
800-231-7724

North Dakota Department of Human Services, Medical Services Division

Jake Reuter, MFP Grant Program Administrator,
Email: jwreuter@nd.gov Phone: 701-328-4090,
Fax: 701-328-1544

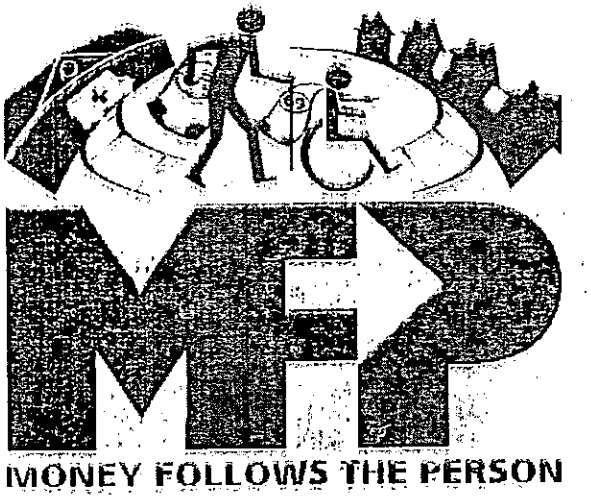
MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

north dakota department of human services

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Award # 1LICMS030171/01

DN 1364 (8-08)



Developmental Disabilities

Program Information and Transition Services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave the North Dakota Developmental Center or other intermediate care facility for persons with mental retardation (ICF/MR, institution) and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in ICFs/MR (institutions) who are Medicaid eligible, who have resided in an institutional setting for at least six months, and who meet the requirements for at least one of the following programs:

- MR/DD waiver (Meets ICF/MR Level of Care, Requires supports for Health & Safety, and needs can be met through specific services for individuals with mental retardation).
- Self Directed Supports for Families or Adults waivers (Meets ICF/MR Level of Care, Requires support for Health & Safety, Needs can be met through specific services for individuals with mental retardation, Person lives with a primary caregiver who is capable of self directing services or Person lives with a primary caregiver or independently and is Capable of self directing services)
- Medically Fragile Children waiver (Determined to meet nursing facility level of care, 3 to 18 years of age. Greatest need as determined through a Level of Need ranking process. Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting. Child lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than six months may be assisted with transition from an institution by Developmental Disabilities case management staff through other programs, as appropriate.

How Does MFP Work?

north dakota department of human services

The MFP Program can assist individuals interested in leaving an ICF/MR by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota's Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, home furnishing, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end September 30, 2011.

MFP will provide services to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in an ICF/MR and would like to learn about options available to return to the community please contact: Your local Human Service Center or Jake Reuter, MFP Program Administrator at 701-328-4090.

Transition Coordination Providers

Dakota Center For Independent Living
3111 East Broadway Avenue, Bismarck, ND 58501
Phone (Voice/TTY): (701) 222-3636
Toll Free: (800) 489-5013
E-mail: dcil@dakotacil.org

Options Resource Center For Independent Living
318 3rd Street NW, East Grand Forks, MN 56721
Phone (Voice/TTY): 218-773-6100
Toll Free: (800) 726-3692
E-mail: options@myoptions.info

Freedom Resource Center For Independent Living
2701 9th Avenue SW, Fargo, ND 58103
Phone (Voice/TTY): (701) 478-0459
Toll Free: (800) 450-0459
E-mail: freedom@freedomrc.org

Independence, Inc. Center For Independent Living
300 3rd Avenue SW, Suite F, Minot, ND 58701
Phone: (701) 839-4724, TTY: (701) 839-6561
Toll Free: (800) 377-5114
E-mail: agency@independencecil.org

North Dakota Department of Human Services, Medical Services Division
Jake Reuter, MFP Grant Program Administrator,
Phone: 701-328-4090, Fax: 701-328-1544
E-mail: jwreuter@nd.gov

MFP Website http://www.nd.gov/dhs/info/pubs/mfp.html

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Award # 1LICMS030171/01

DN 1365 (10-10)

MONEY FOLLOWS THE PERSON

Program Information and Transition Services

north dakota department of human services

What is the Money Follows the Person Demonstration Grant?

The Money Follows the Person Demonstration Grant (the MFP Program) is a special program developed by the federal government that provides participating states (like North Dakota) with funding that the State uses to assist people to leave a nursing facility and move to their own home in the community.

Who is Eligible to Participate in the MFP Program in North Dakota?

The MFP Program is limited to persons residing in nursing facilities who are Medicaid eligible for one day, who have resided in an institutional setting for at least three months, who score 8 or higher on the MDS 3.0 cognitive assessment, and do not have an Alzheimer's diagnosis, and who meet the requirements for, and participate, in at least one of the following State programs:

- Home and Community Based Services waiver, (Determined to be in need of nursing facility level of care, and Age 16 and over and physically disabled or at least 65 years of age);
- Technology Dependent Waiver, (Determined to be in need of nursing facility level of care, Age 18 and over and physically disabled or at least 65 years of age, Medically Stable, Competent, and Vent dependent at least 20 hrs per day);
- Medically Fragile Children waiver (Determined to be in need of nursing facility level of care, 3 to 18 years of age, Greatest need as determined through a Level of Need ranking process, Requires support for Health & Safety, Needs at least one waiver service quarterly to remain in family home setting, Lives with a primary caregiver capable of self directing services).

Persons who are not Medicaid eligible or who have resided in an institutional setting for less than three months may be assisted with transition from a nursing facility by Centers for Independent Living staff through other programs, as appropriate (contact information on back).

How Does MFP Work?

The MFP Program can assist individuals interested in leaving a nursing facility (NF) by providing:

- Information to help them make an informed choice regarding transition and participation in the MFP Program;
- Access to transition services and assistance from a transition coordinator through North Dakota Centers for Independent Living;
- Payment for some one-time moving costs or activities; (rental deposits, furniture, household supplies) and
- Post-discharge follow-up to ensure the move is satisfactory and the individual's needs are being met.

What Housing Choices Will Money Follows the Person Offer?

The MFP grant will operate throughout the state of North Dakota and will transition individuals into a qualified residence, such as:

- The individual's home or a family home;
- A shared home, where no more than three other (four total) unrelated individuals reside;
- An adult foster care home (AFCH) where no more than three other (four total) unrelated individuals reside;
- An apartment, including those in HUD subsidized housing complexes or congregate housing complexes.

When is the Money Follows the Person Program in Effect?

The MFP program will operate in North Dakota beginning June 20, 2008 and will end December 31, 2019.

MFP will fund services provided to individuals participating in the program for 365 days after transition to the community. After that, individuals will continue to receive needed services from the State without interruption.

If you, or someone you care about, lives in a nursing facility and would like to learn about options available to return to the community please contact your local Center for Independent Living (contact information on back) or Jake Reuter, MFP Program Administrator at 701-328-4090.

MFP
MONEY FOLLOWS THE PERSON

north dakota
department of
human services

- Attachment THREE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Tina Bay, Director of the Developmental Disabilities Division with the Department of Human Services. I am here today to provide an overview of the Long Term Care Developmental Disability Grants Budget, for the Department of Human Services.

Programs
The Developmental Disability Services grants are funded through the Medicaid State Plan, three Medicaid Home and Community-based waivers, Part C of IDEA (Individuals with Disabilities Education Act) and general funds.

Caseload / Customer Base
In SFY 2010, 5,341 individuals received developmental disability program management through the human service centers,

2,892 Individuals received family support program services, including family subsidy, infant development, family support, parenting support and extended home health,

3,070 individuals received residential and/or days services, and 605 individuals received self-directed support services, which enable individuals and families to hire their own in home support staff and access environmental supports/modifications and equipments and supplies.

Program Trends / Major Program Changes

Services for young children with DD – Caseload growth continues in the number of young children with developmental disabilities needing support.

Autism Spectrum Disorder Waiver – On November 1st, 2010 the Centers for Medicare and Medicaid Services (CMS) approved the state's request for a Medicaid waiver for Autism Spectrum Disorders. This waiver will provide service options for individual's birth through four years of age, living with a primary caregiver. This waiver may serve up to 30 children per year. The services under the waiver are environmental modifications, equipment and supplies, in-home supports and intervention coordination. The goal of the waiver is to support the primary caregiver to maximize the child's development and prevent out of home placements.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Developmental Disability Grants	341,542,546	55,453,487	396,996,033	11,364,049	408,360,082
General Funds	110,730,341	63,500,966	174,231,307	5,021,489	179,252,796
Federal Funds	229,621,551	(6,856,825)	222,764,726	6,342,560	229,107,286
Other Funds	1,190,654	(1,190,654)			
Total	341,542,546	55,453,487	396,996,033	11,364,049	408,360,082

FTE					

Budget Changes from Current Budget to the Executive Budget:

The majority of the caseload growth in the 2011-2013 budget is due to:

- 22 additional high school graduates expected to need services each year of the biennium, and;
- an increase of 5 children per month (120 for the biennium) expected to need infant development services.

Senate Changes:

The Senate added $11.4 million, of which $5.0 million is general fund, to provide a $0.50 per hour wage increase to the staff of Developmental Disability Providers.

Attachment A shows the changes in the Developmental Disability Grants from the 2009-2011 Appropriation, to the 2011-2013 Executive Budget Request; to the Budget to the House.

This concludes my testimony on the 2011 – 2013 budget for Long Term Care Developmental Disability Grants area of the Department. I would be happy to answer any questions.

North Dakota Department of Human Services
Changes in DD Grants from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation	Funding Shift *	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Total Changes	2011-2013 Budget To Senate	Increase DD Staff Salary and Benefits by $0.50	2011-2013 Budget To House
Family Subsidy	1,746,336		4,404,912	(5,289,240)	0	39,192	(845,136)	901,200		901,200
Intermediate Care Fac. for Mentally Retarded	113,446,346		6,146,123	4,556,953		5,342,697	16,045,773	129,492,119	2,502,957	131,995,076
DD Home & Community Based Services	217,483,407		10,529,469	17,174,815	(17,392)	11,149,463	38,836,355	256,319,762	8,861,092	265,180,854
Autism Waiver	1,038,000		(148,272)	889,728		80,868	822,324	1,860,324	0	1,860,324
DD Funding Buckets ^	7,828,457		227,996	0		366,175	594,171	8,422,628	0	8,422,628
Total DD Grants	341,542,546	0	21,160,228	17,332,256	(17,392)	16,978,395	55,453,487	396,996,033	11,364,049	408,360,082
General Funds	110,730,341	1,190,654	10,652,533	2,363,437	41,819,324	7,475,018	63,500,966	174,231,307	5,021,489	179,252,796

* BND Loan Funds of $1,190,654 were replaced with general funds

^ Enhanced funding for various critical needs provided to children and adults with disabilities.

Attachment A

- Attachment FOUR

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Andrea Peña, Executive Director of the State Council on Developmental Disabilities. I am here today to provide you an overview of the Council's budget request.

Programs

The State Council on Developmental Disabilities administers the federal Developmental Disabilities Act Basic State Grant allocated to North Dakota. The Council directs this funding toward projects and activities that advocate policies and support programs which promote choice, independence, productivity, and inclusion for North Dakotans with developmental disabilities.

Program Trends / Major Program Changes

For the 2011-2013 biennium, the Council intends to continue to award grants to state and local private, nonprofit agencies and organizations. Activities under these grants will need to address at least one of four areas of emphasis identified as priorities in the Council's federally approved five-year plan. These priority areas include: Education and Early Intervention; Employment; Community Supports; and Quality Assurance. More specifically, grant-funded activities under these priority areas are intended to assist persons with Developmental Disabilities to:

- Have access to services available in the community that affect their quality of life;
- Get and keep employment consistent with their interests, abilities, and needs;
- Reach their educational and developmental potential; and
- Have the information, skills, opportunities, and supports needed to live free of abuse, neglect, exploitation, and violation of their human and legal rights.

Under its federally approved five-year plan for 2007-2011, the Council is responsible for tracking and annually reporting performance data on 26 performance outcome measures to the federal Administration on Developmental Disabilities. Among other performance outcome data, some of the Council's accomplishments for 2010 include:

- 148 people were trained in employment.
- 22 adults with disabilities in the state received jobs of their choice through Council efforts.
- 141 people became active in systems advocacy about community supports.
- 8 buildings/public accommodations became accessible.
- 819 people received training in quality assurance.
- 538 people were trained in leadership, self-advocacy, and self determination.
- 351 public policymakers were educated about issues related to Council initiatives.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	150,373	11,722	162,095		162,095
Operating	52,831	79,821	132,652		132,652
Grants	812,514	(191,372)	621,142		621,142
Total	1,015,718	(99,829)	915,889		915,889
Federal Funds	1,015,718	(99,829)	915,889		915,889

FTE	1.0	0	1.0		1.0

The DD Council's budget request is 100 percent federal funding.

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item increased by $11,722, which can be attributed to:

- $8,345 in total funds to support the Governor's salary package for state employees.
- $1,711 in federal funds to support the second year employee increase for 24 months versus the 12 months that are contained in the current department budget proposal.
- $1,666 in federal funds which cover Council member meeting stipends. Stipend funds previously came out of the Operating line item.

The Operating line item increased by $79,821, which can be primarily attributed to:

- Personnel which will be contracted with to fulfill federal program requirements for the Council under the DD Act.

The greatest share of the Council's proposed budget continues to be allocated to the Grants line item. The grants line item decreased by $191,372, which can be attributed to:

- In the previous biennium, there were significant carryover monies which needed to be utilized or it would have been lost.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the State Council on Developmental Disabilities. I would be happy to answer any questions.

- Attachment FIVE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Jan Engan, Director of the Aging Services Division with the Department of Human Services. I am here today to provide an overview of the Division's budget for the Department of Human Services.

Programs

The Aging Services Division provides home and community based service options to maintain individuals in their homes and communities and assists in protecting the health, safety, welfare and rights of residents of long-term care settings and vulnerable adults in the community. This includes administration of Older Americans Act federal funds, the Long-Term Care Ombudsman Program, the Guardianship Program for Vulnerable Adults, State Funds to Providers, Telecommunications Equipment Distribution Program, the Senior Community Service Employment Program, Qualified Service Provider Training, support for the Governor's Committee on Aging, Dementia Care Services, the Aging and Disability Resource-LINK, and the Aging and Disability Resource Center pilot grant.

The Aging Services Division is a federally designated single planning and services area, which requires the Division to carry out the responsibilities of the State Unit on Aging and the Area Agency on

Aging as set forth in the Older Americans Act (OAA). Among the requirements in the 2006 reauthorization of the OAA is the following: "require state agencies to promote the development and implementation of a state system of long-term care that enables older individuals to receive long-term care in home and community based settings in accordance with the individual's needs and preferences."

Caseload / Customer Base

The Graying of North Dakota brochure (Attachment 1) provides an outline of the aging demographic in North Dakota. More recent data taken from "Aging Is Everyone's Business" provides the following:

- In 2007, North Dakota counties ranked high in the percentage of population ages 60 and older.
- McIntosh County ranks number one in the nation among 3,142 counties for the highest percent of the population age 60 and older (42.8%) and number two in the nation for percent of population ages 85 and older (9.1%).
- North Dakota has 34% of the counties (18) with concentrations of 30% of individuals ages 60 and older compared to 4% of the counties nationwide.
- Between 2000 and 2020, the older adult population (60 and older) is expected to grow by about 43% while the child population (0-14 years) is expected to decline by 13.4% and the working population (15-64 years) is also expected to decline by 6.1%.
- A population shift of persons 60 years and older from rural North Dakota communities to urban North Dakota communities is expected from 2000 to 2030.

- In 2000, persons 60 years and older living in rural areas was 74,706 (63%) as compared to persons 60 years and older living in urban areas at 44,279 (37%).
- In 2020, this same age group will be about the same; 50% living in rural communities and 50% living in urban communities.
- By 2030, there is a population shift in this age group where 45% will be living in rural communities and 55% will live in urban communities.

- Growth is expected in the older population through 2050;
  - In 2011, the first Baby Boomer will reach age 65 (Baby Boomers include anyone born between 1946 and 1964).
  - In 2030, all Baby Boomers will be between ages 65 and 84 and the population 65 and older will comprise about 25% of North Dakota's total population.
  - In 2050, Baby Boomers will be age 85 and older.

In Federal Fiscal Year (FFY) 2009, 27,479 older persons received Older Americans Act funded services, which included home-delivered meals, congregate meals, information and assistance, outreach, health maintenance services, assistive safety devices, senior companion services, national family caregiver program services, legal services, vulnerable adult protective services, and long-term care ombudsman services.

See Attachment 2 for additional information about Older Americans Act Services.

FFY 2009 Program Utilization

Older Americans Act – Title III Programs		
SERVICE	UNITS OF SERVICE	
Congregate Meals	690,570 meals	1 unit= 1 meal
Home Delivered Meals	508,155 meals	1 unit= 1 meal
Health Maintenance	139,688 units	Set unit/procedure
Information & Assistance	1,655 units	1 unit = 1 contact
Legal Assistance	3,984 units	1 unit = 1 hour
Assistive Safety Devices	2,168 units	1 unit = 1 device
Outreach	86,145 units	Set unit/procedure
Senior Companion	4,534 units	1 unit = 1 contact

Family Caregiver Support Program	
Unduplicated Caregivers Served	453
Unduplicated Grandparents Served	7
Respite Care Provided	56,182 hours

Vulnerable Adults Program	
New Cases	530
Closed Cases	456
Information/referral	395
Brief Services (2 hrs or less)	231
Hours	5,689

Long-Term Care Ombudsman Program	
Number of Complaints	715
Number of Cases Opened	518

- The Qualified Service Provider (QSP) training program, under contract with Lake Region State College has trained 125 QSPs from July 2008 to June 2009 for the provision of in-home care. The training is provided by 29 nurses statewide. To enroll as a Qualified Service Provider, the individual must obtain documentation of competency. Documentation of competency requires a signature of a health care professional. Many QSPs choose to participate in the approved training program provided by Lake Region State College. Successful completion of the program provides the documentation of competency as signed by the nurse trainer. As of November 2010 there were 1,778 QSPs statewide which included 145 agencies. Of the 1,778 QSP's statewide, family home care or family personal care is provided by 368 QSPs, which means that those QSPs provide services to only one client (a family member).
- The Senior Community Service Employment Program (SCSEP) provided on-the-job training to 71 low-income individuals over the age of 55. The Division is contracting with Experience Works (formerly Green Thumb) to provide direct service to the enrollees. From July 1, 2009 to June 30, 2010; there were 26 placements to unsubsidized employment settings. Experience Works serves an additional 287 enrollees in North Dakota through a national contract with the Department of Labor.
- Dementia Care Services was implemented in January 2010 through the passage of House Bill 1043. The Division is contracting with the Alzheimer's Association of MN/ND to provide resources, assistance and support for citizens across North Dakota, in all geographic areas.

DEMENTIA CARE SERVICE January – September 2010	
Public Awareness/Training Activities	2,578 Individuals

Assessment/Care Consultations	344 Individuals
Caregiver Training	1,608 Individuals

The Alzheimer's Association has contracted with the Center for Rural Health to conduct the study and report the outcomes of the program; including the estimated long-term care and health care costs avoided, and the improvement in disease management and caregiver assistance.

- Implementation of the Aging and Disability Resource LINK (ADRC) www.carechoice.nd.gov (Attachment 3) completed the first phase of the "No Wrong Door" or single point of entry approach to services for older adults and persons with disabilities in North Dakota. Receipt of the Aging and Disability Resource Center – Options Counseling grant opened the second phase of this model implemented through a 3-year pilot starting in Region VII. This service delivery model is a process that does not duplicate existing services; nor does it replace the functions of other agencies, but instead strengthens the lines of communication (referral), establishes criteria for follow-up and brings community agencies together to build on existing services; to cross-train staff; to educate and inform the public; to network and enter into collaborative agreements that results in more effective and efficient service to older persons and persons with disabilities and to their families by providing a single point of entry for all persons seeking information and services. The ADRC process addresses gaps, avoids duplication and improves consumer access to service options and information. The roll-out of ADRC Options Counseling throughout the state will take place over the next two years; January 2011, Region II will transition the outreach system to options counseling and this will be followed by Region I and VIII in January 2012; Region VII in September 2012 and Regions III, IV, V and VI in January 2013. The

ADRC concept uses the person centered approach with three main functions: 1) information and awareness through public education and information on long-term support options; 2) assistance through long-term support options including counseling, referral, crisis intervention and planning for future needs; and 3) access through pre-eligibility screening for public pay services, comprehensive assessment and access to private pay services.

AGING & DISABILITY RESOUCE CENTER Pilot OPTIONS COUNSELING (9 mo. 4/10 - 12/10)	
Contacts made to ADRC	369
Contacts by Consumers	170
Contacts by Caregivers	73
Contacts by Professionals	123
Contacts by Other	3
Options Counseling Clients	70

Program Trends / Major Program Changes

- The increasing costs of providing nutrition services to include raw food costs and supplies; compliance with federal dietary requirements for congregate and home delivered meals; transportation costs for meal delivery; population shifts from rural to urban, as well as service needs in the sparsely populated rural and frontier communities; along with fairly flat federal funding have increased the burden on contract providers to meet expenses in providing services to older adults, specifically in the area of nutrition services.
- Through the expansion of various initiatives including Money Follow the Person and changes in the Minimum Data Set (MDS 3.0) individuals needing long-term care services and support now have more choice in care options through home and community based services. Many studies have shown that consumers of long-term care services prefer to

remain at home; to live with or near family; and to have the opportunity to maintain independence as supported by the ND Real Choice Systems Change Grant Rebalancing Initiative (9/04-9/07). The trend to keep persons in their homes and communities has increased the demand in the labor market for qualified service providers as evidenced by the increased use in the QSP program provided at Lake Region State College. During 2010 there is an average of 35 to 40 new QSP applications per week. The numbers support a significant turnover in this occupation as there is an increase in applications and persons trained yet the number on the QSP list does not fluctuate. The focus to provide services in the home and community is supported by increased federal initiatives such as Lifespan Respite, ADRC Nursing Home Transition and Diversion Program and the Veterans Directed Home and Community Based Services.

- As increased numbers of North Dakotans reach 80 years of age and older and since the incidence and prevalence of Alzheimer's disease and other related dementias increase with age, it is expected the number of individuals with these conditions will also grow rapidly. Estimates indicate there are about 18,000 North Dakotans with Alzheimer's disease being cared for by some 17,000 family members. Alzheimer's disease impacts the health and well-being of the recipient and also impacts the caregiver who report experiencing high levels of stress and negative effects on their health, employment, income and financial security. Continued efforts to provide access to assessments, referrals and information on services, caregiver training and community education will be needed to sustain the ability of caregivers in their efforts to provide care needed in the home setting.
- The long-term care ombudsman program provides services to protect the health, safety, welfare and rights of residents living in nursing

facilities, assisted living, swing bed, transitional care units and basic care facilities. State and Federal law address the requirements of the program. There has been an increase in both nursing facility and basic care beds and assisted living units in North Dakota. For example: Bismarck-Mandan increased nursing facility and basic care beds 21% from 2008 to 2009 with an additional increase of 14.5% in 2010; this community also increased assisted living units by 105% from 2008 to 2009 with an additional 4% increase expected in 2010.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	1,380,188	81,126	1,461,314		1,461,314
Operating	13,040,730	721,881	13,762,611		13,762,611
Grants	2,935,668	(28,726)	2,906,942	(10,000)	2,896,942
Total	17,356,586	774,281	18,130,867	(10,000)	18,120,867
General Funds	3,784,842	891,434	4,676,276	(10,000)	4,666,276
Federal Funds	13,261,552	(86,961)	13,174,591		13,174,591
Other Funds	310,192	(30,192)	280,000		280,000
Total	17,356,586	774,281	18,130,867	(10,000)	18,120,867
FTE	10	0	10		10

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item is increased by $81,126:

- An increase of $78,694 in total funds of which $78,696 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $25,750 in total funds of which $15,228 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.

- A decrease of $19,579 of federal funds which were included in salaries to cover a portion of existing salaries which will be moved from the ADRC demonstration project salaries to cover additional ADRC operating fees related to the purchase of services.
- The remaining net decrease of $3,739 is a combination of increases and decreases needed to sustain the salary of the 10 FTE in this area of the budget.

The Operating line item increased by $721,881 and is mainly a combination of the following increases and decreases:

- Travel increase of $49,716 ($17,099 general fund) is mainly attributed to the following:
  - An increase of $24,673 of federal funds for the ADRC demonstration project due to an increase of on-site visits;
  - An increase of $5,537 of federal funds related to increased activity in Ombudsman services due to additional Assisted Living facility visits;
  - An increase of $9,250 in Senior Employment due to additional federal funds available to complete mandatory training and increased monitoring activities;
  - An increase of $8,167 of which $4,718 is general fund in Administration due to increased training needs and monitoring activities.
- Net increase of $14,152 of which $7,849 is general fund for the Division and ADRC demonstration project expenses that include office supplies, printing, office equipment, repairs, insurance, IT, postage and telephone.
- Prairie Hills Plaza rent increase and office space for ADRC demonstration project for a total increase of $19,160 of which $16,043 is federal funds.

- Operating Fees and Services has a net increase of $642,402 that mainly includes the following:
  - An increase in federal funds of $99,967 related to the ADRC demonstration project (the $99,967 increase includes the $19,579 moved from salaries to operating fees and services);
  - An increase in federal funds of $35,000 related to increasing the funding available for QSP training;
  - A general fund increase of $83,468 for State Funds to Providers to continue the inflationary increase provided for in the 2009-2011 biennium and to provide a 3% per year inflationary increase in the 2011-2013 biennium;
  - An increase in Title-III federal funding of $649,359 for: Title III-B Support ($115,607), Home Delivered Meals ($235,796), Family Caregiver Support ($71,454) and Congregate Nutrition ($226,502);
  - A general fund increase of $300,000 for Congregate Nutrition;
  - A decrease in federal funds of $485,000 due to the removal of ARRA funds of $325,000 related to congregate nutrition and $160,000 for home delivered nutrition;
  - Decrease in federal funds to the Nutrition Services Incentive Program of $45,384.

The Grants line item decreased by $28,726 and is a combination of the following increases and decreases:

- A federal funds increase of $41,274 in the Senior Employment program comprised of a decrease of $143,288 due to the removal of ARRA funds and an increase of $184,562 due to increased federal funding.
- A general fund increase of $10,000 for the Silver Haired Assembly.

- A decrease of $30,000 of other funds in Telecommunications Equipment because less authority is needed this biennium as a result of less tax being collected for distribution.
- A federal funds decrease of $50,000 due to Senior Legal Hotline federal grant ending.

Senate Changes:

The Senate reduced grants by $10,000 from the general fund due to the removal of the grant for the Silver Haired Assembly.

This concludes my testimony on the 2011 – 2013 budget request for Aging Services Division of the Department. I would be happy to answer any questions.

north dakota department of human services

Older Americans Act Services

Federal Fiscal Year 2009

Background

The Older Americans Act was signed into law July 14, 1965, for the purpose of improving the lives of older individuals in relation to income, housing, employment, long-term care, retirement, and community services. In addition to creating the Administration on Aging (AoA), the Act authorized grants to states for community planning, programs and services, and research, demonstration, and training projects in the field of aging.

The Department of Human Services' Aging Services Division serves as the single planning and service agency for older persons in North Dakota, as designated by the U.S. Department of Health and Human Services, AoA.

Eligibility

The Older Americans Act (OAA) provides funding for services for individuals age 60 and older. Services are not tied to income. Individuals must have an opportunity to contribute to the cost of the service, but no one can be denied service due to inability or unwillingness to contribute toward the cost.

Priority is given to serve older individuals who:

- Reside in rural areas
- Have low incomes/greatest economic and social needs
- Are considered to be of a minority
- Have limited English proficiency
- Have severe disabilities
- Are diagnosed with Alzheimer's disease and related disorders (*as well as, the caretakers of such individuals*)
- Are at risk of institutional placement

ndividuals Served

- During Federal Fiscal Year 2009, a total of **27,479 older individuals** in North Dakota received services funded under the Older Americans Act.

OAA Requirements

Under this federal law, states are required to develop a comprehensive and coordinated system of home and community-based services that allows older individuals to lead independent, meaningful, and dignified lives in their own homes and communities.

To accomplish this, Older Americans Act funds, state funds, and local funds are coordinated to avoid duplication and maximize service. The Department of Human Services' Aging Services Division contracts with local providers for services.

OAA Services Provided

Assistive Safety Devices – A service that provides adaptive and preventive health aids that will assist individuals in their activities of safe daily living.

Senior Center/Congregate Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual eating in a group setting.

Home-Delivered Meals – A service that provides meals consisting of at least one-third of the daily dietary needs for an older individual who is homebound and unable to prepare an adequate meal.

Health Maintenance Services – Services provided to assess and maintain the health and well being of older individuals. Services include blood pressure/pulse/rapid inspection, foot care, home visits, and medication set-up.

Outreach Services – Efforts to seek out older individuals and identify their needs and to then make appropriate referral and linkage to available services.

Senior Companion Services – A service that offers periodic companionship and non-medical support by volunteers (who receive a stipend) to older individuals that require assistance.

Continued on other side →

OAA Services (*Continued*)

Legal Assistance Services - Legal advice and representation are provided by an attorney to older individuals with economic or social needs and includes: 1) to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and 2) counseling or representation by a non-lawyer where permitted by law.

Information and Assistance - A service provided by the Department's **Aging and Disability Resource-LINK**, a nationwide toll-free number (**1-800-451-8693**), that provides information on a wide range of home and community-based and long term care and support services, volunteer opportunities, and benefits. Information can also be accessed on-line at http://www.carechoice.nd.gov/.

Senior Community Service Employment Program - Provides part-time employment opportunities in community service activities for unemployed low-income persons who are 55 years or older and who have fewer employment prospects.

Older Americans Act funds are also used to provide services through the:

- North Dakota Family Caregiver Support Program
- Long-Term Care Ombudsman Program
- Vulnerable Adult Protective Services Program

Separate fact sheets are available for each of the programs.

The Division also administers an **Aging and Disability Resource Center** demonstration grant funded by the Administration on Aging.

Federal Fiscal Year 2009 Older Americans Act Services

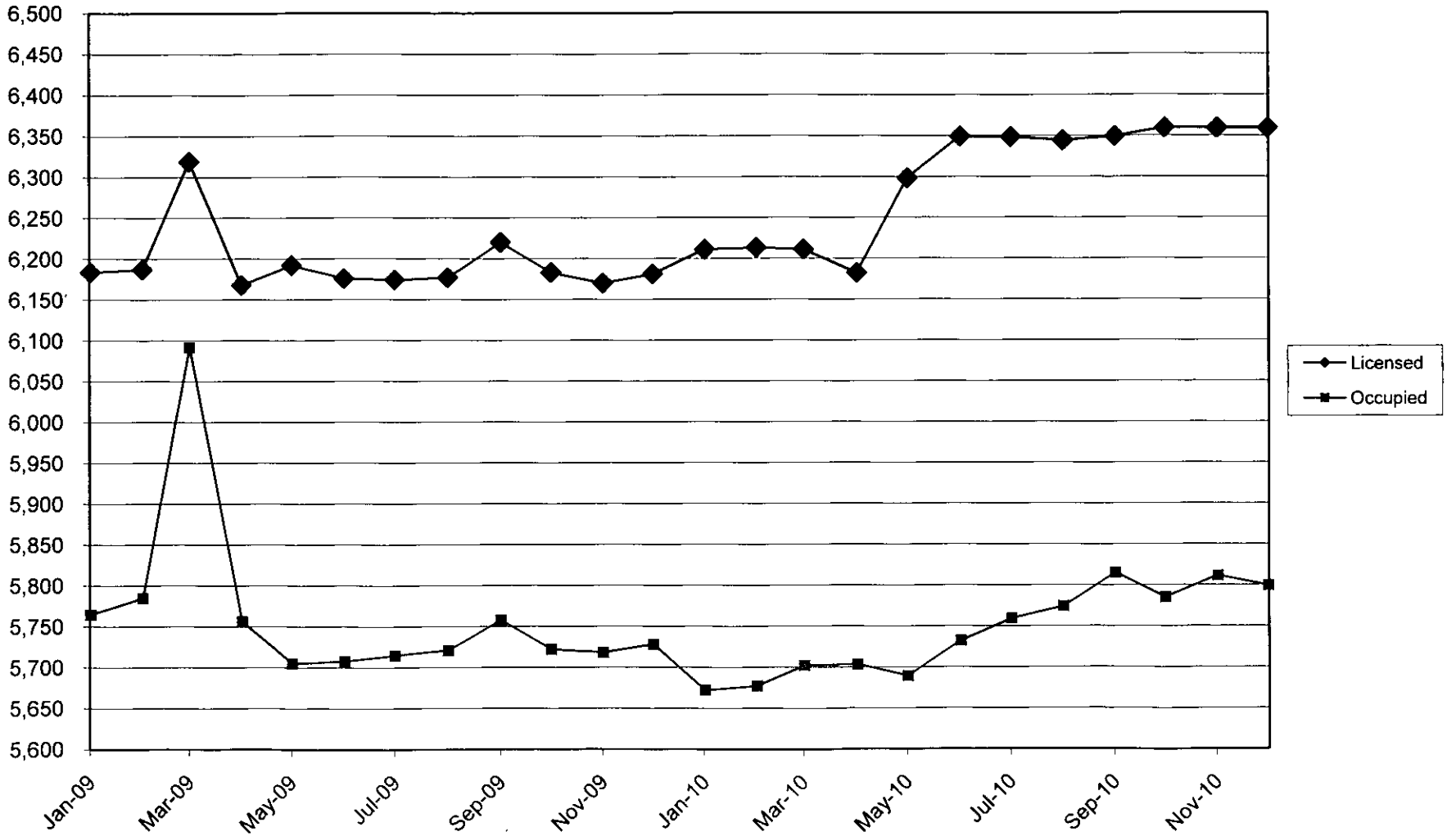
Number of Individuals Served/Units of Service Provided

Service	Individuals Served	Units of Service	
Assistive Safety Devices	1,397	2,168 devices	1 unit = 1 device
Congregate Meals	13,910	690,570 meals	1 unit = 1 meal
Home-Delivered Meals	5,364	508,155 meals	1 unit = 1 meal
Health Maintenance	4,579	139,688 units	Set billing units per service
Information & Assistance	1,655	1,655 units	1 unit = 1 contact
Legal Assistance	955	3,984 units	1 unit = 1 hour
Outreach	12,501	86,145 units	Set billing units per activity
Senior Companion	210	4,534 units	1 unit = 1 contact

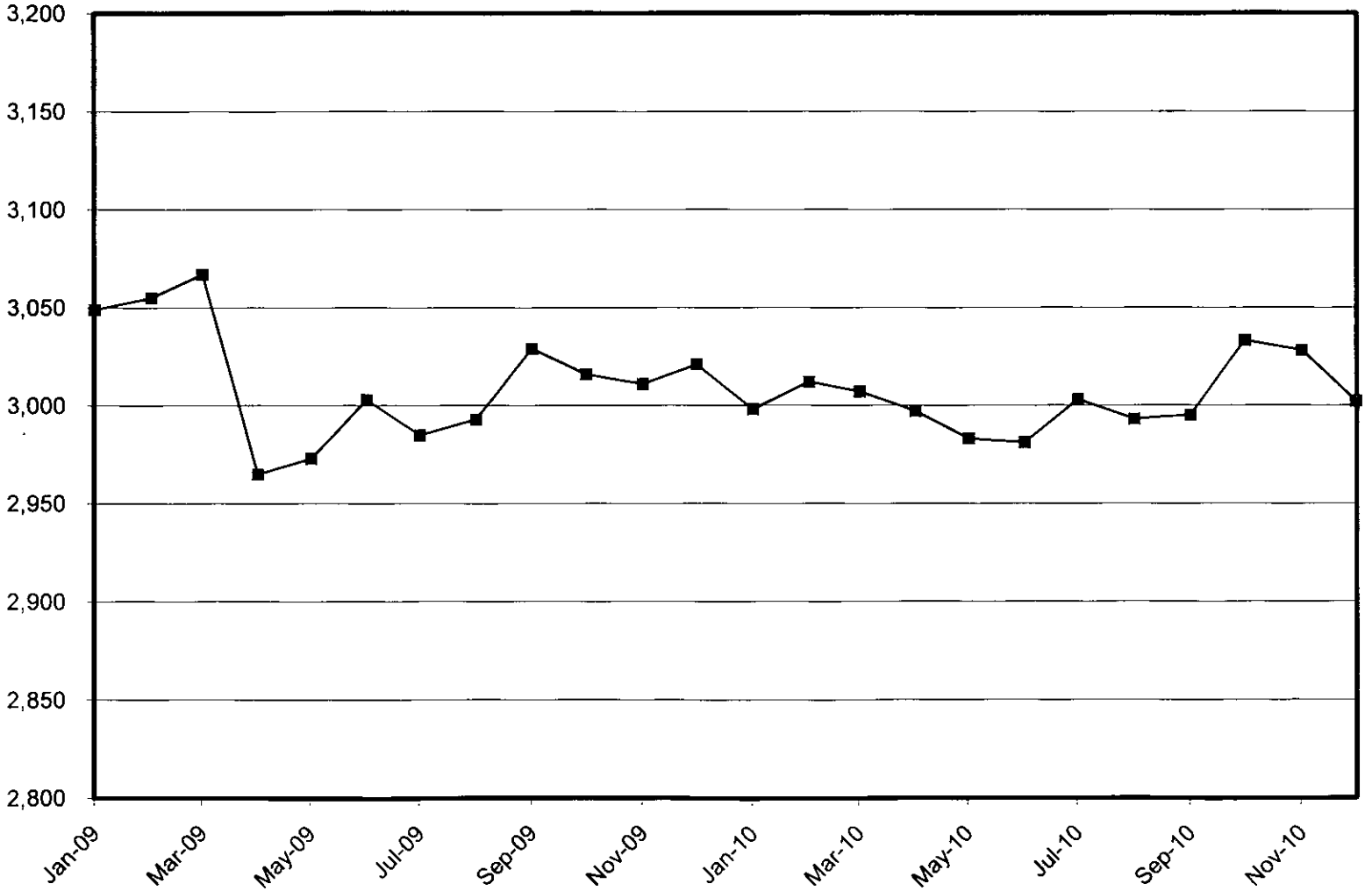
Produced by: **N.D. Department of Human Services - Aging Services Division**, 1237 W Divide Ave, Suite 6, Bismarck N.D. 58501 Ph: 701-328-4601 TTY: 800-366-6888 www.nd.gov/dhs

12/2010

NF Occupancy at Month End

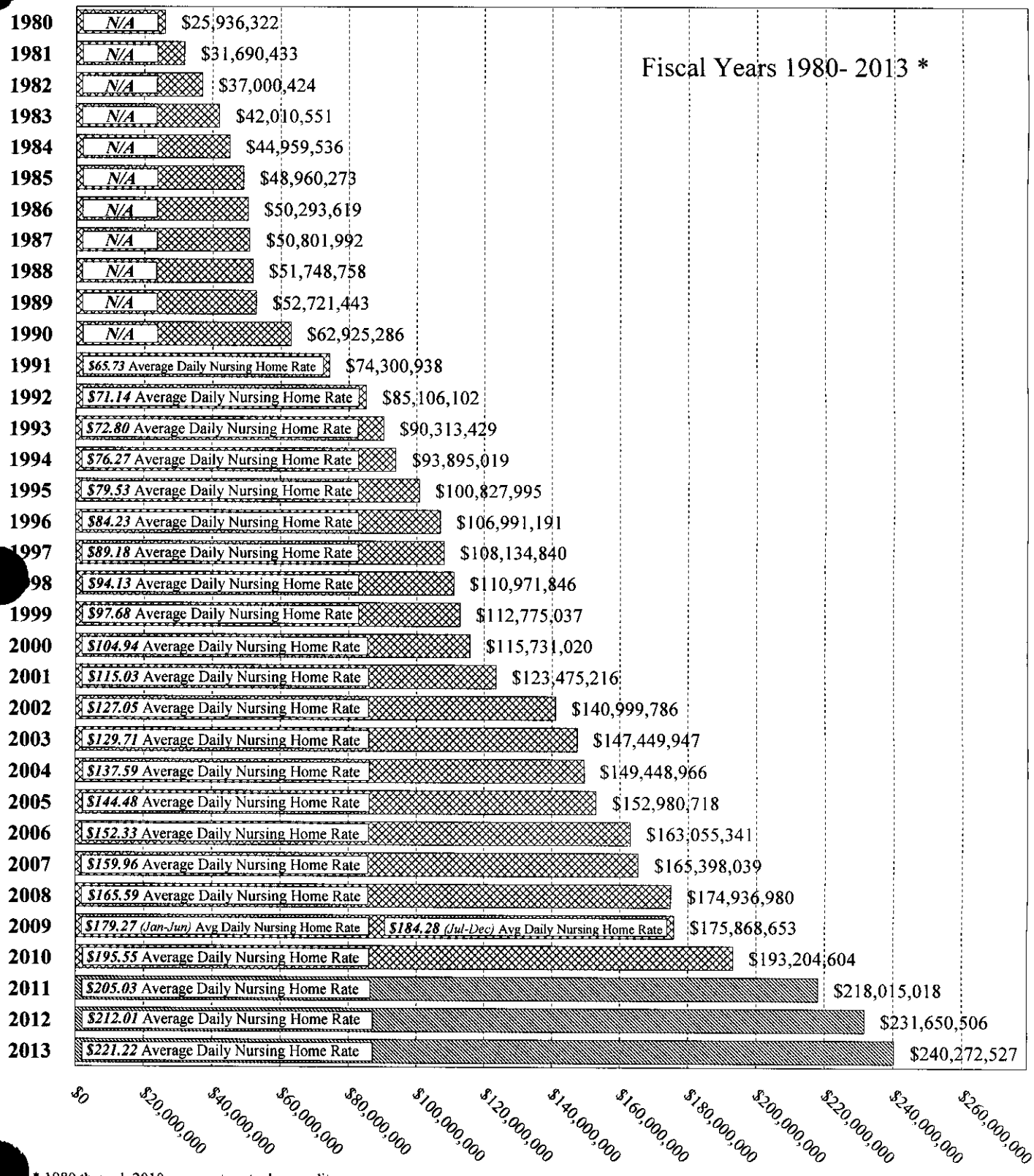


NF Occupancy at Month End Medicaid ONLY



Attachment C

North Dakota Department of Human Services
Nursing Home Facilities
Senate Bill 2012 to House
2011 - 2013 Biennium



* 1980 through 2010 represents actual expenditures.
2011 represents one month actual and eleven months estimated expenditures.
2012 and 2013 represents estimated expenditures included in the Governor's budget.
The average daily nursing home rate is effective January 1 of each year as indicated.
NOTE: Budget amount for 2012 and 2013 reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

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North Dakota Department of Human Services
Changes in Long Term Care from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Offset for General Fund Carryover **	Total Changes	2011-2013 Budget To Senate	Total Changes	2009-2011 Budget To House
Nursing Homes	425,713,210		18,306,125	16,979,110		10,924,588	(12,800,000)	33,409,823	459,123,033		459,123,033
Basic Care ^	18,113,925		2,995,658	3,726,798		1,136,014		7,858,470	25,972,395		25,972,395
Home & Community Based Services	63,862,579		1,538,520	(248,688)		2,550,667		3,840,499	67,703,078	0	67,703,078
SPED ^^	17,495,327		(1,901,567)	(2,411,820)		601,048		(3,712,339)	13,782,988		13,782,988
Ex-SPED ^^^	726,578		121,856	85,229		43,061		250,146	976,724		976,724
Personal Care Services	25,044,599		2,830,627	(6)		1,274,685		4,105,306	29,149,905		29,149,905
Targeted Case Management	1,957,896		(552,024)	90,558		68,319		(393,147)	1,564,749		1,564,749
Home & Community Based Services Waiver	8,707,606		705,502	404,800		450,478		1,560,780	10,268,386		10,268,386
Children's Medically Fragile Waiver	1,147,844		(771,555)	(71,873)		14,364		(829,064)	318,780		318,780
Technology Dependent Waiver	532,608		65,376	(119,592)		21,744		(32,472)	500,136		500,136
PACE	7,393,711		1,049,983	927,286				1,977,269	9,370,980		9,370,980
Children's Hospice Waiver	856,410		(9,678)	846,730		76,968		914,020	1,770,430		1,770,430
Total	**507,689,714**		**22,840,303**	**20,457,220**	**0**	**14,611,269**	**(12,800,000)**	**45,108,792**	**552,798,506**	**0**	**552,798,506**
General Funds	**172,803,502**	**6,817,423 ***	**7,702,004**	**6,162,907**	**60,084,630**	**7,078,870**	**(12,800,000)**	**75,045,834**	**247,849,336**	**-**	**247,849,336**

Other Areas:

Community of Care Funds $120,000 for both the 09-11 and 11-13 Bienniums- 100% General funds

Personal Care Needs Allowance SSI $148,068 for the 09-11 Biennium and 108,000 for the 11-13 Biennium - 100% General Funds

Assisted Living Rent Subsidy $200,000 for the 09-11 Biennium and $0 for the 11-13 Biennium - IGT Funds

* BND Loan Funds of $2,692,917 and IGT Funds of $4,124,506 were replaced with General Funds.

** Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

^ Room & board costs are funded with general funds and retained funds.

^^ SPED is funded with 95% general funds and 5% county funds.

^^^ Expanded SPED is funded with 100% general funds.

Attachment D

Cost and Caseload Comparison

2011 - 2013 Executive Budget To the Senate

Compared to 2009 - 2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Cost per Case ^	2011-2013 Budgeted Avg Monthly Cost per Case ^	Difference: Increase (Decrease)	2009-2011 Budgeted Avg Monthly Caseload *	2011-2013 Budgeted Avg Monthly Caseload *	Difference: Increase (Decrease)
Nursing Homes (Daily Rates)	175.55	187.09 ^^	11.54	101,072	105,104	4,032
Basic Care (Daily Rates)	27.23	33.14	5.91	27,706	32,651	4,945
Personal Care	1,551.83	1,810.10	258.27	671	671	-
Technology Dependent Waiver	8,825.30	10,419.32	1,594.02	3	2	(1)
Children's Medically Fragile Waiver	4,276.19	1,473.38	(2,802.81)	11	9	(2)
SPED	456.02	425.40	(30.62)	1,597	1,350	(247)
Expanded SPED	235.13	287.61	52.48	129	142	13
PACE	4,053.57	4,620.80	567.23	76	85	9
Targeted Case Management	178.12	133.74	(44.38)	458	488	30.00
HCBS Waiver	1,084.98	1,215.48	130.50	334	352	18.00
Children's Hospice Waiver	2,378.91	2,458.93	80.02	30**	30	-

^ With the exception of Nursing Homes and Basic Care which are daily rates all other categories are average monthly cost per case.

^^ 11-13 Nursing Home rate above reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

* Nursing Homes and Basic Care caseload represents the number of "Days" paid in a month for recipients. All other categories represent the number of recipients paid for in a month.

** The Children's Hospice was budgeted to begin in the 2nd year of the 09-11 biennium at 30 persons per month. The average shown is for the 12 months of SFY 2011.

Attachment E

Attachment ONE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Tara Lea Muhlhauser, the Director of Children and Family Services (CFS) in the Department of Human Services. I am here today to provide an overview of Division of Children and Family Services for the Department of Human Services.

Programs

- **Child Protective Services**: provides protection for children who have been or are at risk of being neglected and/or abused. Services provided include child protection assessments, case management, child fatality review, institutional child protection services and child abuse and neglect prevention programs.

- **Family Preservation Services**: provides therapeutic intervention to families whose children have been or are at risk of abuse, neglect and out-of-home placement. Services include parent aide, prime time child care, intensive in-home treatment services, respite care, family team decision making, family group conferencing and safety/permanency funds to prevent placement. This program places emphasis on preventing removal of children from their homes.

- **Foster Care Services**: provides a substitute temporary living environment for children who cannot safely remain with their families. Services include recruitment and retention of foster

homes; and licensing and placement services for relative homes, family foster homes, group homes, and residential child care facilities and licensed child placing agencies. This also includes foster care eligibility determination and payment, case planning and reviews, subsidized guardianship, and Interstate Compact on the Placement of Children, and services for Unaccompanied Minors. Independent Living services to assist transitioning youth, including skills assessment, training and stipends is another program area within foster care.

- **Adoption Services**: provides permanent adoptive homes for eligible children. Services include recruitment, adoption assessment, placement, follow-up services, post adoption services, adoption subsidy, birth family services, adoption search, licensure of child placing agencies, and the Interstate Compact on the Placement of Children for Adoption.

- **Early Childhood Services**: coordinates activities, establishes standards, and provides training to providers of early childhood care and education. Services include licensing, child care resource and referral, providing consultation to the tribes on licensing, and coordination through the Head Start Collaboration Office.

All these services are **provided either by the county social service agencies or through contracts with non-profit providers** with a focus on the safety, permanency, and well-being of children and their families.

Caseloads/Customer Base

The number of **Child Abuse and Neglect assessments** completed for federal fiscal year (FFY) 2010 was 3887, a slight decrease from FFY 2009.

The daily snapshot of **children in foster care** on 9/30/10 was 1,131 children in comparison to the daily snapshot on 12/31/09 which included 1,018 children. This snapshot includes tribal IV-E cases, Division of Juvenile Services (DJS) youth placed in foster care, and pre-adoptive placements. Approximately 35.5% of these children are Native American (402 children) in the most recent daily snapshot.

As of December, 2010, 25 youth were placed out-of-state in institutional care. This number has varied slightly throughout the year with a low of 24 and a high of 32. This number has continued to decline in the past two years.

The number of foster children gaining permanency through subsidized adoption has increased over the last three years and this trend is projected to continue through the 2011-13 biennium. Of the 160 finalized adoptions in FFY 2010, 109 were special needs adoptions with 71% of these children adopted by foster parents.

At current, there are an average of 39 guardianship payments per month during state fiscal year (SFY) 2010. In both 2008 and 2009, payments were made to 36 children (average) a year.

At present we have 33 youth receiving foster care services as unaccompanied minors. In the past year, CFS transferred administration of the Refuge Services Program to Lutheran Social Services of North

Dakota. Federal requirements provide that the state foster care administrator must retain administration of the Unaccompanied Minor Program.

Program Trends/Major Program Changes

CFS continues to place emphasis on safety, permanency and well-being of children across all programs in the division. **Family preservation programs** and **involvement of relatives and kin** when children are in need of placement, during service delivery and during reunification efforts are central to our work in achieving this emphasis. In October 2008, a new federal law, P.L. 110-351 "Fostering Connections" brought us several new federal requirements. These requirements related to notification of relatives when a child is placed in care, and guidance for involving school, medical providers, relatives and other services providers in providing a comprehensive plan for a child while in care, and at the time of transition to adulthood from care. This requirement also placed emphasis on placing siblings together and working diligently to locate and maintain family connections for children involved with child welfare services.

The second **Federal Child and Family Services Review (CFSR) in North Dakota took place in April 2008.** North Dakota did not reach "substantial conformity" (e.g. we did not pass). The second national round of the reviews was just completed in 2010 and no state has yet passed the CFSR in either the first or second round of federal reviews. All states in this category must develop a Performance Improvement Plan (PIP) in negotiation with federal partners. While we were noted in this recent round to have many strengths and a few challenges, our performance did require a PIP. The ND PIP was formalized in June of 2010 and we have two years to complete the work in this plan. Work of

this plan is focused around further refinement of the Wraparound Case Practice Model for child welfare practice. North Dakota was recently notified by our federal partners in December that we have met all the national data standards, a significant indicator of positive changes in practice outcomes for the state.

Family Preservation programs and prevention services (to prevent child abuse and neglect or to prevent child placement) continue to be a primary focus of the work of CFS. When foster care placements occur we emphasize placement with relatives and reunification efforts to keep the child(ren) connected with families and in close proximity to relatives.

Services in this program area include **Family Group Decision Making** available to most county social services agencies, the Division of Juvenile Services and the tribes. This service brings family members to the table to develop a plan for children who are either in foster care, at risk of being placed in foster care, or children who are being cared for by their extended family. This also brings significant people in the life of the child(ren) together to discuss how to maintain and build family connections. In 2009-2010 there were 215 referrals with 136 conferences completed. A new pilot program, Family Team Decision-making (FTDM), recently began and will provide an early opportunity (either immediately prior to placement or immediately upon removal) to bring families and agency personnel to the table with a neutral facilitator to make plans and seek opportunities to maintain safety and reduce the need for removal. The pilot sites for this work are in Burleigh/Morton and Cass counties. This differs from Family Group Decision Making in that it is an expedited process that can happen more quickly to address emergent issues such as emergency removals. This is a promising practice

nationally with positive outcomes targeted to reducing foster care placements and enhancing the engagement of parents in protecting and maintaining relationships with their children.

Over the past three years we have worked hard with our IT partners to develop a new component to our **child welfare data system**. This new system, FRAME, allows us to take the current individual program applications, streamline and connect them. Development was targeted to reduce duplication and create ease in using all the programs developed for safety, permanency and well-being together; enhancing program and data links. FRAME and the data warehouse will also support the generation of usable and accessible data to assist with data-driven decision making for child welfare programs in the Division. This new system was launched in December of 2009 and is in use for all child welfare programs. While the overall development and rollout went smoothly, we continue to work with the community of FRAME users to troubleshoot and resolve FRAME system issues.

There are still significant challenges in the **availability of child care** across the state. There are currently 1422 licensed early childhood programs in the state (Family-394, Group-844, Center-139, School-age-45) with a licensed capacity of 33,100 children. The proportion of North Dakota mothers (with children ages 0 to 5) in the labor force was 76.1% and rises to 84.9% for mothers with older children (ages 6 to 17) in 2009. Current national and state-level data indicate that these proportions have changed little since 2000. This has created a demand for assurances of safety in childcare settings and the need to provide training opportunities for this large workforce industry in North Dakota.

This industry includes workers in home-based and center-based care settings.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	2,578,175	(22,767)	2,555,408		2,555,408
Operating	5,817,823	(73,193)	5,744,630		5,744,630
Grants	120,930,241	5,863,720	126,793,961		126,793,961
Total	129,326,239	5,767,760	135,093,999		135,093,999
General Funds	25,060,229	5,993,008	31,053,237		31,053,237
Federal Funds	85,194,925	(2,216,867)	82,978,058		82,978,058
Other Funds	19,071,085	1,991,619	21,062,704		21,062,704
Total	129,326,239	5,767,760	135,093,999		135,093,999

FTE	17.0		17.0		17.0

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item decreased by ($22,767) and can be attributed to the following:

- $129,923 in total funds of which $65,838 is general fund to fund the Governor's salary package for state employees.
- $50,357 in total funds of which $33,085 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- A decrease of ($30,117) due to retirement payouts during the 2009-2011 biennium. There are no retirements anticipated for the 2011-2013 biennium.

- A decrease of ($82,904) due to appropriations for child care background check fees to be paid to the Attorney General's office from Senate Bill 2162 in the 2009-2011 legislative session inadvertently included in the salary line. A corresponding increase is included in the operating line later on in my testimony.
- A decrease of ($90,026) is the result of transitions in key positions and retirements of key personnel as well as a combination of increases and decreases needed to sustain the salary of the 17.0 FTE in this area of the budget

The Operating line item decreased by ($73,193) and is a combination of the increases expected next biennium which are offset by decreases, with the majority of changes as follows:

- A decrease in travel ($93,068). This decrease is attributed to use of technology tools to facilitate meetings without travel costs, including polycom and webinar meetings.
- A decrease in professional development ($67,862) was made using creativity and internal resources to conduct a peer review process.
- An increase in background checks $95,988 for adoption, foster care and child care checks, with a corresponding decrease in salaries and wages.

The Grants line item increased by $5,863,720 which can be mainly attributed to the following:

- An increase in subsidized adoption caseload and cost per case, as well as a 3 % inflationary increase each year of the biennium for an overall program increase of $2,361,638 of which $2,156,749 is general fund. The large general fund increase is mainly due to the change in FMAP, and an increase in caseload for non IV-E eligible adoptions.

- An increase in the foster care caseload and cost per case, as well as a 3% inflationary increase for foster care providers each year of the biennium for an overall program increase of $8,761,251 of which $5,160,076 is general fund.
- Increase of $377,253 of which all are general fund for 5 additional child abuse and neglect assessments per month and a 3% inflationary increase for each year of the biennium.
- A ($4,514,667) decrease of one-time ARRA funding for Foster Care Subsidized employment ($870,667) and Child Care Grants (House Bill 1418 of the 2009-2011 legislative session appropriated $3,644,000 for the Quality Rating Improvement System).
- A ($2,722,300) decrease of federal Refugee Assistance grants that were moved to Lutheran Social Services.
- A $1,689,992 increase for County administration reimbursement all of which are federal and other funds.
- Attachment A lists all the grants and compares the cost & caseload of the 2009-2011 appropriation to the 2011-2013 budget to the Senate for Foster Care & Adoption grants.

The general fund request increased by $5,993,008 with 44% of that increase ($2,662,910) related to the 3% inflationary increase. The remaining increase of $3,330,098 is associated with the increase in the grant changes described above.

The net change of the federal and other funds is a result of the increases and decreases noted above.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011-2013 budget requests for CFS. I would be happy to answer any questions.

Children & Family Services

Listing of All Grants:

Child Abuse & Prevention Activities	$	2,200,000
Independent Living Programs	$	1,100,000
Refugee Grants	$	1,200,000
Child Care Licensing Payments to Counties	$	700,000
Child Care grants to nonprofit Agencies	$	3,000,000
Child Abuse/Neglect Assessment Payments to Counties	$	6,000,000
Reimbursement to Counties for Administration of Child Welfare Programs	$	11,700,000
Family Preservation & Family Services Grants	$	11,200,000
Training Child Welfare Professionals and Family Foster Parents	$	1,900,000
Subsidized Adoption Grants	$	20,200,000
Foster Care Maintenance, Therapeutic and Subsidized Guardianship	$	67,600,000

Cost & Caseload Comparison
2011-2013 Biennium to Senate
Compared to 2009-2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference - Increase (Decrease)	2009-2011 Budgeted Avg Monthy Cost per Case	2011-2013 Budgeted Avg Monthy Cost per Case	Difference - Increase (Decrease)
Therapeutic Foster Care	242	245	3	1,095.20	1,080.65	(14.55)
Services Foster Care	196	217	21	545.15	688.51	143.36
Foster Care - Family Homes	523	597	74	1,677.99	1,705.35	27.36
Foster Care - RCCF & GH	252	264	12	4,755.12	5,238.70	483.58
Subsidized Adoptions	992	1,073	81	749.11	785.11	36.00

Attachment A

Attachment TWO

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am JoAnne Hoesel, Division Director from the Department of Human Services. I am here today to provide you an overview of the Division of Mental Health & Substance Abuse Services.

Programs

The Division of Mental Health & Substance Abuse provides regulation, grants management, reporting, technical assistance, training, and development and implementation of appropriate mental health & substance abuse services throughout the state. This division also is charged with department-wide data analysis and research support. In addition, I serve as the Chairperson of the Governing Board of the North Dakota State Hospital. Division staff provide support to the Mental Health Planning Council in its required oversight for the statewide plan for mental health services. The division is also charged with writing both annual federal block grants for mental health treatment and promotion and substance abuse prevention and treatment, and the grant for individuals in transition from homelessness. The division is responsible for the annual Synar study and report which measures compliance in tobacco sales.

Service programs directly managed by the Division are compulsive gambling treatment, community-based high-risk sex offender treatment, statewide prevention specialists, and long-term

methamphetamine & other controlled substance residential treatment. The Division manages the Governor's Prevention Advisory Council and I serve as the chairperson. This Council, established by executive order in 2007, leads multisystem prevention efforts drawing upon the resources and talents at the community, state, and federal levels. The Division also manages the Autism Spectrum Disorder (ASD) Task Force formed through 2009 legislation and as its chairperson, facilitated the initial state plan for ASD in 2010. The Prevention Resource & Media Center (PRMC) is a clearinghouse and library providing free materials and resources to North Dakota residents regarding substance abuse prevention.

Caseload / Customer Base

During SFY 2010 the public mental health system provided services to 14,465 children, youth, and adults and the public substance abuse system provided services to 4,542 adolescents and adults. The Division licenses 81 substance abuse treatment programs, 37 DUI seminar providers, eight regional human service centers, and six psychiatric residential treatment facilities for children and adolescents.

Program Trends

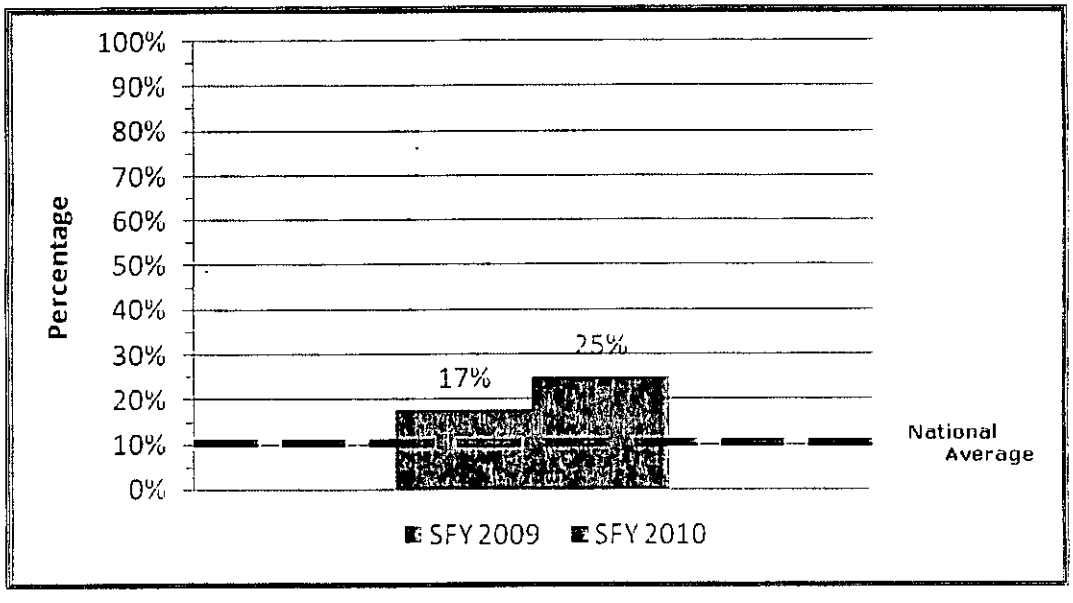
Individualized treatment approaches and outcome reporting

With the advancement of research, effective medication management, public education, targeted services methods, focus on service outcomes, North Dakota's public system offers a broad array of services many of which can be individualized to best meet the needs of the clients leading to best outcomes.

What we know about effective treatment services has expanded greatly over the last years. Several of these evidenced-based

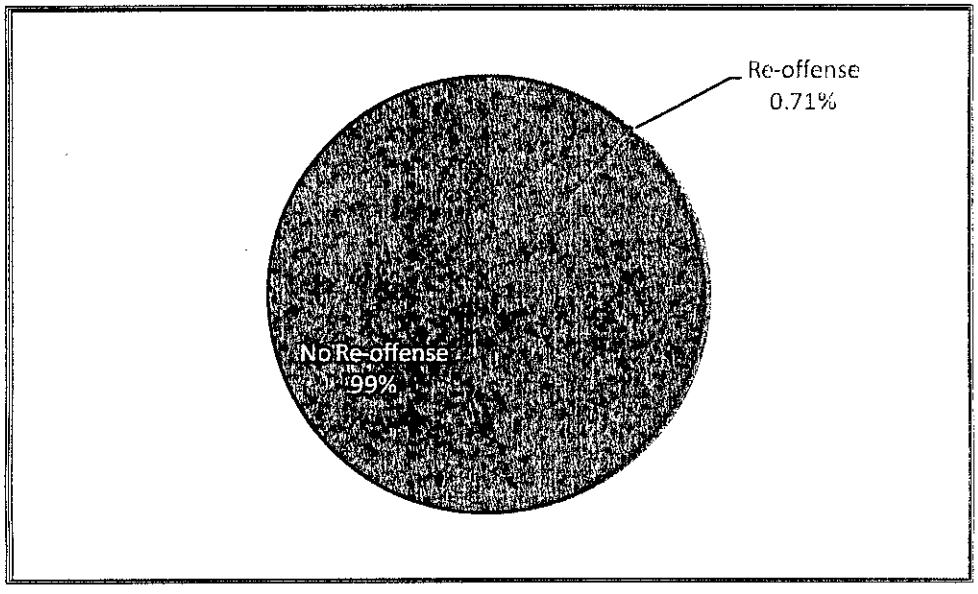
methods are implemented and showing positive results. Methods are currently in place to treat individuals addicted to methamphetamine and opiates, those who have experienced traumatic situations, those with both a severe mental illness and a chronic substance abuse disorder, those who have never had employment due to their mental illness or substance abuse disorders, and those who are new to recovery.

Employment increases for individuals with serious mental illness.



Percent of adults in North Dakota who receive public mental health services, are diagnosed with a serious mental illness, and are employed. Source: FY 2011 Community Mental Health Services Block Grant Application for the State of North Dakota.

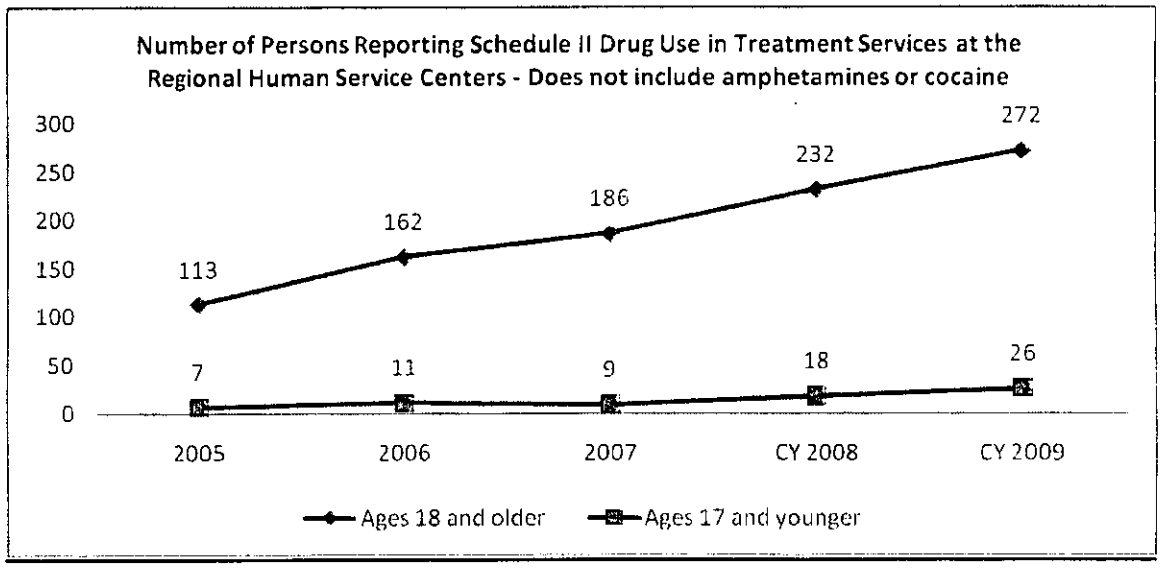
High Risk Sex Offender Treatment Program – Recidivism Rate

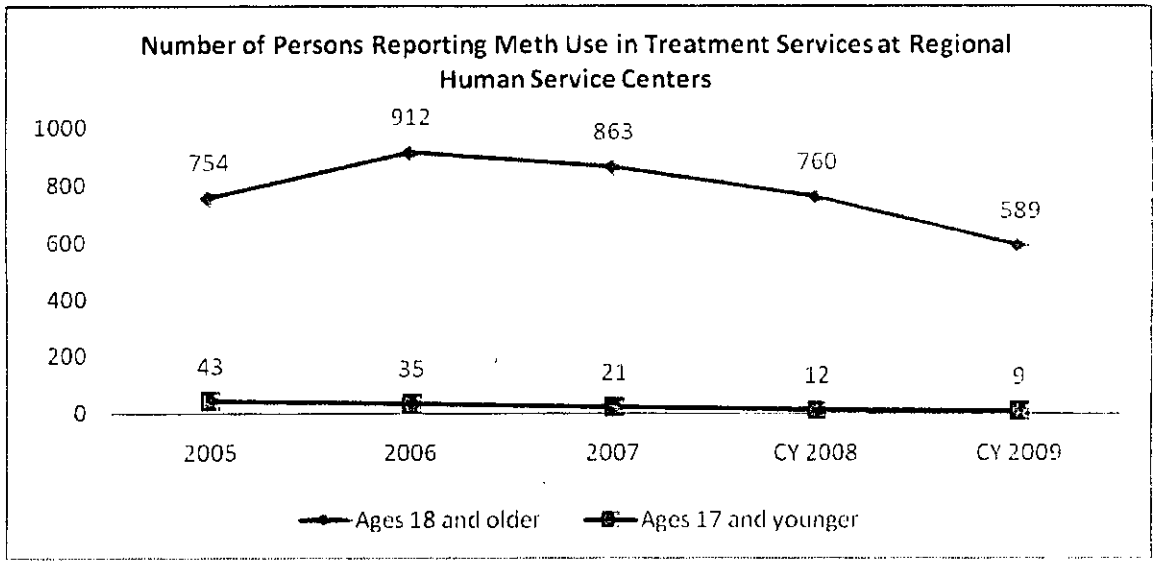


Since the program's inception, 1 out of 140 individuals in the program have had a sexual re-offense. That is 0.71% of the total population involved with treatment.

Prescription Drug Abuse Climbing

Prescription drugs that are abused or used for nonmedical reasons can alter brain activity and lead to dependence. Commonly abused classes of prescription drugs include opioids (often prescribed to treat pain), central nervous system depressants (often prescribed to treat anxiety and sleep disorders), and stimulants (prescribed to treat narcolepsy, ADHD, and obesity).


Number of Persons Reporting Schedule II Drug Use in Treatment Services at the Regional Human Service Centers - Does not include amphetamines or cocaine
300
250
200
150
100
50
0
113
162
186
232
272
7
11
9
18
26
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger


Number of Persons Reporting Meth Use in Treatment Services at Regional Human Service Centers
1000
800
600
400
200
0
754
912
863
760
589
43
35
21
12
9
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger

Substance Use Trends

Rank	1/1/2005-12/31/2005		1/1/2008 – 12/31/2008		1/1/2009-12/31/2009		1/1/2010-9/30/2010	
#1	Alcohol	55.6%	Alcohol	59.6%	Alcohol	59.3%	Alcohol	58.3%
#2	Marijuana	21.4%	Marijuana	25.8%	Marijuana	27.8%	Marijuana	27.4%
#3	Meth	13.3%	Meth	7.3%	Meth	5.2%	Opiates	6.1%
#4	Other Amph	4.6%	Opiates	4.1%	Opiates	4.8%	Meth	5.6%

Using 2005 as the baseline year, alcohol continues to be the primary substance reported by those in treatment. Marijuana continues to hold second place but in 2010 opiates are now in third place followed by methamphetamine.

This trend line reflects regional trends except for Northwest, Southeast, and Southcentral, where methamphetamine is in third place and opiates in fourth.

Major Program Changes

1. Extended Services

This division, along with the Vocational Rehabilitation Division, is reviewing the current method of providing employment supports for those with mental illness, traumatic brain injuries, and types of autistic disorders. Over the next months, the Division will work with consumers and providers to arrive at best methods to support individual employment goals. Most people who work show improvement in their mental health and greater satisfaction with their lives. With the national unemployment rate for persons with serious mental illnesses hovering at 90 percent, the goal is to positively impact this outcome for North Dakotans with targeted adjustments to this program.

2. Substance Abuse Prevention System Changes

North Dakota has among the highest rates in the nation in recent alcohol use and binge drinking, regardless of age group. For example, among North Dakotans aged 12 to 20 years old, 40 percent consumed alcohol in the past 30 days and 29.5 percent engaged in binge drinking use in the last 30 days (Hughes et al., 2009) North Dakotans rank near the bottom among U.S. states regarding the percentage of persons who perceive great harm associated with consuming five or more drinks at a time once or twice a week (Hughes et al., 2009).

Alcohol Consequences

- In 2009, 5,819 arrests were made for driving under the influence of alcohol.
- It is estimated that 23 percent of assaults, 30 percent of physical assaults, and three percent of burglaries are related to alcohol use. (SAMHSA, 2006b).
- In March 2010, upon admission to the ND State Penitentiary, 77% of males and 74% of females had a drug and/or alcohol abuse/dependence diagnosis. (DOCR)
- 46.1% of all arrests in 2008 were for DUI, liquor law, and drug abuse violations. (BCI, 2009)

Domestic violence, alcohol spectrum disorder (fetal alcohol syndrome), alcohol-related motor vehicle crashes and fatalities, school expulsions, and mortality rates all have significant ties to alcohol use.

North Dakota's underage drinking and binge drinking numbers are not changing. There is a saying that "If you keep doing what you've been

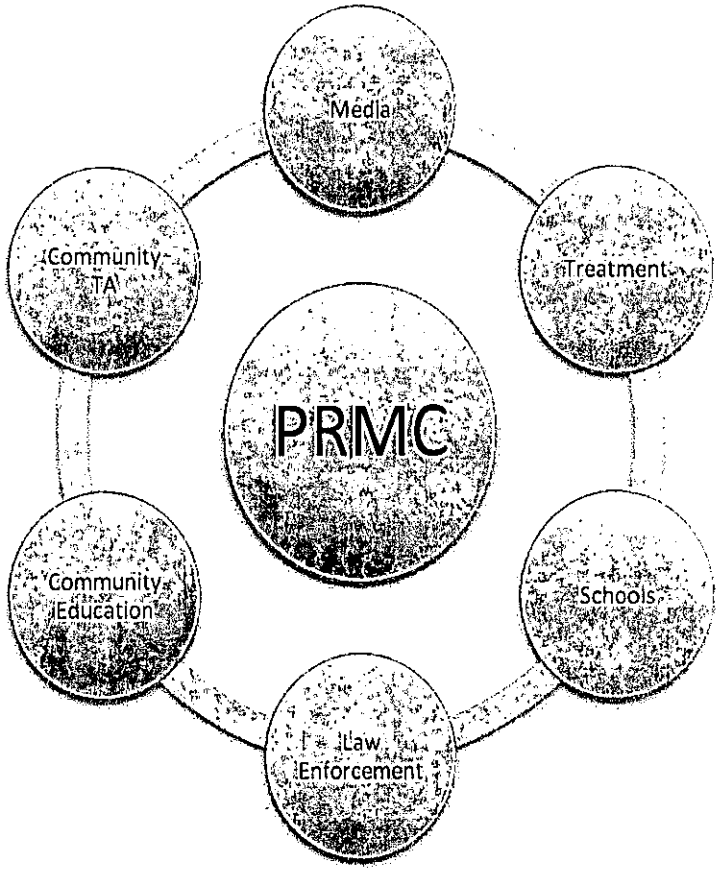
doing, you keep getting what you've been getting". So we have changed the entire prevention system. This is what's happening:

Completed a Statewide readiness survey

- The readiness survey showed that some North Dakotans hear these numbers and recognize that alcohol and other drug use is a local problem, but there is no immediate motivation to do anything about it.
- From this survey and related information, each region and Tribal area will have their own data booklet to drive decisions on the best prevention strategies.

Transformed from a regional –based system to a role-based prevention system

- The substance abuse prevention system has been coalition-based for over 15 years. Prior to 2004, there were 75 substance abuse community coalitions in North Dakota, in 2010, there were 22 coalitions statewide. The previous infrastructure was based on locating one coordinator in each of eight regions. This coordinator was identified as the overall expert in prevention. With the current system, communities have the time and talents of staff in the areas of law enforcement, media, treatment, education, and local level expertise. The specialists are able to identify and implement effective prevention strategies customized to each communities needs.



Transformed the prevention resource and media center (PRMC) from a passive library to an active media and resource-rich center for communities

- The PRMC has campaigns, toolkits, and resource guides on alcohol, prescription drugs, server training, refusal skills, community prevention ideas, plus supplies and information for prevention activities held around the state.

Use of environmental prevention strategies

- Historically, alcohol education and prevention has focused on changing behavior of individuals. The thought being: if people know risks, they will change behavior. This is not the case.

- Environmental prevention targets entire communities rather than individuals. It has the potential to bring sustainable reductions to problems. (Attachment A)
- By making changes in the environment, people are given better choices. Tobacco use reduction uses environmental prevention strategies. By reducing where people can use tobacco, significant reductions in tobacco have occurred.
- A 14 year old, if given a choice between an apple and a Snickers bar, will most likely choose the Snickers bar. But if the choice is between an apple and a cheese stick, they have been provided with better choices. This is an environmental strategy.
- A Serving-Size campaign planned for this spring is based on environmental change. A drink is not a drink – is not a drink. By choosing a 6 oz glass of wine versus a Long Island tea, a person has consumed one drink versus the equivalent of five drinks.
- Currently, five communities are involved in the 'targeted' community initiative, where the resources from the statewide team are individualized to their culture and needs.
- 40 communities chose to participate in new ways to address the culture of drinking in North Dakota.

This was all done with cost neutrality and the entire process involves tracking impact and outcomes.

<u>Strategic Prevention Framework State Incentive Grant</u>

- DHS was recently awarded a prevention grant applied for three years ago, that was initially denied. The strategic prevention framework state incentive grant's (SPF-SIG) will move 85% of

the grant funds to targeted communities using prevention strategies. With this national grant award, all 50 states now have a SPF-SIG grant. The SPF-SIG is advised by the Governor's prevention advisory council. The grant's structure requires the prevention process described earlier but will help condense the time to implement across the state and enable significant resources to move to communities. Communities will walk through five phases of strategic planning, implementation and evaluation grounded in prevention science.

- This one time grant and the prevention framework described will impact the state by combining strategic consultation, training, and research-based tools.

Overview of Budget Changes:

Description	2009 - 2011 Budget	Increase/ Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	2,489,443	1,102,759	3,592,202		3,592,202
Operating	8,637,130	3,050,855	11,687,985		11,687,985
Grants	2,382,446	2,063,138	4,445,584		4,445,584
Total	13,509,019	6,216,752	19,725,771		19,725,771
General Funds	6,180,518	948,123	7,128,641		7,128,641
Federal Funds	6,743,842	5,282,428	12,026,270		12,026,270
Other Funds	584,659	(13,799)	570,860		570,860
Total	13,509,019	6,216,752	19,725,771		19,725,771
FTE	18.00	6.00	24.00		24.00

Budget Changes from Current Budget to the Executive Budget:
The Salary and Wages line item increased by $1,102,759 and can be attributed to the following:

- $189,556 in total funds of which $63,938 is general fund needed to fund the Governor's salary package for state employees.

- $49,827 in total funds of which $32,764 is general fund needed to fund the second-year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $837,637 in federal funds represents a move from the operating-purchase of service contract area in the 2009-2011 biennium to six (6) FTE in salary for prevention specialists.
- The remaining increase of $25,739 includes a combination of increases and decreases needed to sustain the salary of 24 FTE in this area of the budget.

The Operating line item shows a net increase of $3,050,855 for a variety of reasons:

- Increase in travel of $82,944 driven by the move from the operating-purchase of service contract area for the prevention specialists. All federal funds.
- Decrease of $155,717 in supplies and a decrease of $88,569 in miscellaneous supplies are both driven by the loss of the Safe & Drug Free Schools and Communities grant and increased use of electronic and web-based resources which is all federal funds.
- Increase of $60,340 in printing is driven by the change in the prevention system previously paid through contract which is all federal funds.
- Decrease of $43,274 in Professional Development driven by the loss of the Safe and Drug Free Schools and Communities grant which is all federal funds.
- Increase of $3,180,088 of federal funds in operating fees and services which is a result of being awarded the strategic prevention framework grant.

Grants

The Grants line shows a net $2,063,138 increase of which 86.6% is federal funds. The increase is mainly due to a combination of reasons; with the major driving force being spending authority for the next traumatic brain injury grant ($1,069,397) anticipated to be submitted in the next biennium and an increase in extended services which purchases job coaching for individuals with serious mental illness ($755,383). In addition, $230,923 is due to contracts previously in the operating line being more correctly reflected as grants.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the Division Mental Health & Substance Abuse Services. I would be happy to answer any questions.

ENVIRONMENTAL PREVENTION

Environmental Prevention involves changing the environment in which alcohol-related problems (such as drinking and driving, binge drinking, and underage drinking) occur. But what does it mean to "change the environment?" One way to explain the concept of Environmental Prevention is to first identify what it is ***not***:

- It is ***not*** focused on changing individual behavior(s) through education and treatment.
- It is ***not*** "prohibition" of alcohol in the community.
- It is ***not*** condemning those who drink or sell alcohol responsibly.
- It is ***not*** eliminating personal responsibility for those whose behavior causes damage or injury to others.

Instead, the Environmental Prevention approach works to modify community conditions that condone and/or encourage unhealthy and unsafe behaviors.

Environmental Prevention requires a new way of thinking on the part of prevention professionals. In this case it involves:

- Rejecting the assumption that, "We can't change things because this is how it is, and always will be!"
- Critically examining those aspects of our society that support or sustain alcohol-related problems.
- A willingness to do things differently.
- Insisting that policy makers and law enforcement work together with community groups so changes will have significant and sustainable effects on the problem.
- Holding accountable all those who profit from irresponsible alcohol sales and use.
- Supporting those responsible for making and enforcing alcohol-related laws/policies.
- No longer solely blaming kids for underage drinking and related problems.

Ultimately, Environmental Prevention is based on the fact that people's behavior is powerfully shaped by their environment. Environmental Prevention considers four areas of concern or causal factors: social availability of alcohol, retail availability of alcohol, criminal justice, and promotion of alcohol.

Just look at the change in public attitudes toward seatbelts and smoking. Environmental Prevention Campaigns related to both these issues have created a dramatic cultural shift in thinking and behavior that has had a positive effect on public health and safety throughout the United States.

Environmental Prevention targets entire communities rather than individuals. That way, it has the potential to bring about enduring reductions in the problems. Still, it is not a quick fix; it may require several years or even a generation to see the changes occur, but these changes are generally permanent and dramatic.

north dakota department of human services

NORTH DAKOTA PREVENTION RESOURCE & MULTIMEDIA CENTER

Institute for Public Strategies for the Montana Community Change Project (March 2009)
"Environmental Prevention: An Approach to Reducing Drinking and Driving and Binge Drinking in Montana"

NORTH DAKOTA
PREVENTION
RESOURCE AND MEDIA CENTER

We are a **FREE** resource to North Dakota residents

Our Mission Is To:

Increase community awareness of substance abuse prevention by providing innovative, quality, and culturally appropriate information to the residents of North Dakota

What We Offer:

Pamphlets • Activity Books • Posters • DVDs
Games • Kits • Toolkits • and more!

Visit Our Website:

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Prevention E-Newsletter:

A timely e-mail newsletter covering substance abuse prevention news briefs, new resources, and event announcements

To sign up, go to: **www.nd.gov/dhs/prevention**

Contact Us At:

Prevention Resource and Media Center
1237 West Divide Avenue Suite 1D
Bismarck, ND 58501
P: 701-328-8919
F: 701-328-8979
ndprmc@nd.gov

www.nd.gov/dhs/prevention

north dakota
department of
human services

MISSION:

The ND prevention system provides innovative, quality, and culturally appropriate substance abuse prevention infrastructure, strategies, and resources to the individuals and communities in North Dakota.

SERVICES:

Prevention specialists are available to provide technical assistance to:

COMMUNITIES

LAW ENFORCEMENT

SCHOOLS

CRIMINAL JUSTICE ENTITIES

MEDIA

WORKPLACES

SUBSTANCE ABUSE PROFESSIONALS

FOCUS:

North Dakota data identifies six priorities:

1. Increasing awareness of substance abuse issues
2. Alcohol abuse among adults
3. Alcohol use/abuse among underage youth
4. Inhalant abuse

- Attachment THREE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Tina Bay, Director of the Developmental Disabilities Division with the Department of Human Services. I am here today to provide an overview of the Developmental Disabilities Division, for the Department of Human Services.

Programs

The Developmental Disabilities Division is made up of 9 FTEs who are responsible for the needs assessment, staff training, development of policy, quality assurance, compliance with federal oversight agency rules, and service monitoring functions relating to the provision of home and community based services for individuals who have a developmental disability, as well as children who are at risk of developmental delays.

Division staff interact regularly with the developmental disability staff at the regional human service centers, the Developmental Center, federal agency representatives, school systems, universities, consumer advocates, and a variety of public and private entities that play a vital role in the delivery system and monitoring of services.

Caseload / Customer Base

In SFY 2010, 5,341 individuals received developmental disability program management through the human service centers, and

7,746 Right Track screenings were completed for infants and toddlers birth to three years of age at risk for developmental delays.

412 wards were served through the Catholic Charities Corporate guardianship for SFY 2010.

Program Trends / Major Program Changes

Increased federal accountability requirements and oversight – Centers for Medicare and Medicaid Services (CMS) has placed greater emphasis on providing evidence of compliance with the health and welfare assurances required in the Medicaid waivers. CMS has become more prescriptive, requires more state reporting, and requires more oversight of providers on the part of the state.

During the 2009 Legislative Session, HB 1556 directed the Department to contract with an independent contractor to study the methodology and calculations for the rate setting structure used by the Department to reimburse public and private providers. Through workgroups that included the independent contractor, stakeholders and Department staff, a recommendation was made to change from a cost-based reimbursement system to a prospective reimbursement system.

ARRA Funding – the Division will continue work on 3 contracts that are utilizing ARRA Funding through September 30, 2011, if approved by the Legislature. The contracts are for a data base for the Right Track program, technical assistance which includes the development of training modules and the development of informational materials for

families and other stakeholders concerning the importance of early intervention.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase/ Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	1,186,236	200,904	1,387,140		1,387,140
Operating	7,573,440	(222,905)	7,350,535		7,350,535
Grants	166,767	271,440	438,207		438,207
Total	8,926,443	249,439	9,175,882		9,175,882
General Funds	2,947,015	204,414	3,151,429		3,151,429
Federal Funds	5,969,513	(95,063)	5,874,450		5,874,450
Other Funds	9,915	140,088	150,003		150,003
Total	8,926,443	249,439	9,175,882		9,175,882
FTE	9.00	0.00	9.00		9.00

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item increased by $200,904 and can be attributed to the following:

- $66,260 in total funds of which $23,980 is general fund needed to fund the Governor's salary package for state employees.
- $24,731 in total funds of which $17,199 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- During the biennium, the Department recognized an increased need in this division and moved an FTE internally to accommodate this priority. Increased federal requirements from CMS led to this need. The position resulted in an additional need of $115,989 in total funds for salary and fringes of which $39,149 is general fund.
- The remaining decrease of $6,076 includes a combination of increases and decreases to sustain the salary of 9 FTE in this area of the budget.

The Operating line item decreased by $222,905 and can be attributed to the following:

- Increase in travel of $226,309, of which $200,075 is for Part C, which is all federal funds and the remaining $26,234 of which $8,820 is general fund. This increase reflects additional visits and monitoring of regions and additional training for DD Program Managers working with the Part C program.
- Increase of supplies/material-professional of $47,500 of which $46,500 is for Part C for resource library materials, which is all federal funds.
- Increase in other equipment under $5,000 of $136,917 for additional equipment to allow for in home hearing screenings, which is all federal funds.
- Increase of repairs of $29,283 for maintenance agreements for the equipment described above, which is all federal funds.
- Increase in rental/leases of $15,335 due to an increase in rent at Prairie Hills Plaza and the addition of new office space due to the restructuring of the division, of which $4,517 is general fund.
- Decrease of $651,600 in operating fees and services. The increases and decreases are as follows:
    - Decrease of $1,690,000 due to the reduction of ARRA funds, which is all federal funds
    - Increase of $76,740 for other miscellaneous contracts, of which $25,803 is general fund.
    - Increase of $273,279 for the Catholic Charities Corporate Guardianship contract for the 3% and 3% inflationary increases, and for additional staff needed due to new accreditation rules, and to fund the second year of the 6% inflationary increase for 24 months versus the 12 months

that were contained in the current budget, of which all is general fund.

- $122,227 increase in our fiscal agent contract as the demand for self directed supports continues to rise.
- $65,690 increase for Right Track screenings due to an increase in assessments, which is all federal funds.
- Increase of $500,464 due to contracts being added to the Divisions budget that were previously paid at the human service center level, of which is all federal funds.

- Decrease of $16,977 for professional fees due to the cost for administrative hearings being included in the department's legal unit. $6,642 of this decrease is general fund.
- Decrease of $9,672 in supplies, printing, postage and other office administrative costs.

The Grants line item increased by $271,440 due to the following reasons:

- Increase of $200,000 to reflect contracts that were previously included in the operating line but are more correctly reflected as grants. The authority has been moved from the operating line to grants. All of these funds are federal funds.
- Increase of $71,440 due to an increase in an agreement with Protection and Advocacy to conduct follow up investigations, all of which is federal funds.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for Developmental Disabilities Division area of the Department. I would be happy to answer any questions.

-Attachment Four

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Russell Cusack, Vocational Rehabilitation Director with the Department of Human Services. I am here today to provide an overview of programs and services that make up the budget request for the Vocational Rehabilitation Division for the Department of Human Services.

Programs

The Division of Vocational Rehabilitation contains two units: Vocational Rehabilitation and Disability Determination Services.

The Vocational Rehabilitation Unit (VR) is made up of 11 FTEs responsible for the administration of Titles I, VI and VII of the Rehabilitation Act as amended. As such, the staff is responsible for the needs assessment, staff training, state plan development and outcome monitoring, development of policy, quality assurance, client advocacy through the Client Assistance Program, oversight of expenditure of federal VR funds, and compliance with federal rules. To carry out these responsibilities, the VR policy division staff interact regularly with the Vocational Rehabilitation staff residing in the human service centers, and with community businesses, schools and universities, Job Service, the State Rehabilitation Council, the State Independent Living Council, centers for independent living, federal oversight agencies, and other private and public entities involved in rehabilitation service. The services are funded through federal funds received through the U.S. Department of Education

and Rehabilitation Services Administration, along with the required general fund match. The federal portion of the funding is over 78.7%; the state match comprises just under 21.3% of the budget.

The Disability Determination Unit includes 24 FTEs responsible for individual eligibility determination for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) statewide. The staff review claims from the local Social Security offices, gather supporting data, and determine whether an individual meets the criteria to receive federal benefits. The funding for this program is 100% federal funds.

Caseload / Customer Base

Vocational Rehabilitation – Federal Fiscal Year 2010

- 6,992 individuals received employment services through VR.
- 10,662 individuals received independent living services.
- 1,074 individuals were served through the Older Blind Program.
- 170 is the average caseload size for a VR counselor.

Disability Determination Unit

- 5,898 eligibility determinations were made for SSDI/SSI benefits.

Program Trends / Major Program Changes

Vocational Rehabilitation continues to see a high percentage of youth apply and receive services. Thirty five (35) percent of the DVR caseload are youth that experience disabilities. The percentage of youth served remained consistent during the past five years. The division has actively outreached to school districts, community providers, the Department of Public Instruction, and Job Service to develop outreach efforts to teach these youth about the employment possibilities in North Dakota. The emphasis of this outreach has been tailored to connecting youth with the

support services they need to be successful in job training and to realize that many occupations are available with two years or less vocational training. The division proposes to continue this activity as well as support the efforts of the human service center transition coordinators to enhance the independence of youth.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase/ Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	4,244,123	428,409	4,672,532		4,672,532
Operating	2,065,906	(16,676)	2,049,230		2,049,230
Grants	21,396,891	(838,260)	20,558,631		20,558,631
Total	27,706,920	(426,527)	27,280,393		27,280,393
General Funds	4,844,905	14,221	4,859,126		4,859,126
Federal Funds	22,770,553	(444,285)	22,326,268		22,326,268
Other Funds	91,462	3,537	94,999		94,999
Total	27,706,920	(426,527)	27,280,393		27,280,393
FTE	35.00	0.00	35.00		35.00

Budget Changes from Current Budget to Executive Budget:

The Salary and Wages line item increased by $428,409 and can be attributed to the following:

- $247,351 in total funds of which $17,614 is general fund needed to fund the Governor's salary package for state employees.
- $57,114 in total funds of which $13,377 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $32,741 to provide for the annual and sick leave lump sum payouts for three FTE expected to retire of which $27,120 is federal funds and $5,621 general fund.
- $38,880 which is all federal funds to provide for salary increase for four FTEs that underwent reclassifications.

- The remaining $52,323 includes a combination of increases and decreases needed to sustain the salary of 35 FTE in this area of the budget.

The Operating line item decreased by $16,676 (.8%) and is a combination of the increases expected next biennium which is offset by decreases as follows:

- Increase of $39,976 for medical consultant contracts for DDS in order to complete the number of disability claims required by the federal Social Security Administration.
- Increase of $15,185 for professional development activities for non-state and state employees to attend regional and national meetings.
- Increase of $50,191 in rent at Prairie Hills Plaza.
- Increase of $56,797 in travel to required federal meetings.
- Decrease of $32,164 in the purchase of assistive technology devices for client use.
- Decrease of $8,309 in office supplies, office technology service and postage.
- Decrease of $31,264 in other one-time equipment purchases.
- Decrease of $95,019 in operating fees and services reflecting the removal of one-time ARRA contracts.
- Decrease of $12,069 lease cost for copiers.

The Grants line item decreased by $838,260 (3.9%). This funding is used to support the efforts to increase awareness of Assistive Technology; to continue focus through Vocational Rehabilitation on outreach to youth; and, to support the efforts of the DDS to make timely eligibility determinations for North Dakotans with disabilities.

- Increase of $187,522 to support the Interagency Program Assistive Technology (IPAT). All federal funds due to the availability of carryover federal funds.
- Increase of $260,000 for contractual services that provide soft-skill training and vocational assessment activities to clients. This training serves to improve skills that include communication, problem-solving and time management.
- Increase of $102,500 for youth transition activities that support summer youth employment.
- Increase of $151,944 for client service related to increased cost for academic and vocational technical school training.
- Increase of $257,100 for DDS payments due to the increase in the volume of claims. This is all federal funds.
- Increase of $80,000 for extended service based on the increase in number of clients that require this current method of providing employment supports. These clients are the most significantly disabled experiencing a mental illness, traumatic brain injuries, and intellectual disabilities.
- Increase of $110,000 for supported employment because of increased usage of providers. This is all federal funds.
- Increase of $5,000 to support the blind vendor program.
- Decrease of $18,501 to purchase equipment for the administration of the older blind program.
- Decrease of $1,976,995 in one time ARRA funding.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the Vocational Rehabilitation area of the Department. I would be happy to answer any questions.

- Attachment FIVE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Nancy McKenzie, Director of the Human Service Centers (HSCs) with the Department of Human Services. I am here today to provide you an overview of the budget and program trends in the regional centers.

Human Service Centers

This area of the budget includes the eight (8) Regional Human Service Centers (HSCs), one in each of the geographical regions of the state.

- The HSCs are the network of public outpatient clinics that serve individuals who, because of illness, addiction, or disability are at risk of harm or institutional placement. The centers provide the community safety net for our most vulnerable citizens. Their mission is to provide services that are accessible at the most appropriate and cost-effective level of care.
- We place a high value on alignment across the regions, operating as one system that shares resources as needs and demands shift. Where possible, we implement consistent and systematic processes such as our common electronic medical record and data reporting.
- Services are provided within the clinic setting, rural outreach centers, client homes, or other community settings, and include 24-hour emergency services as well as follow-up services. Response to local community disasters/mental health tragedies are another service provided.

- Telemedicine services are being provided in several rural areas of the state to improve client access, and gradual expansion of this capability is allowing us more flexible use of our medical staff across the state.
- The HSCs are also responsible for program supervision and regulatory oversight of the Child Welfare services provided by county social services, and oversight of the Aging Services programs in their regions.

Caseload / Customer Base

Data regarding those served in State Fiscal Year 2010 include:

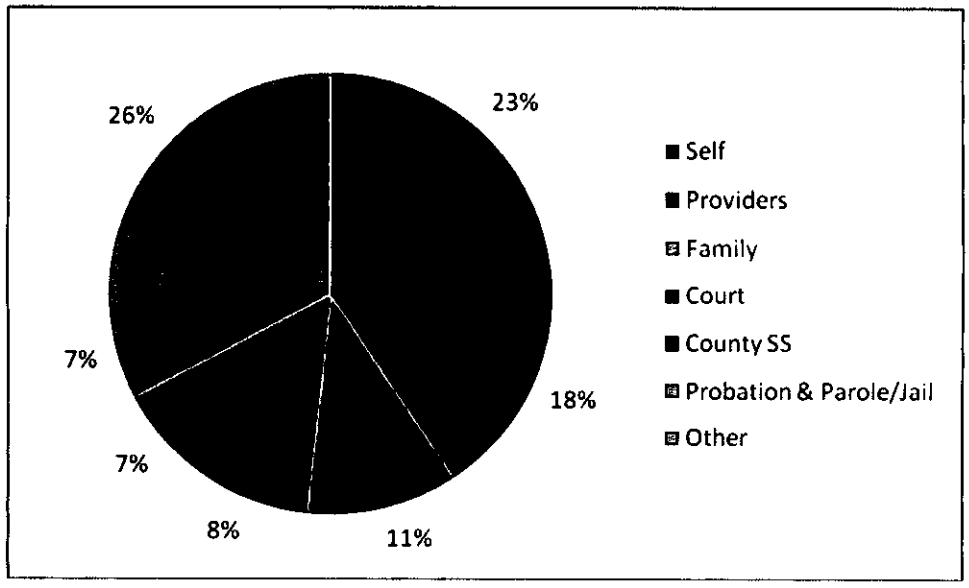
- 26,195 individuals were served excluding Vocational Rehabilitation (VR); this is an increase of 906 individuals served over the prior year (an increase of 3.5 %), and represents 4% of North Dakota's residents.
- Approximately 25% of clients served were children; 75% were adults.
- During the same period, VR served 6,992 individuals, many of whom also received other HSC services. Older Blind programs served 1,074 individuals
- 39% of HSC clients qualified for no fee on the sliding fee scale; of those, 32% had no third party payment source. This compares to 43% and 33%, respectively, in 2008.

Program Trends / Major Program Changes

- Many of the clients served by the HSCs receive multiple services. This is not surprising as many have multiple diagnoses, a tendency to homelessness, and the need for services over time. We work to wrap critical services around these individuals in the community, to support

their stability and recovery, minimize symptoms, and decrease the potential for more costly hospitalization.

- Referral to HSC services came from the following in SFY 2010:



The primary difference seen when compared to referral sources reported during the last session, is a decrease in court referrals and an increase in the miscellaneous "other" category. This provides quicker intervention at the local level before formal commitment may be needed.

- Much work has been done in this interim period to assess local inpatient hospital needs through the Human Service Center contracts, and to plan with our partners in the private sector for needed bed capacity and funding. The budget section of my testimony further describes this part of the funding, which assists in meeting gaps in the current capacity.
- Community residential capacity for clients needing additional supports increased in the current biennium, due to funding supported by the Legislature in previous biennia. This enables us to provide appropriate alternatives to hospitalization and to have available a more complete continuum of community services.

- An excellent example of effective community supports is the Cooper House "housing first" residence in Region V. This budget includes funding to assist with this community collaborative by providing contract funding to have two front-door staff on duty at all times to ensure client safety and effective operations.
    - The residence is now full, with 42 individuals who were chronically homeless or at risk of homelessness residing there.
    - When Cooper House opened in May of 2010, 4 of these individuals were SEHSC clients. Today, 20 are receiving needed services, and 6 more are in the process of engaging/considering treatment. The remainder either don't currently need services or are receiving them through the Veteran's Administration.
    - Fargo law enforcement reports indicate that admissions to the city detoxification facility decreased by nearly 600 for the period of January-November 2010. They believe the opening of Cooper House has contributed significantly to that reduction.
- This budget includes funding to allow for the important crisis care level in Minot, and to better meet demand in Bismarck by adding a few beds to their crisis capacity. Both will impact hospital admissions and give clients better local care.
- Further implementation of evidence-based practices in all of the regions continues. This results in more consistent implementation of services and better outcome tracking for those services.
- We speak often of the benefits to both client care and the budget when the right level of care is provided at the right time. Please refer now to Attachment A for case-specific examples that demonstrate these benefits.

- Telemedicine need and growth is a continued focus across the state. We provide some services through a contract psychiatrist due to staff vacancies, and have also utilized our own psychiatrists to provide telemedicine services across regions. At this time, we are in the testing process of an application hosted by the Information Technology Department (ITD) that will allow even more connectivity (laptop-to-laptop; laptop-to-desktop), which then opens up new opportunities for rural clients to more easily access professional consultation when needed.
- The HSCs continue to work closely with the Department of Corrections & Rehabilitation, who refer a number of individuals with mental illness and/or substance abuse problems who are returning to the community. The joint Release & Integration project, which provides specific release planning with prison staff, Human Service Center staff, Probation & Parole staff and the inmate scheduled for release, has resulted in more smooth transition by ensuring that psychiatric appointments and medication needs are addressed prior to release.
- We have worked hard on internal staff development to assist in filling addiction counselor positions, and continue to have ongoing psychology and psychiatry vacancies. The recent designation of Southeast Human Service Center in Fargo as an approved internship site by the American Psychological Association is a very positive achievement. This will allow more psychology residents to consider that site, including those from the University of North Dakota.

Overview of Budget Changes – Human Service Centers Combined

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
HSCs / Institutions	146,717,139	18,015,219	164,732,358	-	164,732,358
General Funds	72,640,149	17,988,727	90,628,876	-	90,628,876
Federal Funds	67,159,214	(1,008,379)	66,150,835	-	66,150,835
Other Funds	6,917,776	1,034,871	7,952,647	-	7,952,647
Total	146,717,139	18,015,219	164,732,358	-	164,732,358

FTE	836.48	1.00	837.48	-	837.48

Budget Changes from Current Budget to the Executive Budget:

- $6 million in total funds of which $4.6 million is general fund needed to fund the Governor's salary package for state employees.
- $2.2 million in total funds of which $1.6 million is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $600,000 to cover an underfunding of salaries from the 2009 – 2011 budget, all general funds.
- A decrease of $500,000 to underfund the 2011 – 2013 pay plan, all general funds.
- An increase of 1 FTE for a Psychiatrist position at North Central, $411,000 total, $269,000 general fund.
- An increase of $1.0 million for added psychiatry positions at both NEHSC (by replacing two contracted part-time psychiatrists) and at BLHSC (instead of contracting for the service) by utilizing existing FTE.
- The remaining increase of $270,000 in the Salaries and Fringe Benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 837.48 FTEs in this area of the budget.

- $1.24 million increase, with $1.09 million in general fund to allow for a 3% inflationary increase for contracted providers each year of the biennium.
- An increase of $3.4 million (for a total of $4.26 million among Centers) to provide approximately 4,900 psychiatric inpatient hospital days to be paid at the Medicaid equivalent rate for those who are not eligible for Medicaid but are clients of the department. The department also plans to move forward with a centralized contract allowing for consistent contract terms statewide and allowing flexibility for amounts to be moved from region to region based upon need.
- Includes an additional $3.35 million to address the following residential capacity issues using general fund.
    - Includes $1.4 million for a 10 bed Crisis Unit for those who are Seriously Mentally Ill in the Minot region.
    - Includes $939,000 for a 15 bed Chemical Dependency Residential Unit in the Fargo region.
    - Provides for 4 additional Adult Crisis Beds in the Bismarck region at a cost of $309,000.
    - Provides for an additional 24/7 contracted staff at the Cooper House in the Fargo region to ensure safety at a cost of $498,000.
    - Includes $201,000 to continue the 8 bed short term residential services for alcohol and drug clients in the Fargo region.

Summary of General Fund Changes

- $4.6 million to fund the Governor's salary package for state employees.
- $3.9 million for the decrease in the FMAP.
- $3.4 million is to increase the inpatient hospitalization days provided under contract throughout the state.

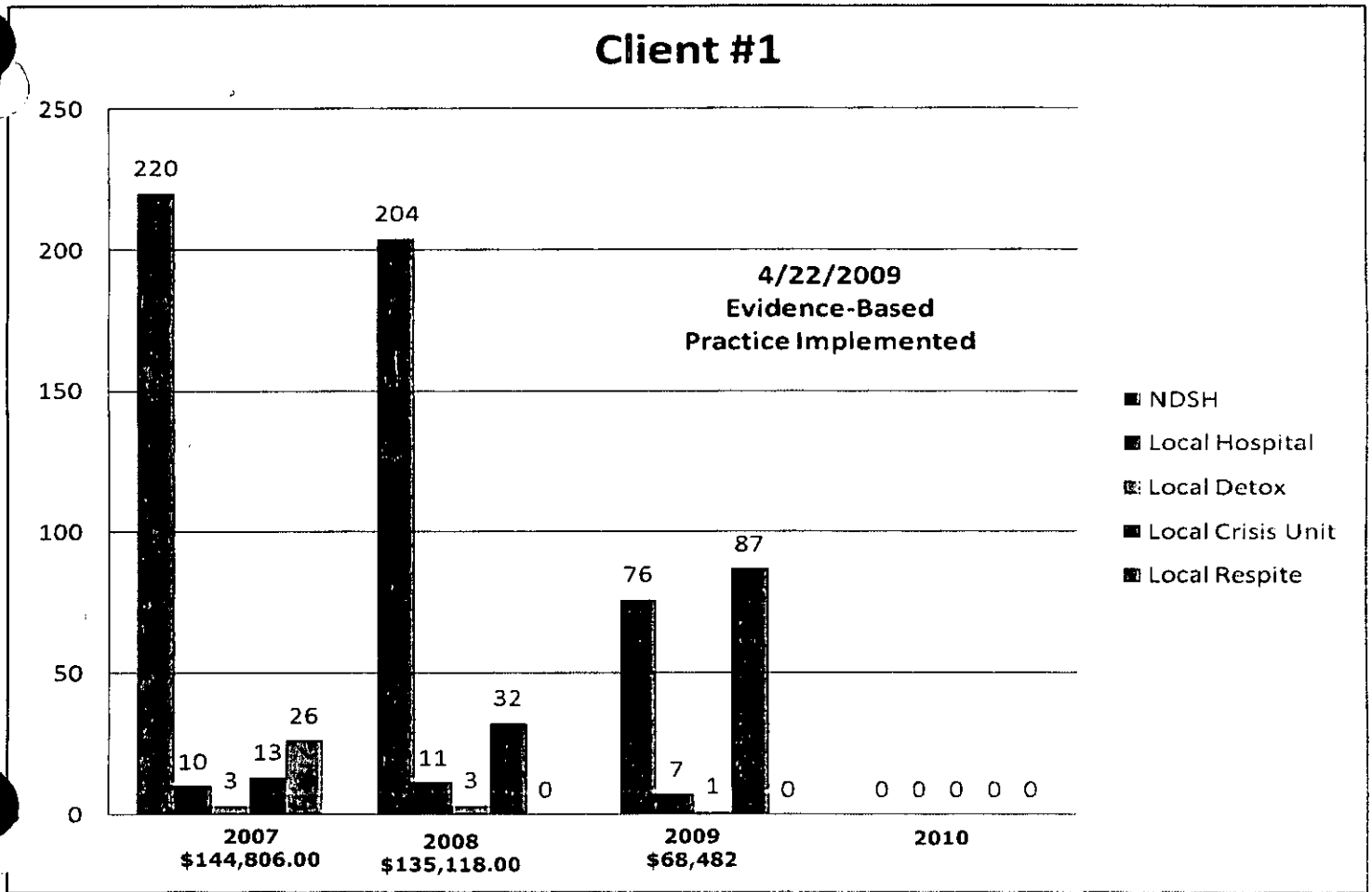
- $3.4 million to address the residential capacity issues at 3 of the human service centers.
- $1.6 million to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $1.1 million for the 3% / 3% provider inflationary increase.
- $269,000 for the full-time psychiatrist position at NCHSC.
- $174,000 to relocate the human service center in the Dickinson region.
- ($454,000) is a combination of miscellaneous decreases and increases at the human service centers.

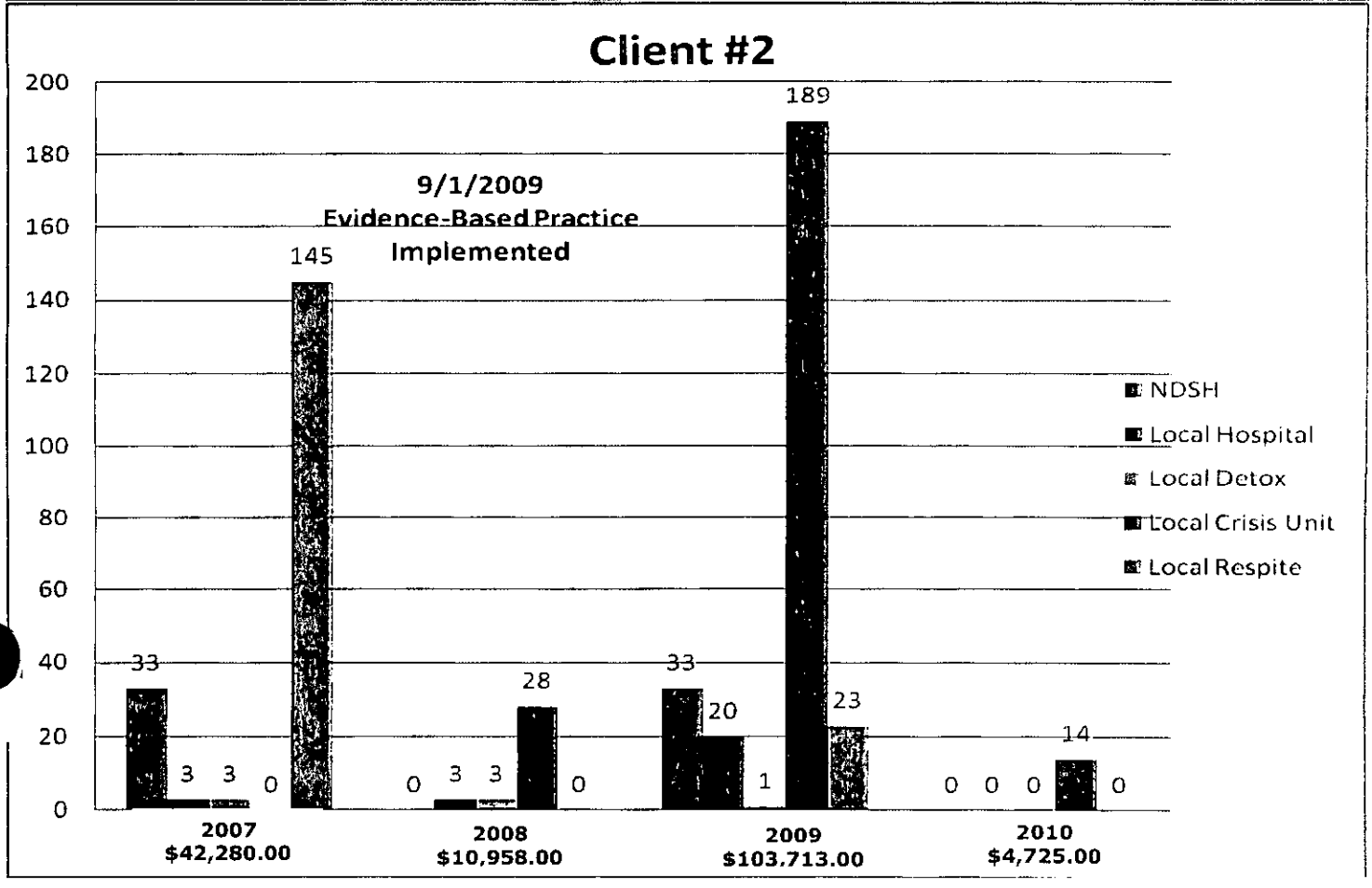
Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my formal testimony I would be glad to answer any questions you may have. Thank you.

Attachment A





-Attachment SIX

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 4th, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Alex C. Schweitzer, Superintendent of the North Dakota State Hospital and North Dakota Developmental Center (One Center) with the Department of Human Services. I am here today to provide you with an overview of the One Center.

North Dakota State Hospital Programs:

The North Dakota State Hospital provides short-term inpatient and long-term residential psychiatric, chemical addiction, and forensic services for adults. Within this group of adult patients are offenders referred to the Tompkins Rehabilitation and Corrections Center by the Department of Corrections and Rehabilitation for residential addiction services.

The State Hospital also provides inpatient services for children and adolescents with serious emotional disorders and substance abuse problems. The Jamestown Public School System provides educational services to the child and adolescent population in a school located on the grounds of the State Hospital.

The above-mentioned patients are considered to be the traditional patient population of the Hospital.

The Hospital also provides inpatient evaluation and treatment services for sexually dangerous individuals. This group of patients are housed and treated in the secure services unit of the Hospital.

North Dakota State Hospital Census:

The State Hospital operates 307 beds.

The Hospital utilizes ninety (90) of these beds to provide addiction services to offenders in the Tompkins Rehabilitation and Corrections Center, comprised of 60 male and 30 female offenders.

The Hospital utilizes one hundred thirty-two (132) beds for inpatient and residential psychiatric services for the treatment of adults, children and adolescents with serious and persistent mental illness, serious emotional disorders and chemical addiction. Inpatient and residential services were highly occupied from 2006 through 2008, with occupancy often running between 95% - 100% and occasionally exceeding 100%. The major reasons for this high occupancy were the admission of first time patients, chronic patients awaiting referral to residential settings and the increased need for treatment of patients with complex medical and psychiatric issues.

The inpatient psychiatric service during the past two years (2009 – 2010) saw an increase in total admissions and a decrease in average daily census. Average occupancy was 86% during the past year and this better aligns with the ratio of staff to patient as the Hospital staffs patient units for 85% occupancy.

The decrease in occupancy can be attributed to increased community service options, treatment in local psychiatric inpatient facilities and discharge options for chronic patients.

The Tompkins Rehabilitation and Corrections Center and the Inpatient Psychiatric Service admissions and average daily census data is outlined in Attachments A (1) & (2) based on a calendar year.

The Hospital operates 76 beds in the sex offender unit, and at the end of 2010 we had occupancy of 59 patients. The Hospital also operates a Transitional Living Home on the campus for one sex offender in the late stages of their commitment to the program.

The census data on the sex offender population is outlined in Attachment B.

In summary, the Executive Budget recommendation for the North Dakota State Hospital is for a total capacity of 298 patients. The breakdown by program includes; 90 beds in the Tompkins Rehabilitation and Corrections Center, 76 beds in the Secure Services Unit (sex offender program) and 132 beds for inpatient psychiatric services.

Major Program Changes/Trends:

- The North Dakota State Hospital is providing more residential services for individuals with dual diagnosis, mental illness, chronic recidivistic alcoholics and individuals with intellectual disabilities that present with chronic medical and behavioral issues.

- After years of dramatic decline, because of the increased availability of community-based services, the State Hospital's patient census grew modestly after 2003. The growth was attributed to sex offenders, the Tompkins Program and first time admissions.

- The North Dakota State Hospital had pending waiting lists in the years 2006, 2007 and 2008. The Hospital adapted with the addition of more hospital beds. This moderated in 2009 and 2010 – frequently the Hospital was at 85% occupancy. The need for more inpatient beds was removed from the 2011 budget request and instead internal reorganization is meeting our patient needs.

- Individuals admitted to the North Dakota State Hospital have higher acuity levels than in the past.

- Secure Services had its first discharge in 2008 and we have discharged 17 individuals from the sex offender program to date. (Two returned to prison).

Overview of Budget Changes in Traditional Services:

Description	2009 - 2011 Budget	Increase/ Decrease	2011 – 2013 Executive Budget	Senate Changes	To House
Capital Construction Carryover	1,179,625	(1,179,625)			
Institutions	58,870,713	3,337,572	62,208,285	161,840	62,370,125
General Funds	40,114,197	1,947,685	42,061,882	161,840	42,223,722
Federal Funds	4,803,599	(2,193,816)	2,609,783		2,609,783
Other Funds	15,132,542	2,404,078	17,536,620		17,536,620
Total	60,050,338	2,157,947	62,208,285		62,370,125
FTE	380.96	.49	381.45		381.45

Budget Changes from Current Budget to Executive Budget:

The Overall Budget increase of $2,157,947 can be explained as follows:

- $2,558,189 in general fund needed to fund the Governor's salary package for state employees.

- $936,178 in total funds of which $882,686 in general fund and $53,492 in federal funds needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.

- An increase of $1,346,480 to cover an underfunding of salaries from the 2009 – 2011 budget.

- The 2011 – 2013 Executive Budget recommendation has a salary underfund of $796,986 for traditional services.

- The Executive Budget recommendation includes $222,970 to hire a pharmacist to provide telepharmacy services to the eight (8) regional human service centers.

- A decrease of $282,860 in temporary salaries as the 11 – 13 request splits the cost of patient employment between the traditional budget and secure services budget.

- The remaining decrease of $30,597 is a combination of increases and decreases needed to sustain the salary of the 381.45 FTE in this area of the budget.

- A increase in operating costs of $535,514, which includes; an increase in travel costs, educational supply costs, chemical supply costs, office supply costs, furniture replacement, insurance costs, a pharmacy bar code system for the pharmacy and increased stipend and professional development costs.

- The Executive Budget recommendation for major extraordinary repairs at the Hospital is for $733,650, which is a decrease of $2,267,367 from the current budget; Major extraordinary repairs include; $220,000 for replacing the LaHaug sanitary sewer system, $50,000 for siding and windows for transitional living houses, $20,000 for

overhauling chillers, $75,150 for asbestos and lead based paint abatement, $25,000 for the LaHaug fire alarm system upgrade, $15,000 for replacing the windows in the south end of the Chapel, $25,000 for roof repairs, $25,000 for new security lights, $25,000 for one unisex handicapped accessible bathroom in the Chapel, $30,000 for water supply repairs, $25,000 for coal handling equipment, $18,000 for boiler repairs,$33,500 for fuel oil pump, $27,000 for heating coils, $20,000 for handicapped accessible doors and $100,000 to upgrade the elevators in the LaHaug building.

- Other capital payments decreased by $437,729 as bond payments were paid off for the North Dakota State Hospital in 2010.

- Land and Buildings increase in the Executive Budget of $1,800,000 to include; $1,500,000 for Joint Commission accreditation items, the cost of replacing the emergency generator $1,300,000 and testing of fire/smoke dampers $200,000, and $300,000 for the rewiring and updating of electrical equipment in the New Horizons building.

- Equipment over $5,000 in the Executive Budget recommendation shows a decrease of $246,220.

- Capital Construction Carryover - Extraordinary Repairs also decreased by $1,179,625, which was a carryover of funds from the 2007 – 2009 biennium for capital projects in progress on July 1, 2009.

- The 2011 - 2013 Executive Budget recommendation contains an increase of .49 FTE. This includes the one (1) FTE for the telepharmacy position and a reduction of .51 FTE because of a transfer to secure services.

- The increase in General Fund is the result of the Executive Budget recommendation for the state employee's salary package and the one-time expense of capital projects.

- Federal Funds decrease by $2,193,816 because of the reduction in Federal Participation and fewer patients covered by Medicaid.

- Other Funds increase by $2,404,078 because of increased payments for Medicare Pharmacy Part D, Medicare Inpatient Part A and contract payments for Tompkins Rehabilitation Center patients.

Senate Changes:

The Senate added $161,840 which fully funds OAR 501, State Hospital Capital Projects, for flooring projects.

Overview of Budget Changes in Secure Services:

Description	2009 – 2011 Budget	Increase/ Decrease	2011 – 2013 Budget	Senate Changes	To House
Institutions	10,480,123	784,792	11,264,915		11,264,915
General Funds	10,429,000	835,915	11,264,915		11,264,915
Federal Funds	17,824	(17,824)			
Other Funds	33,299	(33,299)			
Total	10,480,123	784,792	11,264,915		11,264,915
FTE	85.55	.51			86.06

Budget Changes from Current Budget to Executive Budget:

The Overall Budget increase of $784,792 can be explained as follows:

- The salary increase is $553,837 in general fund needed to fund the Governor's salary package for state employees.

- $282,242 in total funds of which $282,078 is general fund and $164 in federal funds needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.

- The 2011 – 2013 Executive Budget recommendation has a salary underfund of $900,000 for secure services.

- The 2011 – 2013 Executive Budget recommendation has an increase of $368,091 to cover underfunding from the 2009 – 2011 budget.

- An increase of $187,432 in temporary salaries as the 11 – 13 request splits the cost of patient employment between the traditional budget and secure services budget.

- The remaining increase of $183,727 is a combination of increases and decreases needed to sustain the salary of the 86.06 FTE in this area of the budget.

- Operating costs increase by $109,463, with the primary increases in educational supplies, health supplies, office supplies, flooring costs, estimated building repairs, added cost of psychological evaluations, stipends and professional development costs.

- Total FTEs increase by .51 because of the transfer of a RN II and Forensic Psychologist from the traditional services budget to the secure services budget.

- The increase in general fund in the Executive Budget recommendation for secure services is the result of Governor's salary package.

- Federal Funds decrease by $17,824, as we were unable to collect any federal dollars for the secure services unit.

- Other funds decrease of $33,299 is the result of patients not having private funds or third party payers for payment.

Senate Changes:

The Senate made no changes to the Secure Services budget.

North Dakota Developmental Center Programs:

The North Dakota Developmental Center provides services for individuals with intellectual disabilities. The Center provides residential services, work and day activity services, medical services, clinical services and evaluation and consultation services.

Residential Services at the Developmental Center include:

- Secure Services Program – this unit is for individuals with intellectual disabilities who have sex offending behaviors and for other individuals from the campus that require a more secure living environment. These individuals require long-term care.

- Health Services Program – for individuals with intellectual disabilities who are totally dependent on staff to complete daily cares and have medical concerns that require nursing staff accessibility 24 hours per day. Also, in this area are a small number of individuals diagnosed with profound intellectual disability and dual sensory disabilities (vision and hearing). These individuals require long-term care.

- Behavioral Care Program – these individuals with intellectual disabilities present with psychiatric diagnoses and significant challenging behaviors. Some of these individuals may also have less severe medical needs.

- Youth Services Program - these young people between the ages of 16 - 25 have difficulty finding housing and services in the community. The Center provides short-term services to these individuals until a community placement can be found.

- Independent Supported Living Arrangement Program - the Developmental Center has three individuals with sexual health issues living in campus housing. The Center provides staffing to support these individuals in this independent living arrangement.

- Outreach Program – the Center provides outreach services for the community. The Consultation, Assistance, Resource, Evaluation and Service (CARES) team provides these services in order to prevent admissions, readmissions and also assist in transitioning people from the Developmental Center. In 2008 the CARES Team went statewide.

North Dakota Developmental Center (NDDC) Census:

See Attachment C, for the census data at the Center for the period of 1997 through 2010.

Major Program Changes/Trends:

- Census at the Developmental Center was steady for a number of years at an average of 143 individuals until the transition to community initiative started in 2005. The current budget request is based on 95 individuals. The goal is for 67 individuals to be residing at the Center by July of 2013.

- The Developmental Center transformation initiative is preparing the facility for a smaller population and the elements of this initiative include; decentralized dining, reorganized programming, the addition of transitional programs for adults and youth, closing and reorganizing units, suites and buildings, renting or selling underutilized buildings and land and preparing staff for change.

- The Community Assistance, Resources, Evaluation and Support (CARES) team supports people in community settings to prevent admissions and readmissions to the Center. The CARES team, the addition of the transitional programs and the addition of behavioral analysts are the primary drivers in managing admissions and readmissions. No additional dollars are requested for these enhancements.

- The Developmental Center has vacant space because of the transition of individuals from the Center to the community.

- The remaining population at the Developmental Center has higher individual care needs.

Overview of Budget Changes – North Dakota Developmental Center:

Description	2009 – 2011 Budget	Increase/ Decrease	2011 – 2013 Budget	Senate Changes	To House
Capital Construction Carryover	20,100	(20,100)			
Institutions	54,082,240	(2,272,993)	51,809,247		51,809,247
General Funds	14,595,729	5,821,701	20,417,430		20,417,430
Federal Funds	35,363,271	(7,539,811)	27,823,460		27,823,460
Other Funds	4,143,340	(574,983)	3,568,357		3,568,357
Total	54,102,340	(2,293,093)	51,809,247		51,809,247
FTE	441.29	(40.53)	400.76		400.76

Budget Changes from Current Budget to Executive Budget:

The Overall Budget decrease of $2,293,093 can be explained as follows:

- The salary increase is $2,277,341 in total funds of which $1,060,331 is general fund, $1,217,009 in federal funds and $1 in other funds needed to fund the Governor's salary package for state employees.

- $700,042 in total funds of which $367,331 is general fund and $332,711 in federal funds needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.

- An increase of $201,159 to cover an underfunding of salaries from the 2009 – 2011 budget.

- The 2011 – 2013 Executive Budget recommendation has a salary underfund of $738,694 for the Developmental Center.

- Other salary changes include; a decrease of $323,601 because of retirements and a decrease of $3,536,968 as a result of reduced client population.

- The remaining decrease of $162,509 is a combination of increases and decreases needed to sustain the salary of the 400.76 FTE in this area of the budget.

- Operating Fees and Services increase $433,134 due to increased provider assessment costs.

- Other Operating costs decrease by $413,034 due to reduced resident population, with decreases in flex training costs, supply costs, professional fees, and medical, dental and optical costs.

- The Executive Budget recommendation for extraordinary repairs at the Center is for $579,469, which is a decrease of $133,206 from the current budget. Extraordinary repairs include; $199,100 for sprinkler system upgrade for the residential buildings, $203,747 for flooring, $50,000 for replacement of piping for the steam distribution system, $10,000 for campus concrete projects, $25,000 for door and hardware replacement, $50,000 for repairs to the chill water piping system, $18,000 for pool patio covers and $23,622 for ceiling upgrades in the food service area.

- Equipment over $5,000 in the Executive Budget recommendation is a decrease of $75,000 from the current budget because of reduced population.

- Decrease of $501,657 for the final bond payment made in 2010.

- Capital Construction Carryover - Extraordinary Repairs also decreased by $20,100, which was a result of carryover funds from the 2007 – 2009 biennium for capital projects in progress on July 1, 2009.

- The net decrease of 40.53 FTEs at the Developmental Center because of reduced resident population.

- The increase in General Fund is for the Executive Budget recommendation for the state employee's salary package and to cover the reduction in the federal match.

- The Federal Funds decrease is because of the reduction in the federal match and decrease in resident population.

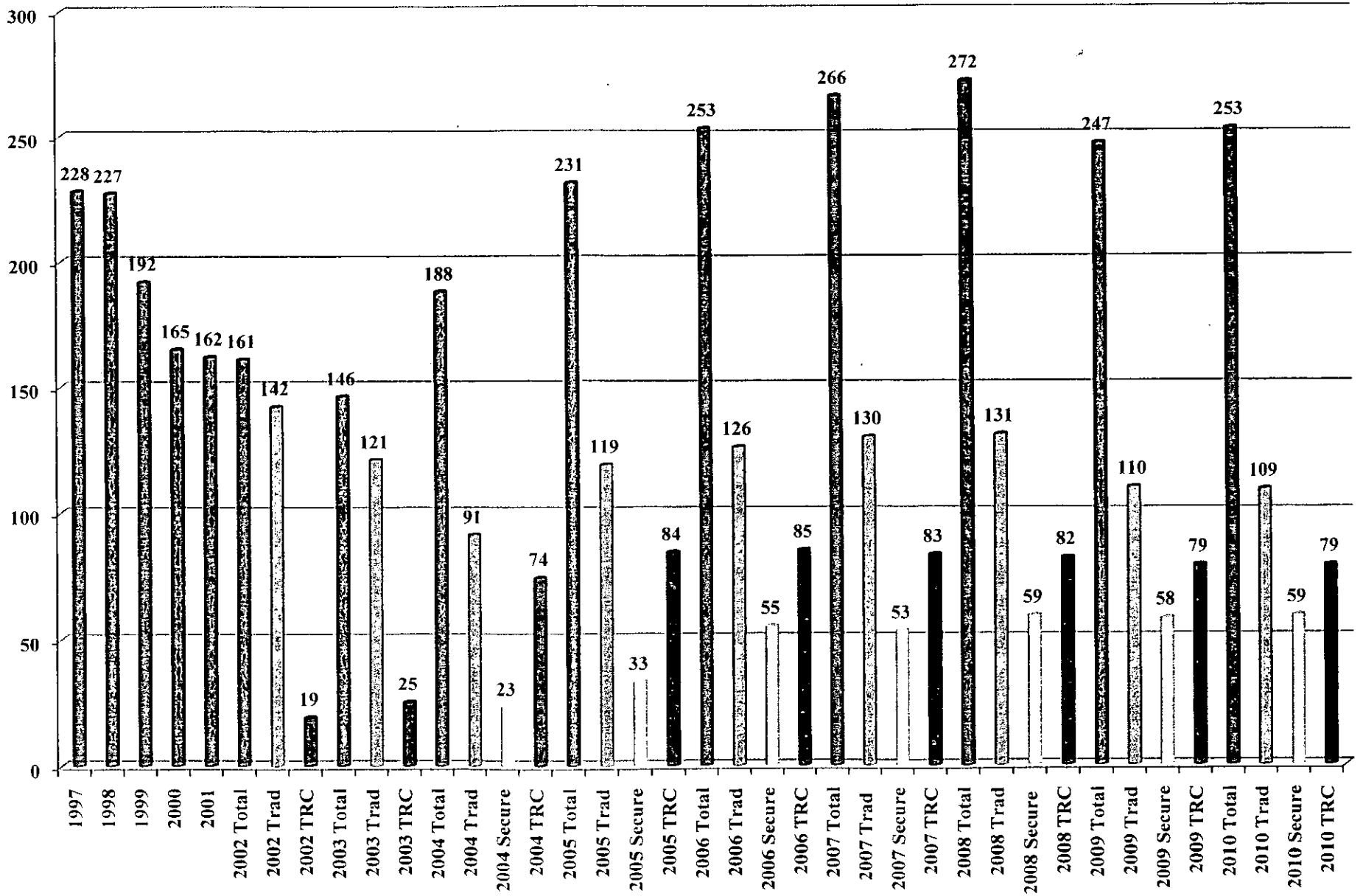
- The Other Funds decrease because of a reduction in recipient liability and Medicare Part D payments because of the decrease in resident population at the Center.

Senate Changes:

The Senate made no changes to the North Dakota Developmental Center budget.

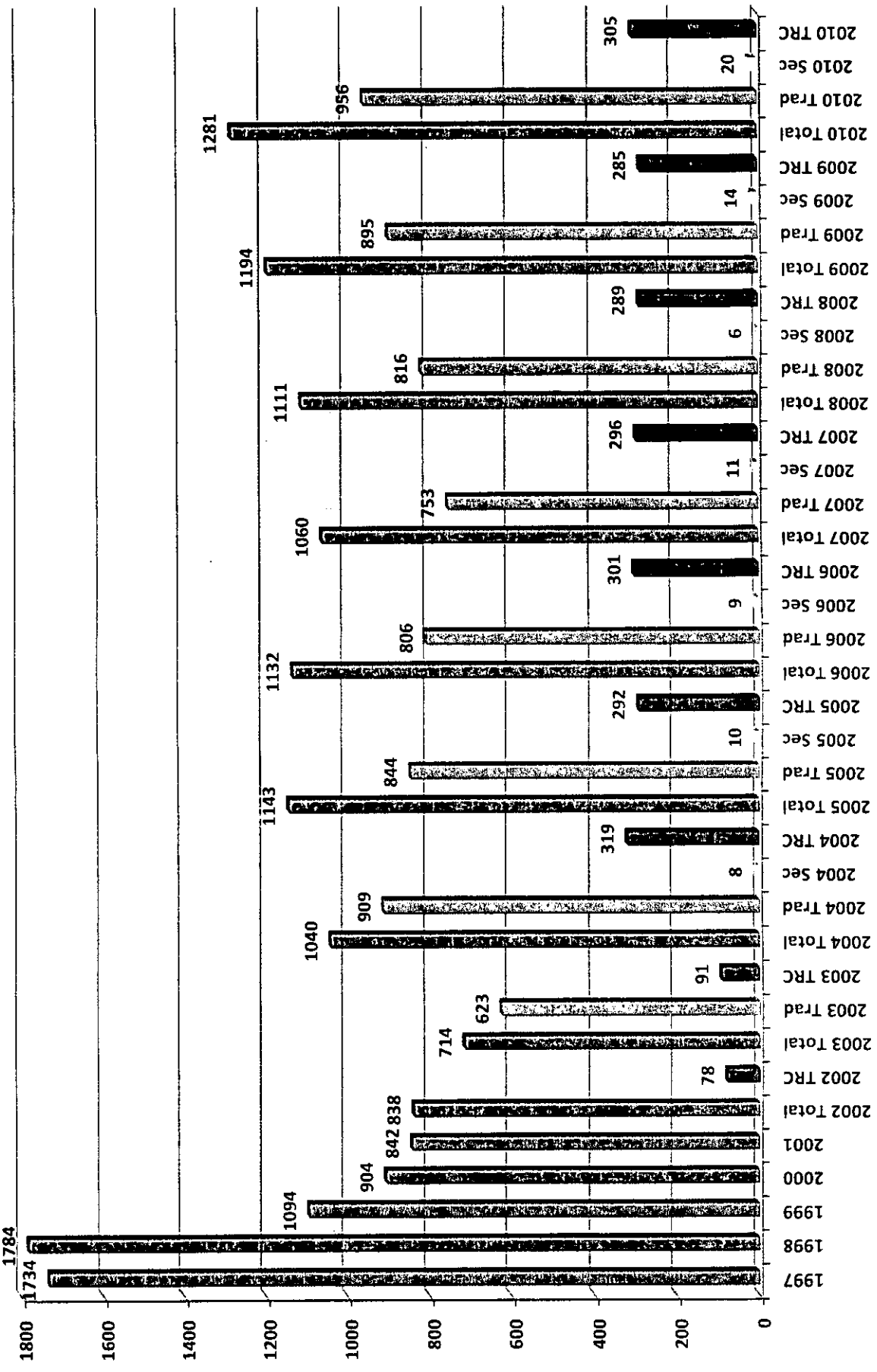
Thank you. I would be happy to answer any questions about the budget request for the North Dakota State Hospital and North Dakota Developmental Center (One Center).

NDSH AVERAGE DAILY POPULATION

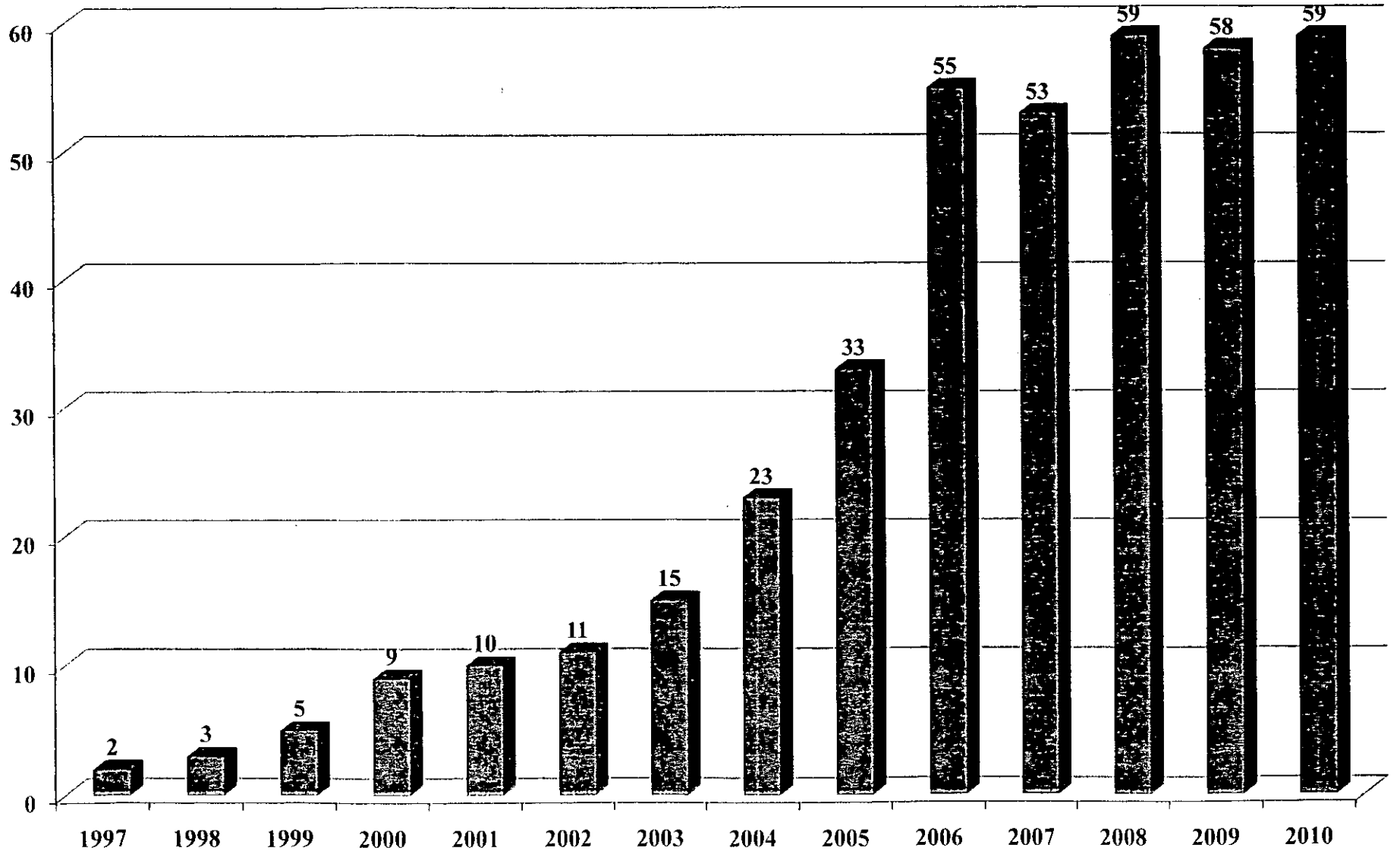


Attachment A (1)

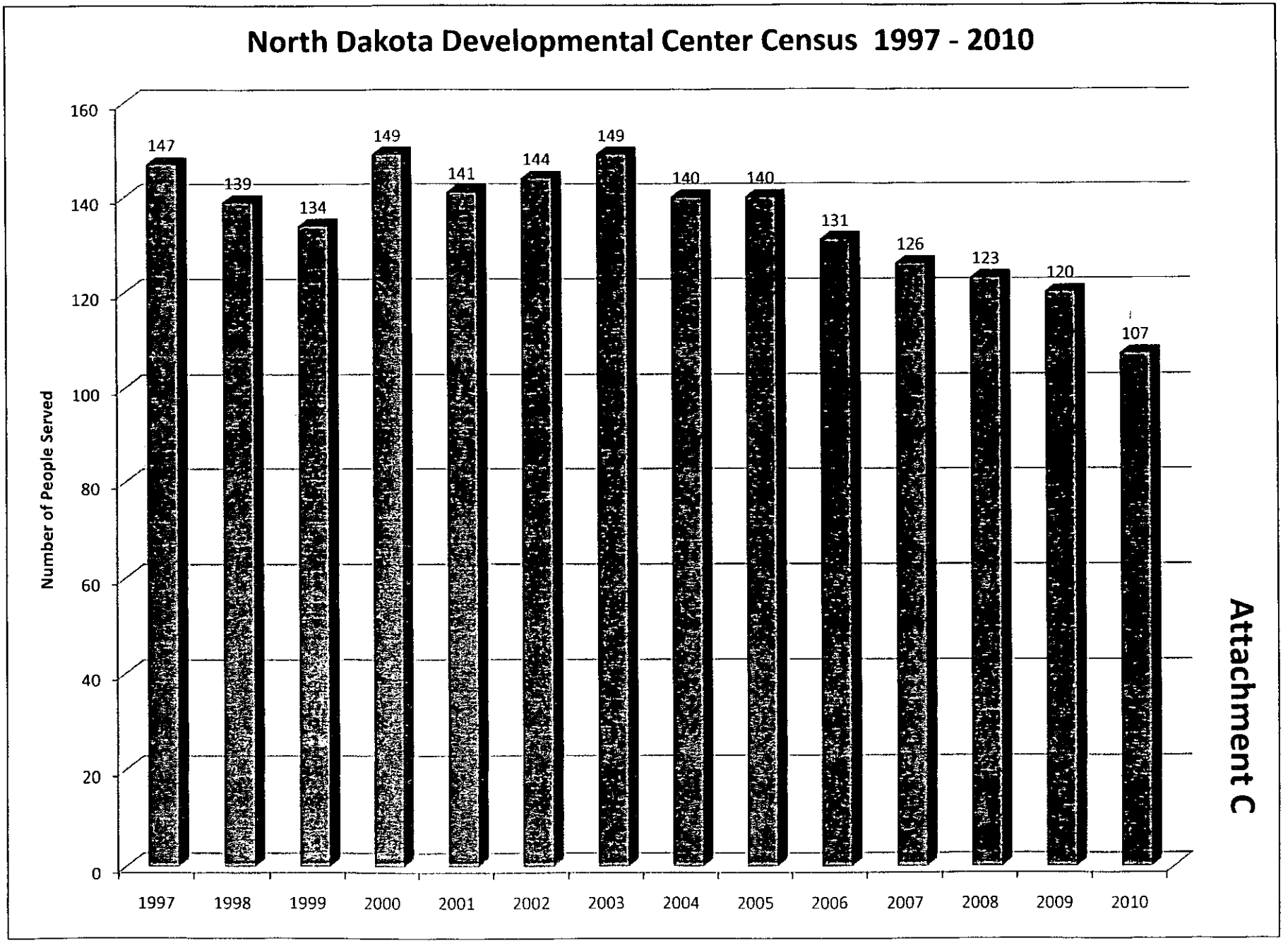
Attachment A (2)



NDSH SEX OFFENDER PROGRAM CENSUS
1997 - 2010



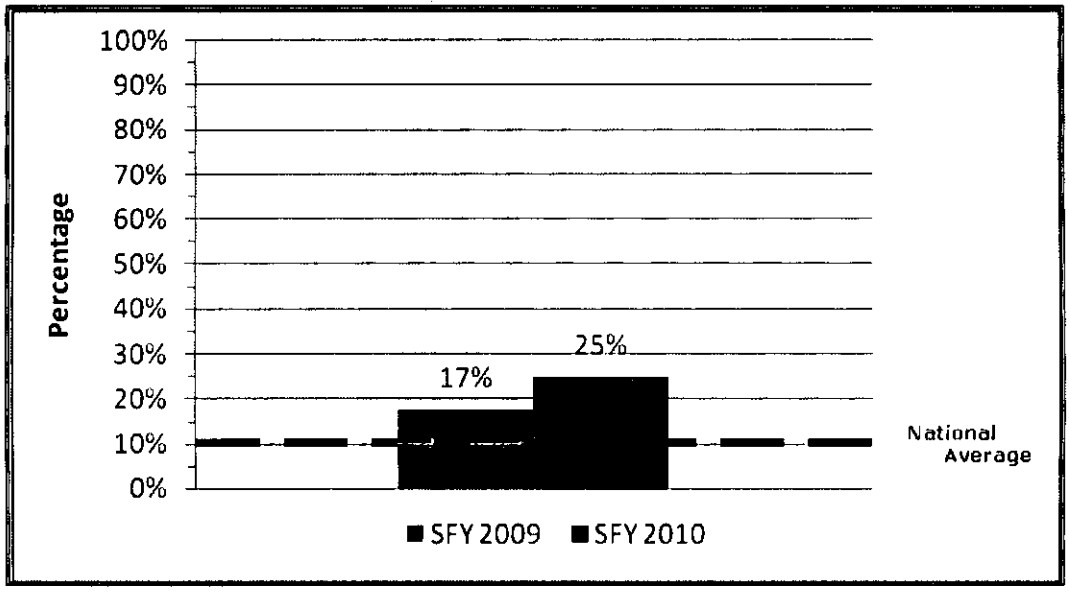
Attachment B



Attachment C

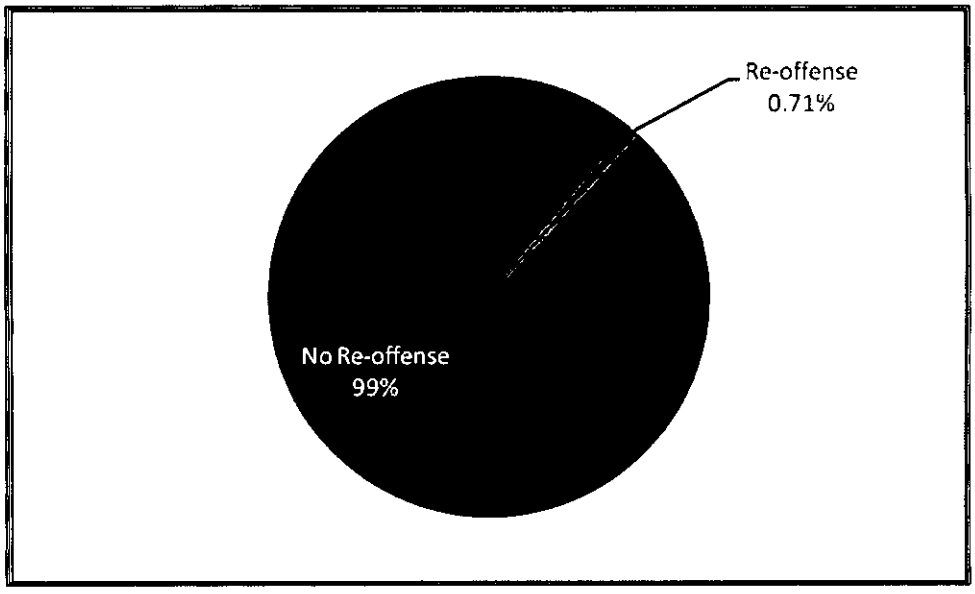
methods are implemented and showing positive results. Methods are currently in place to treat individuals addicted to methamphetamine and opiates, those who have experienced traumatic situations, those with both a severe mental illness and a chronic substance abuse disorder, those who have never had employment due to their mental illness or substance abuse disorders, and those who are new to recovery.

Employment increases for individuals with serious mental illness.



Percent of adults in North Dakota who receive public mental health services, are diagnosed with a serious mental illness, and are employed. Source: FY 2011 Community Mental Health Services Block Grant Application for the State of North Dakota.

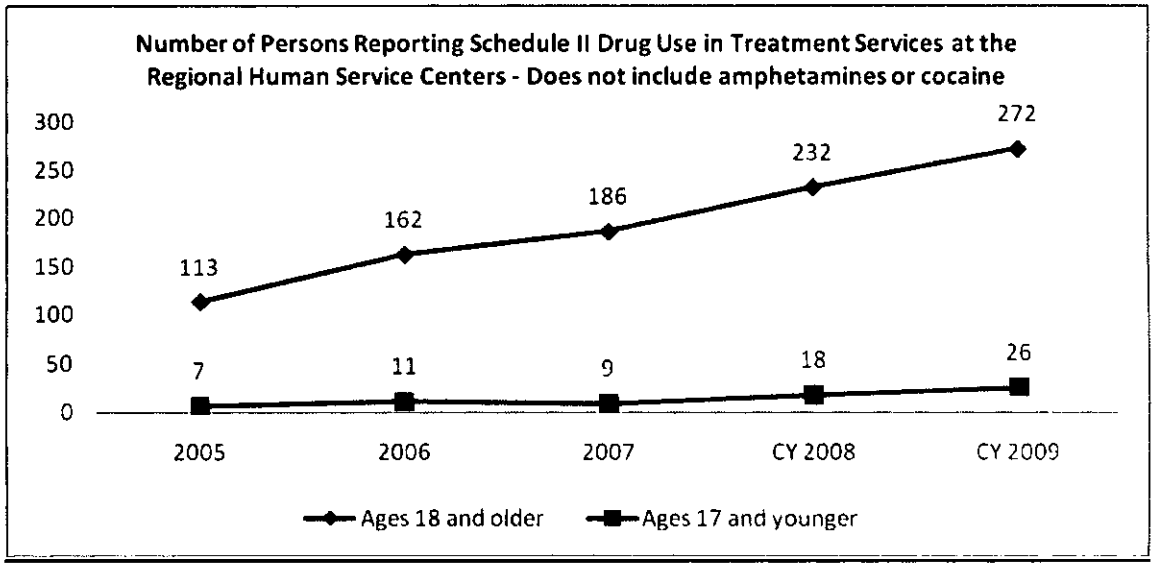
High Risk Sex Offender Treatment Program – Recidivism Rate

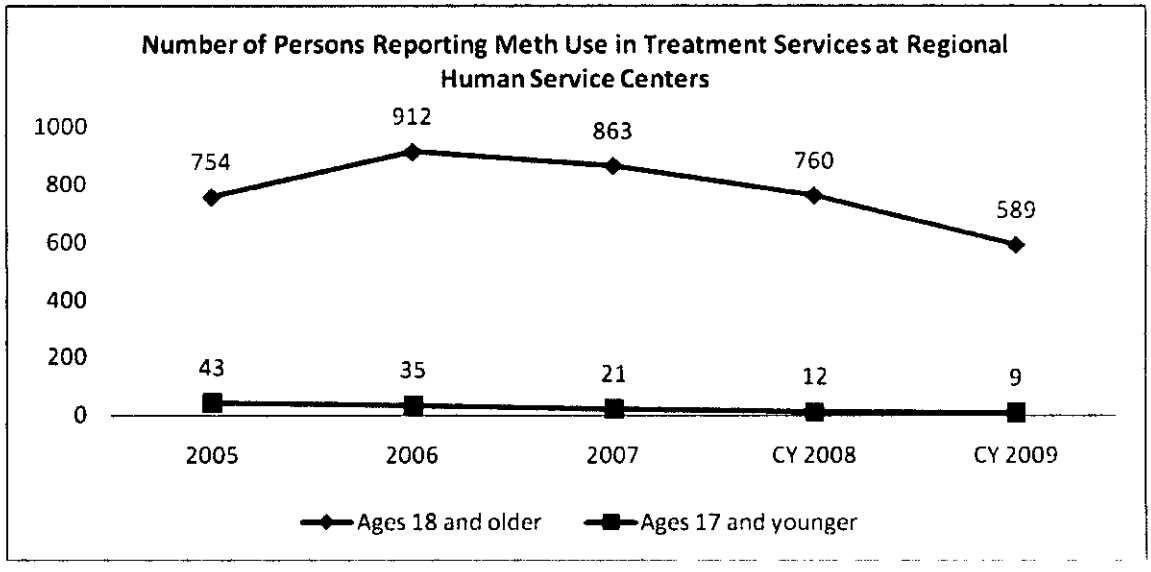


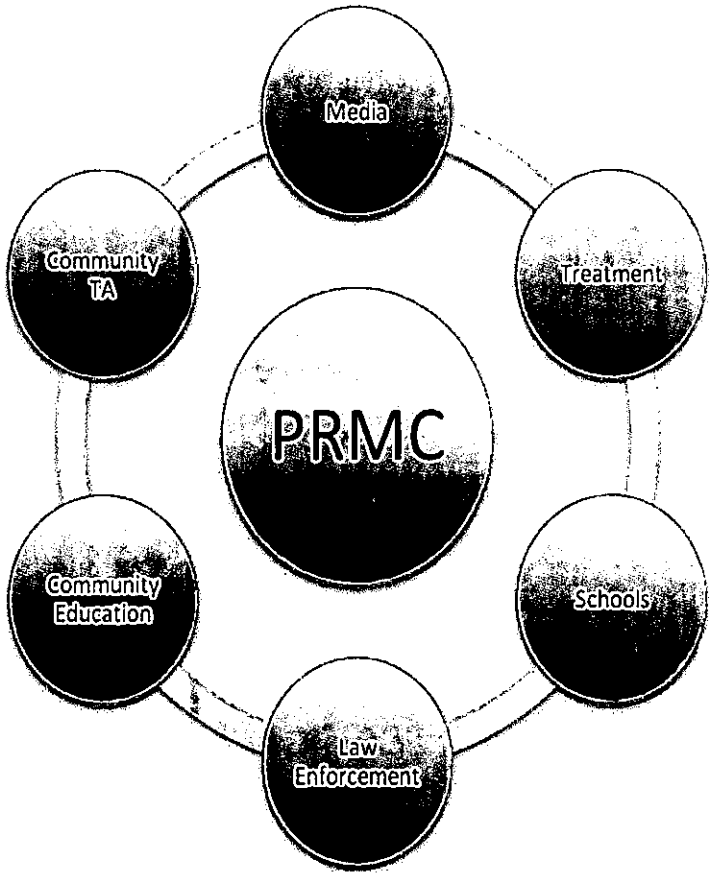
Since the program's inception, 1 out of 140 individuals in the program have had a sexual re-offense. That is 0.71% of the total population involved with treatment.

Prescription Drug Abuse Climbing

Prescription drugs that are abused or used for nonmedical reasons can alter brain activity and lead to dependence. Commonly abused classes of prescription drugs include opioids (often prescribed to treat pain), central nervous system depressants (often prescribed to treat anxiety and sleep disorders), and stimulants (prescribed to treat narcolepsy, ADHD, and obesity).


Number of Persons Reporting Schedule II Drug Use in Treatment Services at the Regional Human Service Centers - Does not include amphetamines or cocaine
300
250
200
150
100
50
0
113
162
186
232
272
7
11
9
18
26
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger


Number of Persons Reporting Meth Use in Treatment Services at Regional Human Service Centers
1000
800
600
400
200
0
754
912
863
760
589
43
35
21
12
9
2005
2006
2007
CY 2008
CY 2009
Ages 18 and older
Ages 17 and younger



Transformed the prevention resource and media center (PRMC) from a passive library to an active media and resource-rich center for communities

- The PRMC has campaigns, toolkits, and resource guides on alcohol, prescription drugs, server training, refusal skills, community prevention ideas, plus supplies and information for prevention activities held around the state.

Use of environmental prevention strategies

- Historically, alcohol education and prevention has focused on changing behavior of individuals. The thought being: if people know risks, they will change behavior. This is not the case.

ENVIRONMENTAL PREVENTION

Environmental Prevention involves changing the environment in which alcohol-related problems (such as drinking and driving, binge drinking, and underage drinking) occur. But what does it mean to "change the environment?" One way to explain the concept of Environmental Prevention is to first identify what it is ***not***:

- It is ***not*** focused on changing individual behavior(s) through education and treatment.
- It is ***not*** "prohibition" of alcohol in the community.
- It is ***not*** condemning those who drink or sell alcohol responsibly.
- It is ***not*** eliminating personal responsibility for those whose behavior causes damage or injury to others.

Instead, the Environmental Prevention approach works to modify community conditions that condone and/or encourage unhealthy and unsafe behaviors.

Environmental Prevention requires a new way of thinking on the part of prevention professionals. In this case it involves:

- Rejecting the assumption that, "We can't change things because this is how it is, and always will be!"
- Critically examining those aspects of our society that support or sustain alcohol-related problems.
- A willingness to do things differently.
- Insisting that policy makers and law enforcement work together with community groups so changes will have significant and sustainable effects on the problem.
- Holding accountable all those who profit from irresponsible alcohol sales and use.
- Supporting those responsible for making and enforcing alcohol-related laws/policies.
- No longer solely blaming kids for underage drinking and related problems.

Ultimately, Environmental Prevention is based on the fact that people's behavior is powerfully shaped by their environment. Environmental Prevention considers four areas of concern or causal factors: social availability of alcohol, retail availability of alcohol, criminal justice, and promotion of alcohol.

Just look at the change in public attitudes toward seatbelts and smoking. Environmental Prevention Campaigns related to both these issues have created a dramatic cultural shift in thinking and behavior that has had a positive effect on public health and safety throughout the United States.

Environmental Prevention targets entire communities rather than individuals. That way, it has the potential to bring about enduring reductions in the problems. Still, it is not a quick fix; it may require several years or even a generation to see the changes occur, but these changes are generally permanent and dramatic.

north dakota department of human services

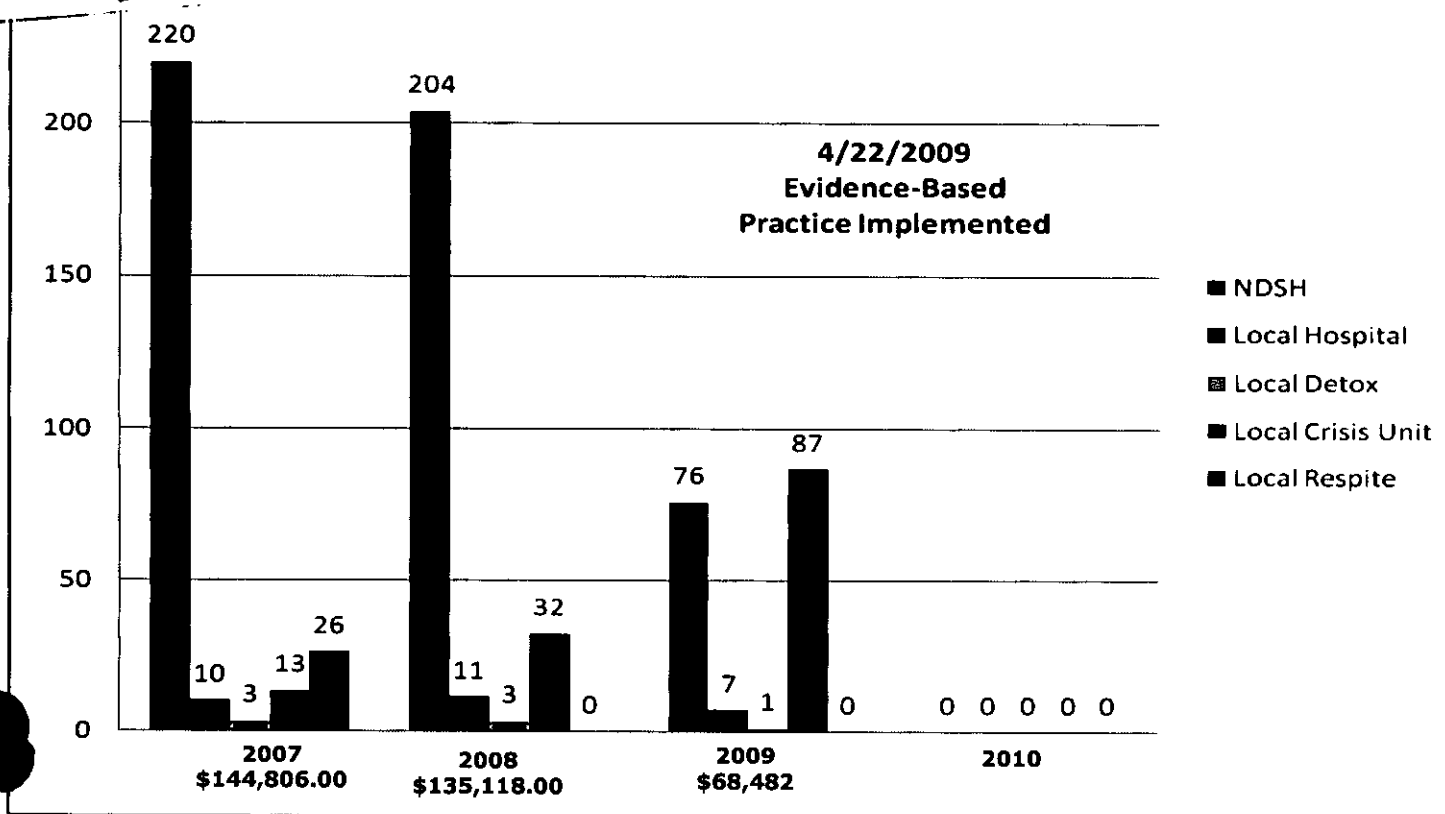
North Dakota Prevention Resource and Mediation Center

Institute for Public Strategies for the Montana Community Change Project (March 2009)
"Environmental Prevention: An Approach to Reducing Drinking and Driving and Binge Drinking in Montana"

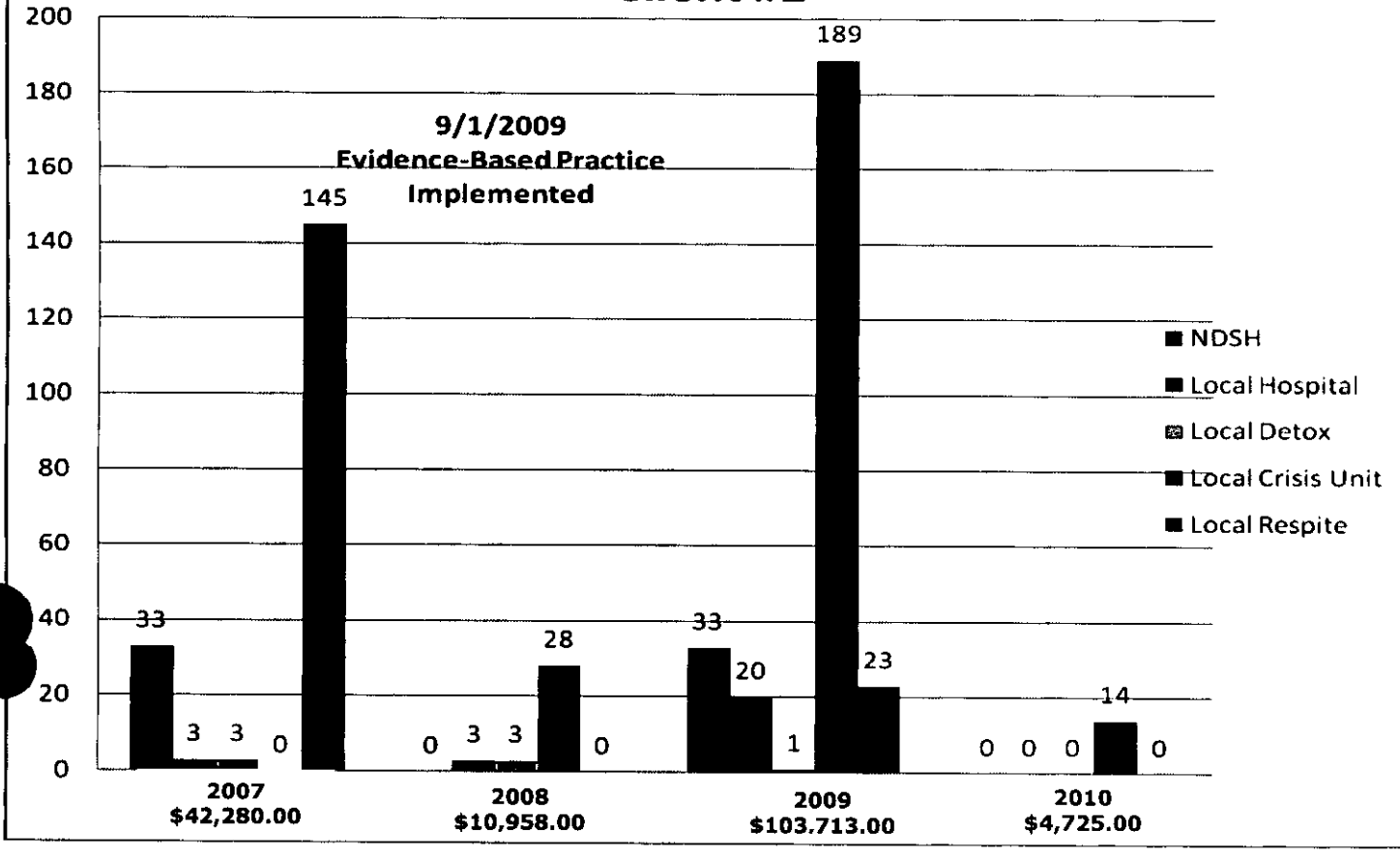
Attachment FIVE 3/4/11 SB2012

Attachment A

Client #1

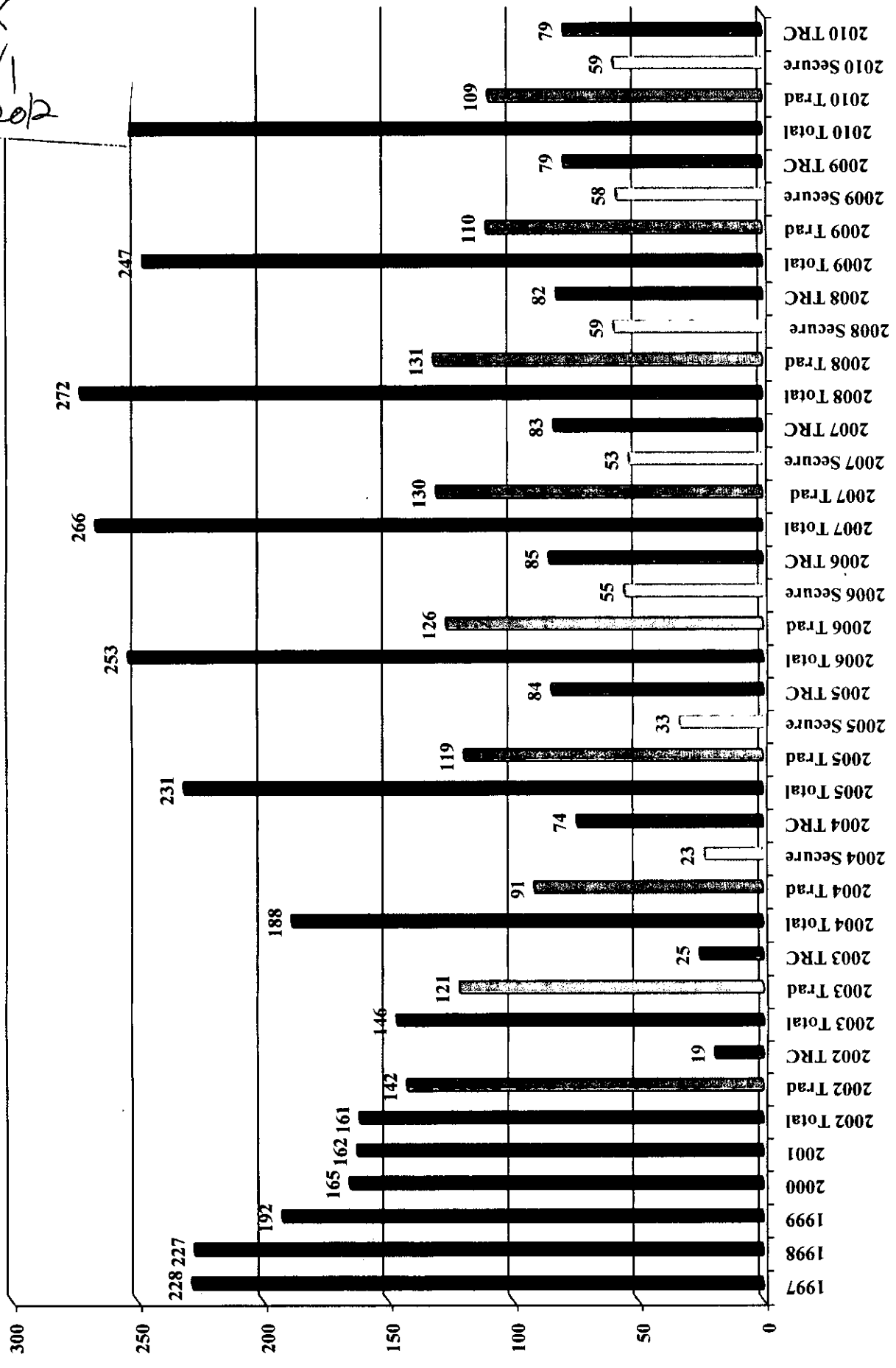


Client #2



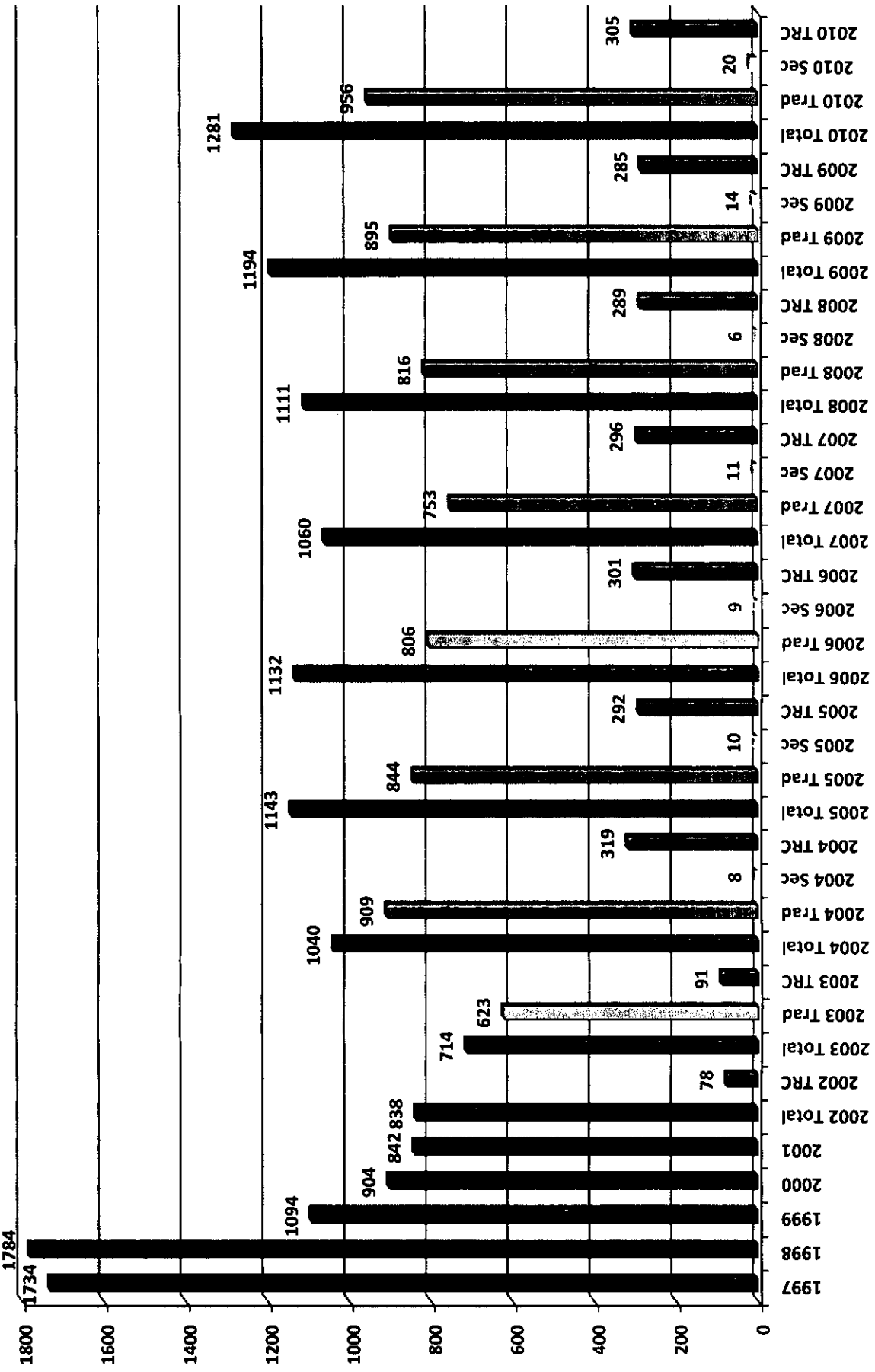
Attachment
SIX
1/4/11
SB 202

Attachment A (1)

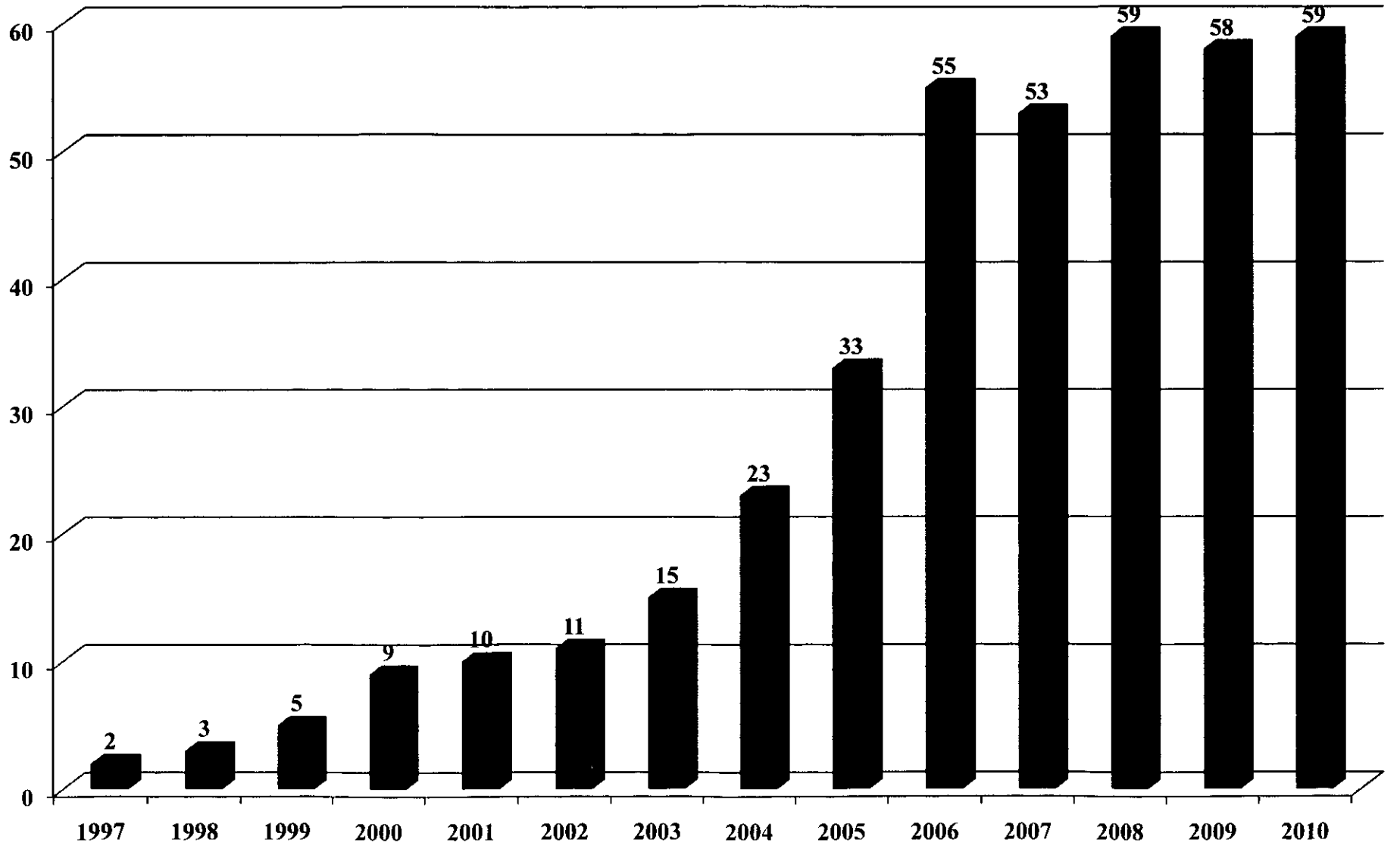


Attachment A (2)

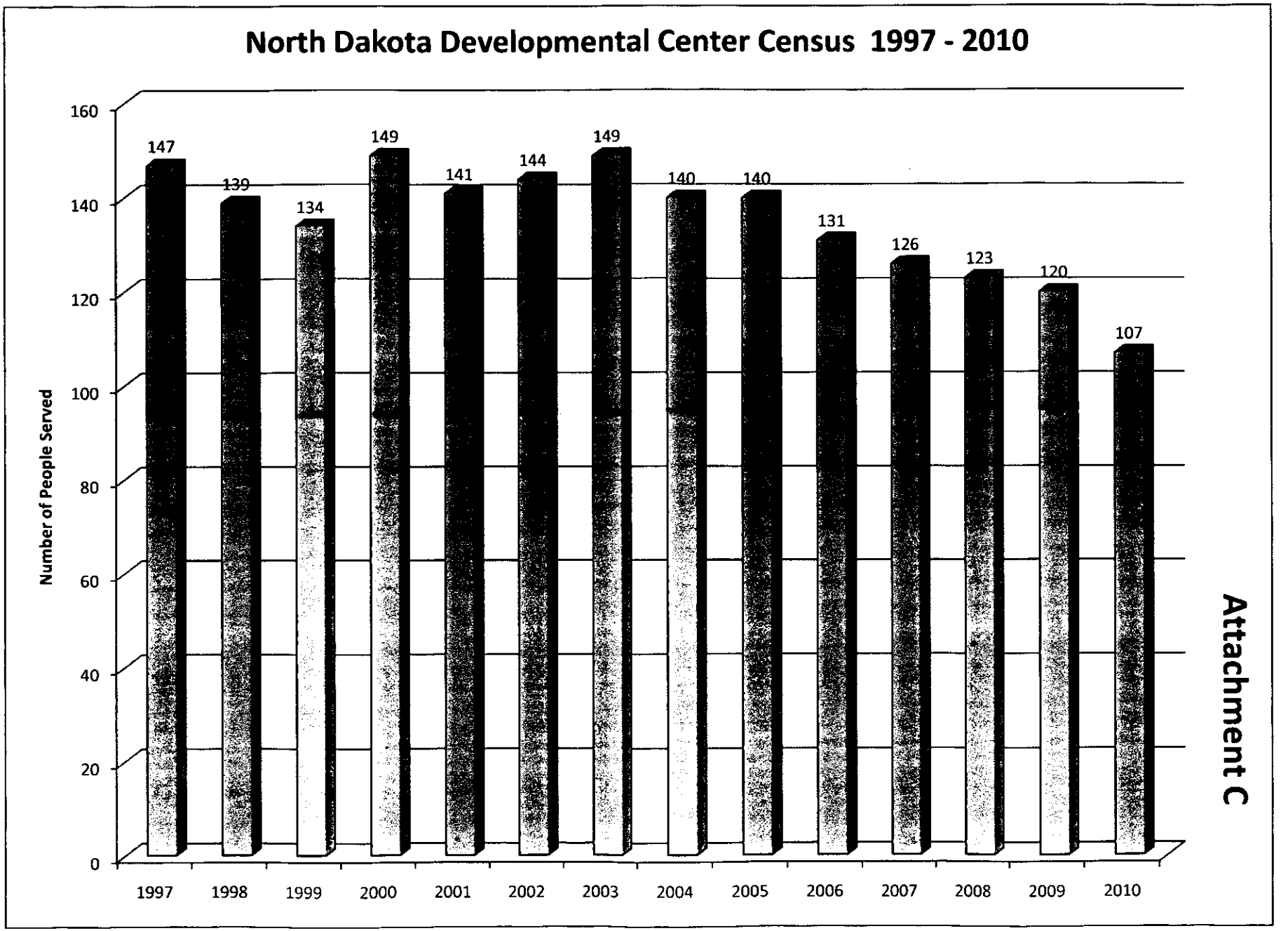
NDSH TOTAL ADMISSIONS



NDSH SEX OFFENDER PROGRAM CENSUS
1997 - 2010



Attachment B



Attachment C

11.8152.02004
Title.
Fiscal No. 1

Prepared by the Legislative Council staff for
Senator Mathern
March 4, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	328,874,163	1,629,516,486
Total all funds	$1,870,492,778	$387,226,319	$2,257,719,097
Less estimated income	1,381,801,240	137,729,602	1,519,530,842
Total general fund	$488,691,538	$249,496,717	$738,188,255"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$287,895,144	$934,244,660
Grand total special funds	1,549,066,932	143,644,024	1,692,710,956
Grand total all funds	$2,195,416,448	$431,539,168	$2,626,955,616"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	47,538,412	0	47,538,412
General fund	$31,521,462	$31,521,462	$0	$31,521,462
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,688	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	$0	$53,488,637
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	$0	$4,958,832
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	4,536,041	0	4,536,041

General fund	$6,882,190	$6,882,190	$0	$6,882,190
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	$0	$13,209,723
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	$0	$22,185,733
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	$0	$9,343,547
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	$0	$14,109,532
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	$0	$6,529,292
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	$2,580,462	$2,626,955,616
Less estimated income	1,683,661,250	1,691,270,800	1,440,156	1,692,710,956
General fund	$927,363,658	$933,104,354	$1,140,306	$934,244,660

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes	House Version
Salaries and wages	$50,346,211	$50,346,211		$50,346,211
Operating expenses	90,850,363	90,850,363		90,850,363
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	2,580,462	1,629,516,486
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,686	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
FTE	374.50	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of House Changes

	Adds Funding for Demonstration Grant[1]	Total House Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	2,580,462	2,580,462
Total all funds	$2,580,462	$2,580,462
Less estimated income	1,440,156	1,440,156
General fund	$1,140,306	$1,140,306
FTE	0.00	0.00

-Attachment ONE
-SB 2012
-Debra McDermott
-March 7, 2011

DHS Office Space Rent
2011-13 Biennium Compared to the 2009-11 Biennium

	2009-11 Biennium	2011-13 Biennium	Difference
Central Office:			
Judicial Wing			
Office Space	8.97	10.21	1.24
Storage Space	1.36	1.42	0.06
Century Center			
Office Space	13.50	14.50	1.00
Storage Space	5.00	5.00	-
Northbrook	11.66	12.35	0.69
Prairie Hills Plaza			
Office Space	14.05	15.34	1.29
Storage Space	6.06	6.12	0.06
Child Support Regional Offices:			
Williston RCSEU	12.00	6.80	(5.20)
Minot RCSEU	12.60	13.50	0.90
Devils Lake RCSEU	12.00	10.50	(1.50)
Grand Forks RCSEU	13.15	13.15	-
Fargo RCSEU	16.00	16.00	-
Jamestown RCSEU	6.13	7.50	1.37
Bismarck RCSEU	12.00	12.50	0.50
Dickinson RCSEU	10.08	9.31	(0.77)
Human Service Centers:			
Northwest HSC	8.50	8.50	-
North Central HSC *	9.62	10.00	0.38
Lake Region HSC			
Devils Lake	10.42	10.49	0.07
Rolla	9.71	9.97	0.26
Northeast HSC	13.15	13.15	-
Southeast HSC	N/A	N/A	
South Central HSC	11.88	11.88	-
West Central HSC			
Main Office Space	14.05	15.34	1.29
Vocational Rehabilitation **	16.00	16.48	0.48
Badlands HSC	12.50	12.75	0.25

* North Central reflected $9.25 on the previous rent schedule for the 2009-11 biennium when it should have reflected $9.62. The $9.25 previously reflected was the rate in effect when the HSC occupied the space.

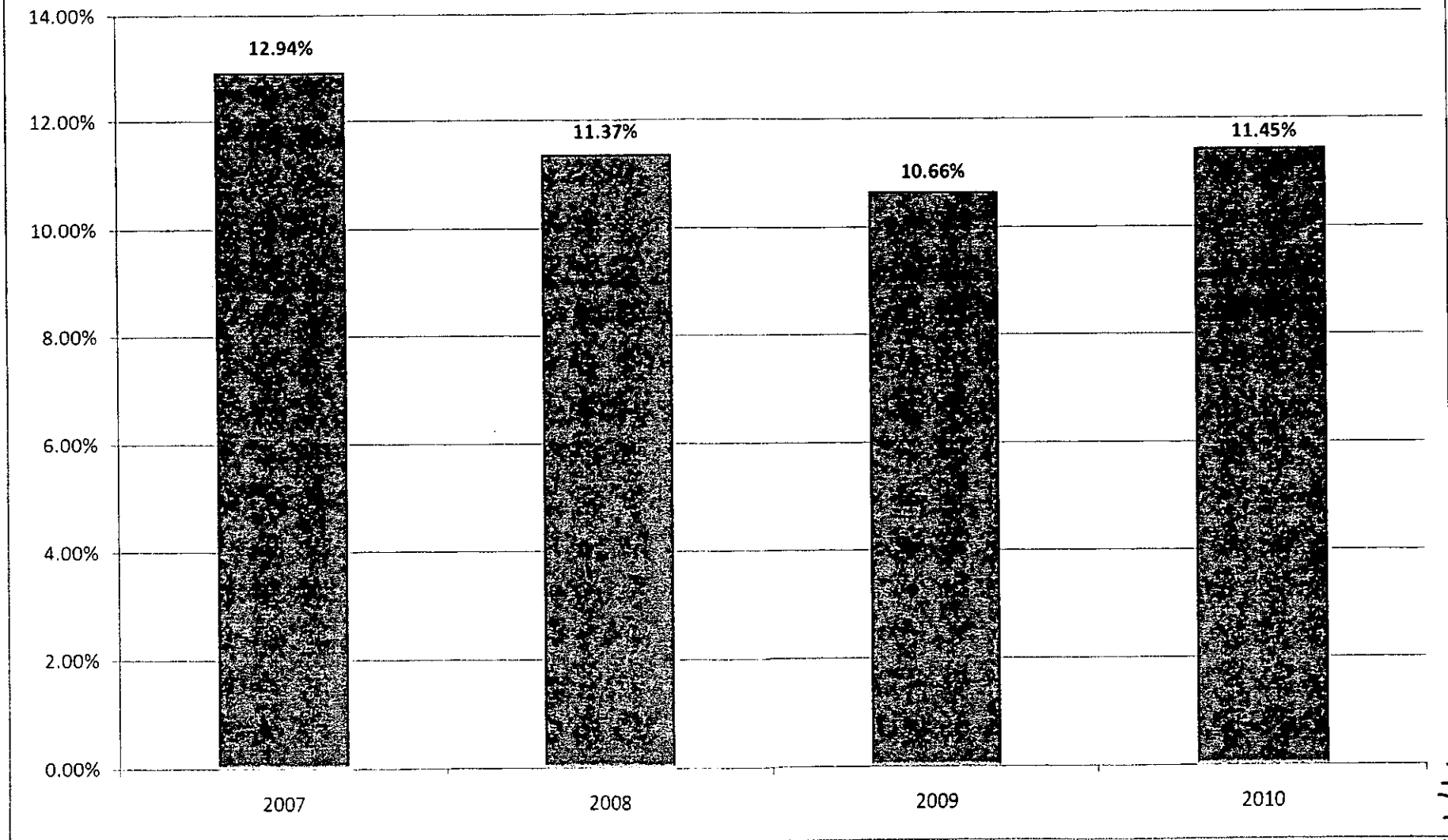
** West Central HSC Vocational rehabilitation space will also incur $13,100 of operating costs to be allocated from the Central Office.

Health Care Trust Fund
Status Statement

	Actual 1999 - 2001		Actual 2001 - 2003		Actual 2003 - 2005		Actual 2005-2007		Actual for 2007-2009		Estimated for 2009-2011		Estimated for 2011-2013	
Beginning Balance		$ -		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,946		$238,644
Revenue:														
April 2000 pool payment	$ 25,902,739													
Sept. 2000 pool payment	17,340,685													
August 2001 pool payment			$15,398,174											
July 2002 pool payment			19,572,291											
Net interest earnings / (loss)	2,171,632		(1,442,407)		2,313,279		1,808,207		136,644		28,944		7,498	
July 2003 pool payment					13,646,405									
July 2004 pool payment					6,349,417									
Principal and interest repayments			329,314		1,182,277		988,573		1,131,466		1,099,260		1,107,884	
Total Revenue		45,415,056		33,857,372		23,491,378		2,796,780		1,268,110		1,128,204		1,115,382
Expenditures:														
Dept. of Human Services														
SPED	(4,262,410)		(6,898,302)											
Loans	(701,477)		(10,859,661)											
Grants	(445,937)		(8,182)											
Administrative costs	(57,700)		(58,830)											
Special Payment to Govt Facilities	(800,000)													
HIPAA			(2,632,773)											
Nursing home bed reduction			(3,435,874)											
Nursing facility			(8,997,758)											
Basic care facility			(382,080)											
Personal care allowance - ICFMR			(43,200)											
Mill levy			(250,000)											
Targeted case management			(139,542)											
Independent living centers			(100,000)											
QSP training grants			(24,158)											
Long term care needs assessment			(237,285)											
Deficiency appropriation			(5,244,576)											
Transfer to State General Fund					(35,990,650)		(16,900,000)							
Provider Inflationary Increase - 0.65%							(3,001,852)							
DD provider Increase							(198,148)							
Nursing Home Provider Inflationary Increase									(525,597)					
Health Care Trust Funding NH											(3,800,000)			
Nursing Facility Bed Limit											(324,506)			
Remodel of assisted living and basic care grant											(200,000)			
Health Department														
Quick response unit pilot project			(50,000)		(30,000)		(10,000)		(5,000)		(50,000)		-	
Nursing student loan repayment			(489,500)		(489,500)		-							
Evaluate State Trauma System			-		-		-		(73,758)					
Total Expenditures		(6,267,524)		(39,851,721)		(36,510,150)		(20,110,000)		(604,355)		(4,374,506)		-
Ending Balance		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,946		$238,644		$1,354,026

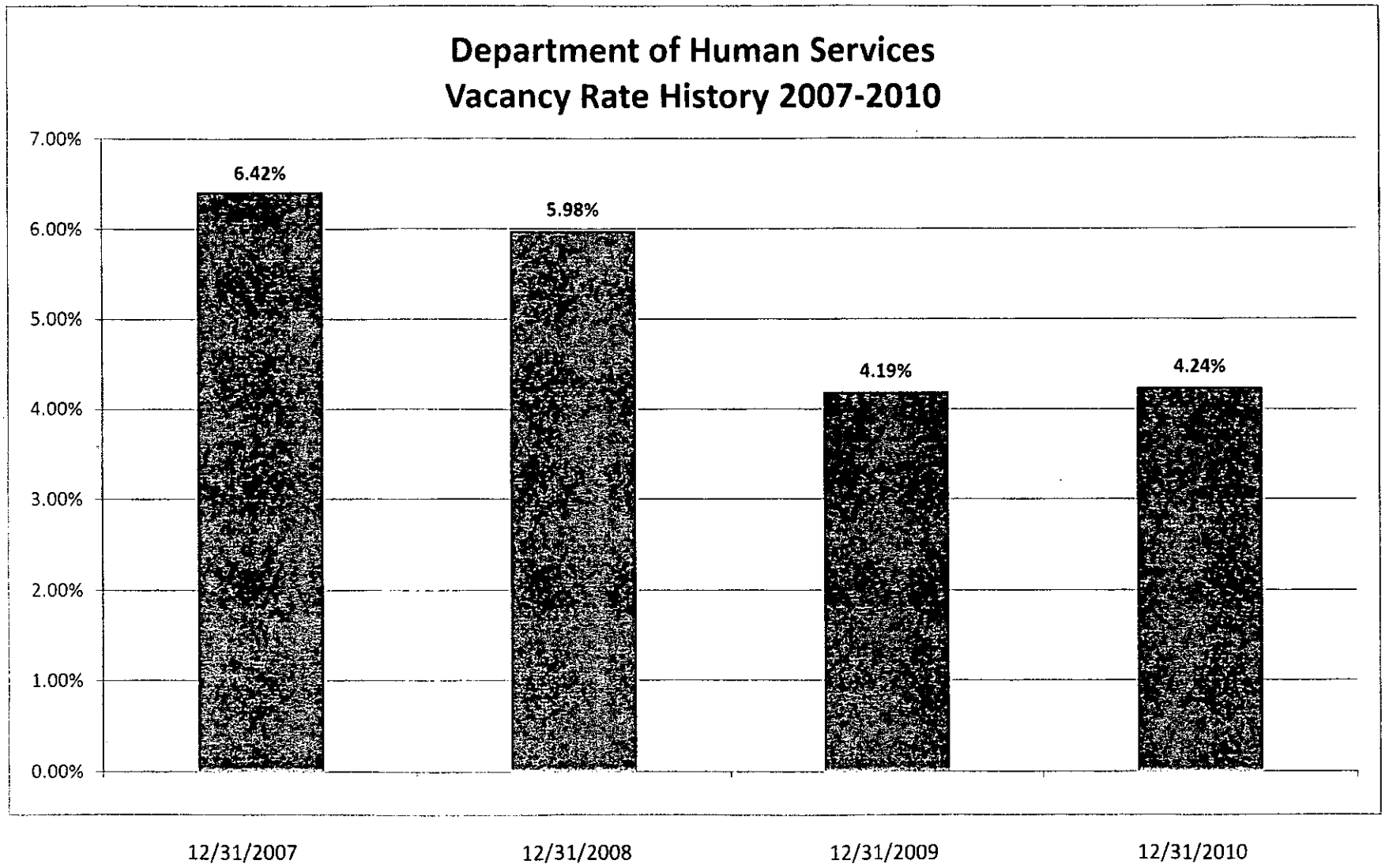
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Department of Human Services
Turnover History 2007-2010



Prepared by DHS HR Division
March, 2011

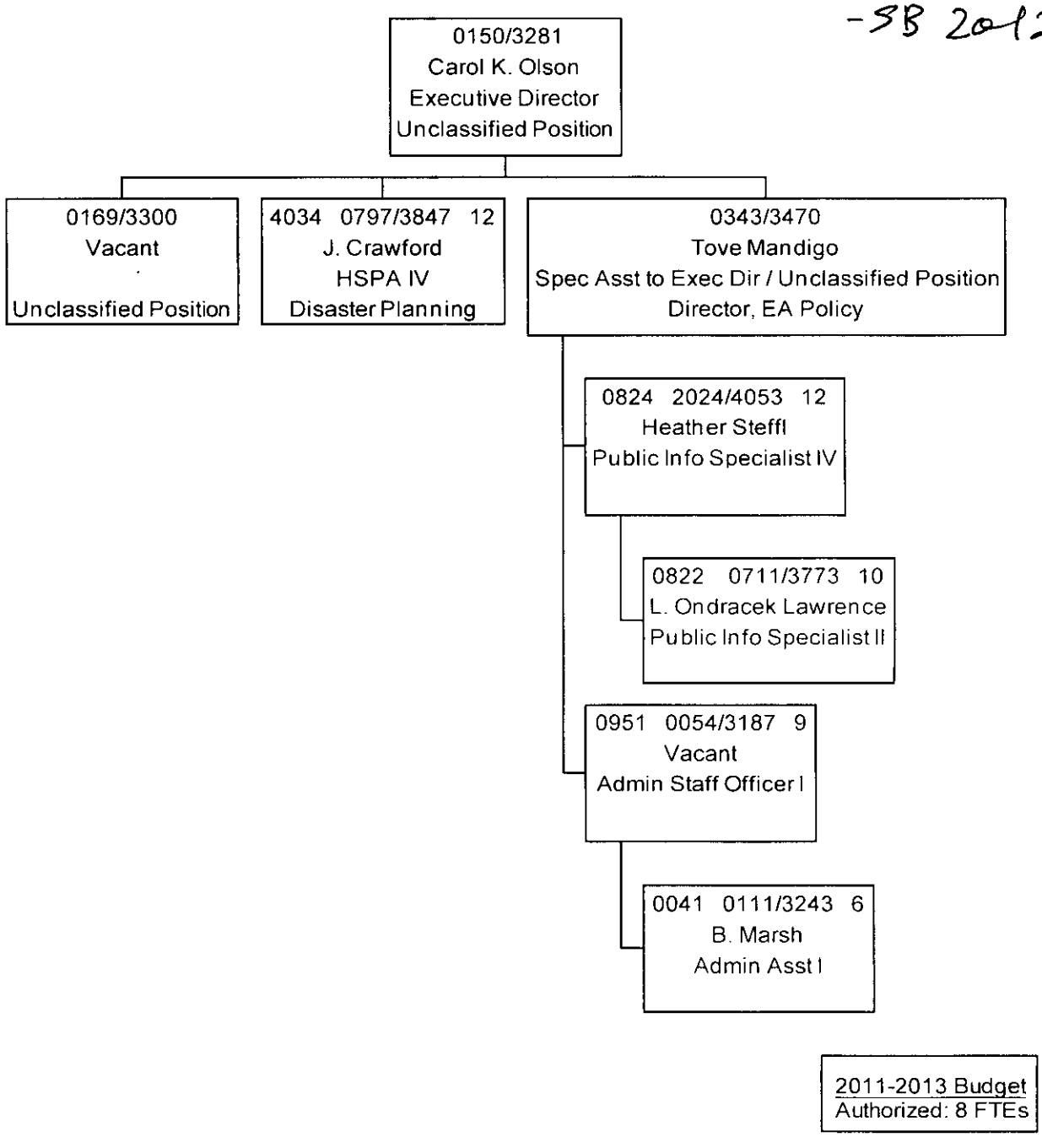
-Debra McDermott - SB 2012
- Mar 7, 2011
- Attachment 1
THREE



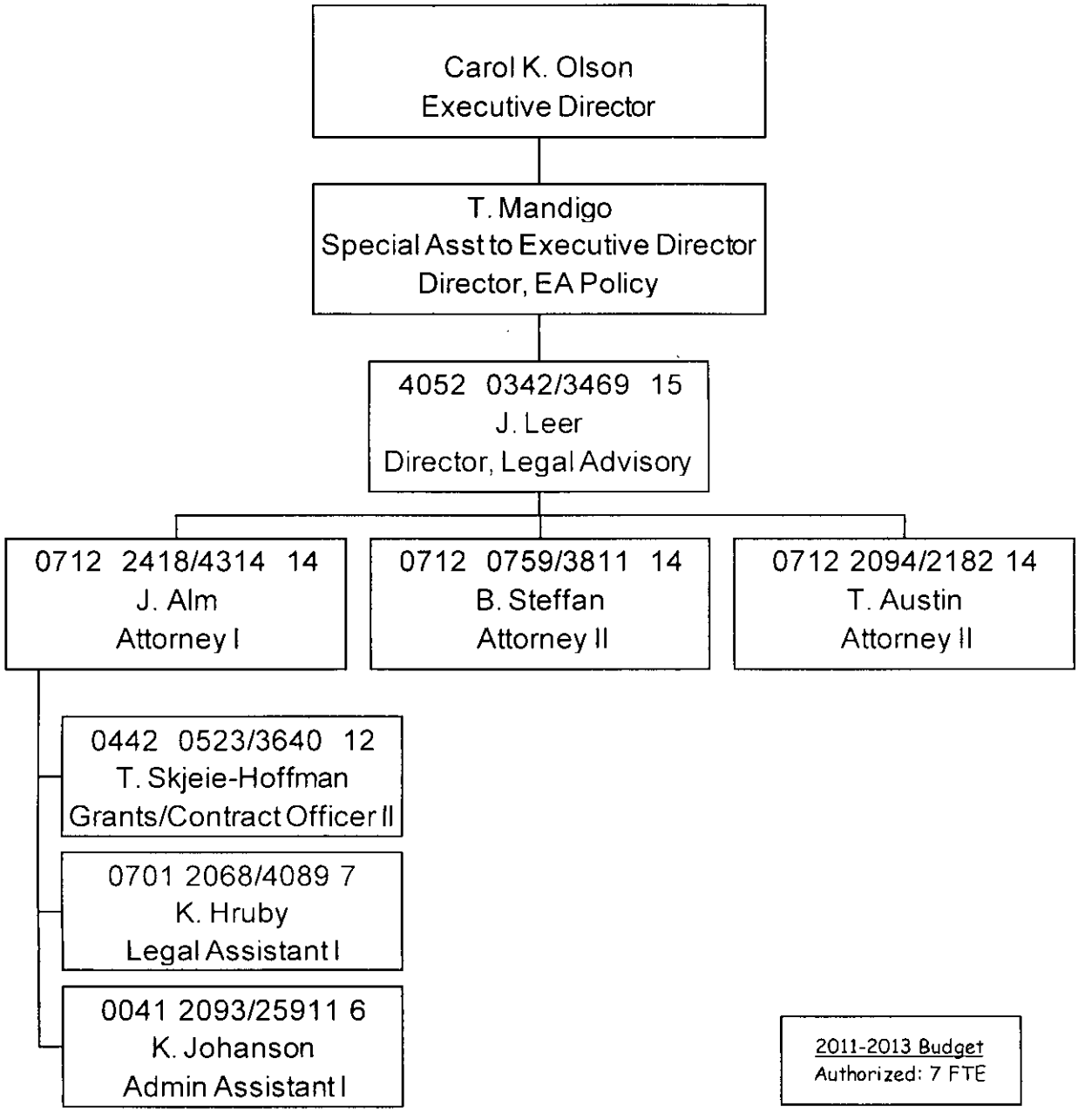
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Department of Human Services
Executive Office

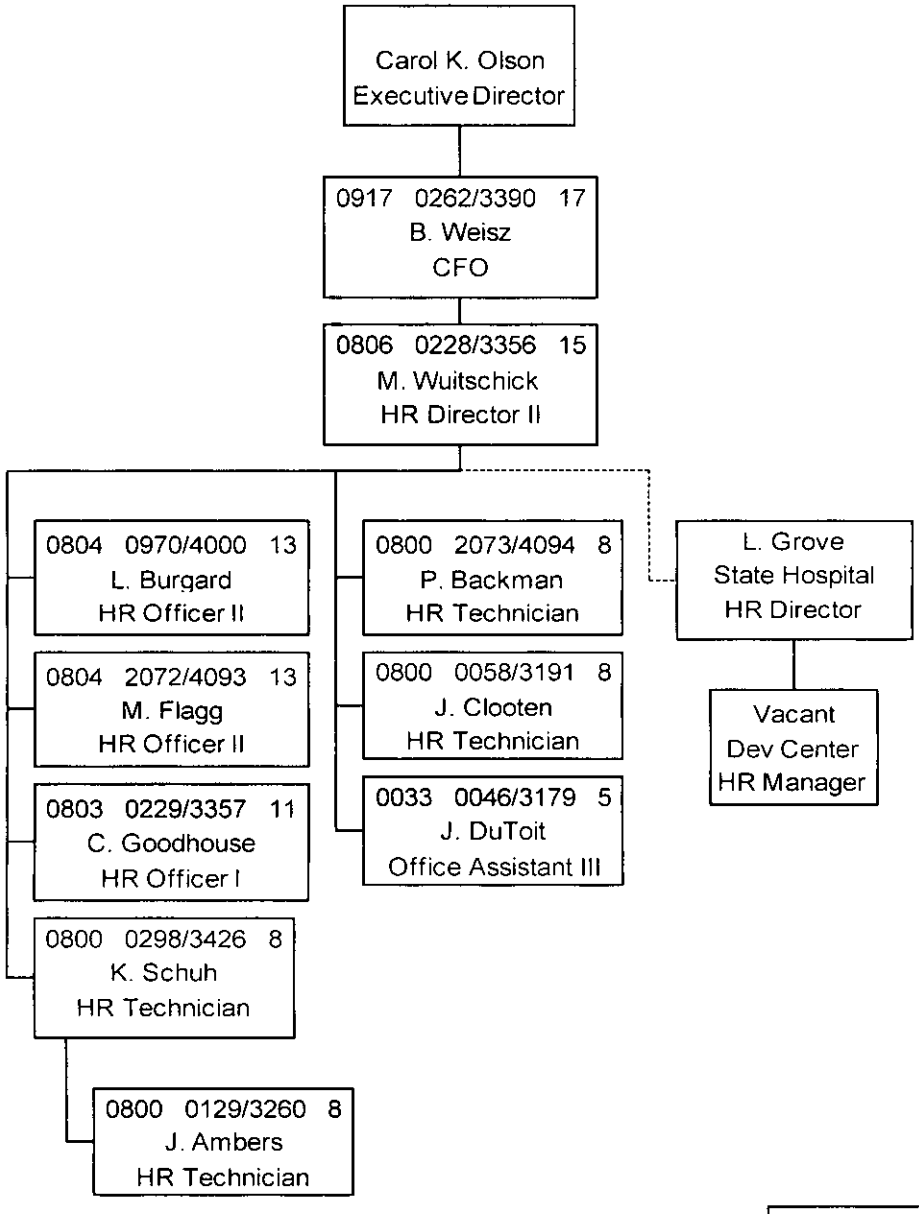


North Dakota Department of Human Services
Legal Advisory Division



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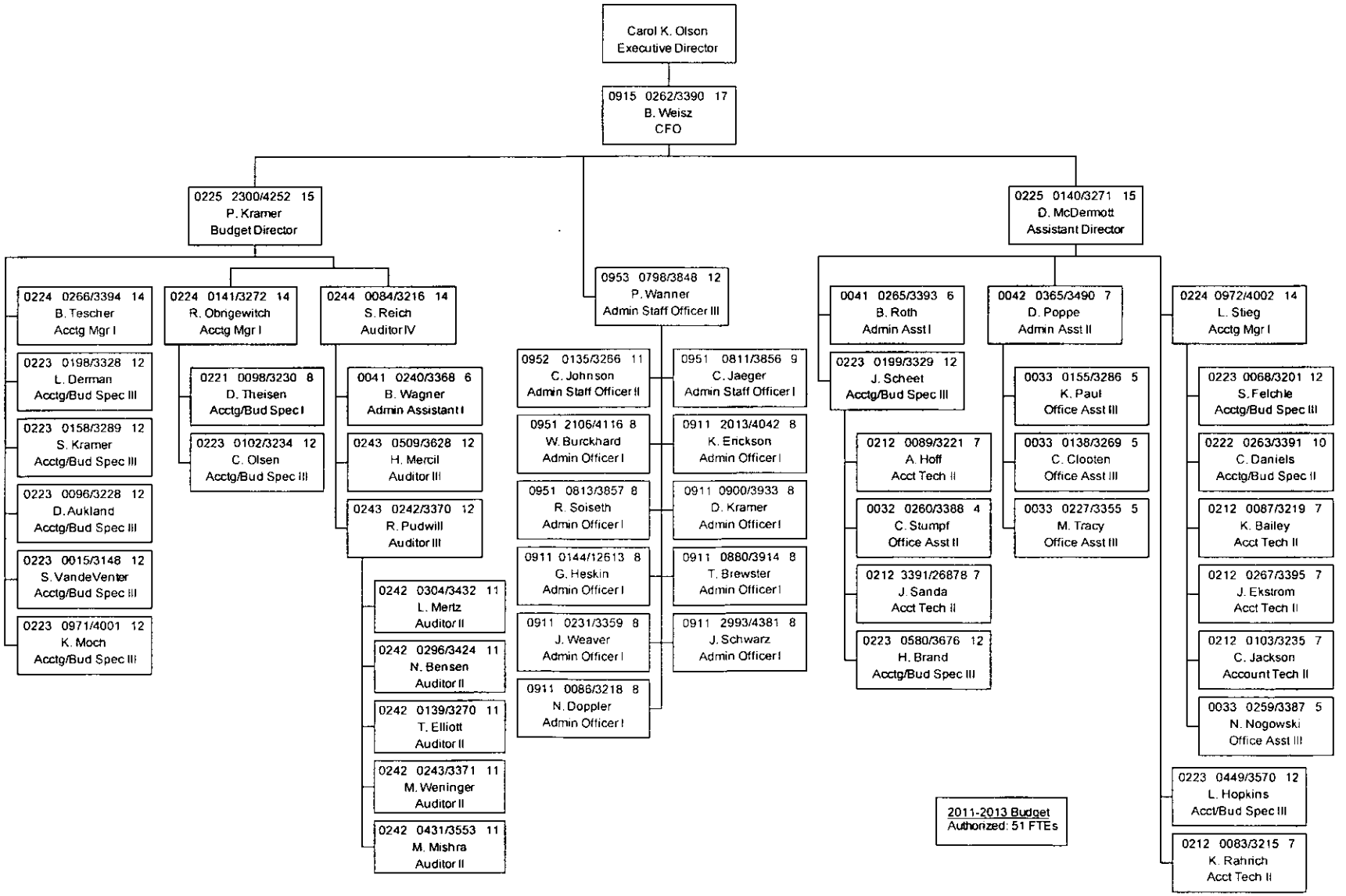
North Dakota Department of Human Services
Human Resource Division



2011-2013 Budget
Authorized: 8.6 FTEs

Revised 2/25/11

North Dakota Department of Human Services
Fiscal Administration Division



Revised 2/25/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 100-15 ADMINISTRATION - SUPPORT											
S101		FULL-TIME EQUIVALENTS (FTEs)		72.600	74.600	0.000	0.000	0.000	74.600	0.000	74.600
32510	B	511000	Salaries - Permanent	5,584,197	6,717,928	3,226,984	310,399	0	7,028,327	0	7,028,327
32510	B	513000	Temporary Salaries	54,371	32,417	32,417	29,167	0	61,584	0	61,584
32510	B	514000	Overtime	25,961	14,000	4,838	(14,000)	0	0	0	0
32510	B	516000	Fringe Benefits	1,982,589	2,581,661	1,243,837	126,482	0	2,708,143	0	2,708,143
32510	B	599110	Salary Increase	0	0	0	0	319,025	319,025	0	319,025
32510	B	599160	Benefit Increase	0	0	0	0	52,529	52,529	0	52,529
32510	B	599161	Health Increase	0	0	0	0	109,166	109,166	0	109,166
32510	B	599162	Retirement Increase	0	0	0	0	72,992	72,992	0	72,992
32510	B	599163	EAP Increase	0	0	0	0	226	226	0	226
			Subtotal:	7,647,118	9,346,006	4,508,076	452,048	553,938	10,351,992	0	10,351,992
32510	F	F_1991	Salary - General Fund	3,508,453	4,722,697	2,283,471	251,983	356,700	5,331,380	0	5,331,380
32510	F	F_1992	Salary - Federal Funds	2,981,564	3,640,774	1,691,603	101,679	197,238	3,939,691	0	3,939,691
32510	F	F_1993	Salary - Other Funds	1,157,101	982,535	533,002	98,386	0	1,080,921	0	1,080,921
			Subtotal:	7,647,118	9,346,006	4,508,076	452,048	553,938	10,351,992	0	10,351,992
32530	B	521000	Travel	313,633	504,209	160,603	53,737	0	557,946	0	557,946
32530	B	531000	Supplies - IT Software	12,650	12,178	8,485	6,642	0	18,820	0	18,820
32530	B	532000	Supply/Material-Professional	21,058	16,906	8,304	231	0	17,137	0	17,137
32530	B	534000	Bldg, Grounds, Vehicle Supply	1,900	0	0	0	0	0	0	0
32530	B	535000	Miscellaneous Supplies	1,364	1,000	812	(500)	0	500	0	500
32530	B	536000	Office Supplies	27,099	35,174	19,468	(178)	0	34,996	0	34,996
32530	B	541000	Postage	1,240,755	1,304,707	682,878	10,313	0	1,315,020	0	1,315,020
32530	B	542000	Printing	145,433	151,708	70,994	21,780	0	173,488	0	173,488
32530	B	553000	Office Equip & Furniture-Under	16,755	8,800	8,717	(2,000)	0	6,800	0	6,800
32530	B	571000	Insurance	114,907	113,361	55,887	52,867	0	166,228	0	166,228
32530	B	581000	Rentals/Leases-Equip & Other	100,078	132,458	64,807	5,518	0	137,976	0	137,976
32530	B	582000	Rentals/Leases - Bldg/Land	343,454	325,395	165,058	35,120	0	360,515	0	360,515
32530	B	591000	Repairs	27,930	30,500	16,418	829	0	31,329	0	31,329
32530	B	601000	IT - Data Processing	5,150	6,214	3,465	311	0	6,525	0	6,525

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 100-15 ADMINISTRATION - SUPPORT										
32530	B	602000 IT-Communications	756,310	798,058	389,791	(16,235)	0	781,823	0	781,823
32530	B	611000 Professional Development	83,931	83,339	44,518	(1,690)	0	81,649	0	81,649
32530	B	621000 Operating Fees and Services	359,802	338,897	187,523	734	0	339,631	0	339,631
32530	B	623000 Fees - Professional Services	1,071,571	1,050,894	603,903	602,146	0	1,653,040	0	1,653,040
		Subtotal:	4,643,780	4,913,798	2,491,631	769,625	0	5,683,423	0	5,683,423
32530	F	F_3991 Operating - General Fund	1,804,689	2,005,285	1,029,466	438,731	0	2,444,016	0	2,444,016
32530	F	F_3992 Operating - Federal Funds	2,718,324	2,827,370	1,423,416	323,006	0	3,150,376	0	3,150,376
32530	F	F_3993 Operating - Other Funds	114,982	81,143	38,749	7,888	0	89,031	0	89,031
32530	F	F_3995 Operating - County Funds	5,785	0	0	0	0	0	0	0
		Subtotal:	4,643,780	4,913,798	2,491,631	769,625	0	5,683,423	0	5,683,423
		Subdivision Budget Total:	12,290,898	14,259,804	6,999,707	1,221,673	553,938	16,035,415	0	16,035,415
100-15 ADMINISTRATION - SUPPORT		**General Funds:**	5,313,142	6,727,982	3,312,937	690,714	356,700	7,775,396	0	7,775,396
		Federal Funds:	5,699,888	6,468,144	3,115,019	424,685	197,238	7,090,067	0	7,090,067
		Other Funds:	1,272,083	1,063,678	571,751	106,274	0	1,169,952	0	1,169,952
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	5,785	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	12,290,898	14,259,804	6,999,707	1,221,673	553,938	16,035,415	0	16,035,415

Admin Support - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
J Wing (Capitol) - Office Space	30,041.00	10.21	-	244,802	24,620	269,422
J Wing (Capitol) - Storage Space	3,453.00	1.42	-	3,913	393	4,306
Denny's Storage	720.00	4.83	2,493	958	29	3,480
Century Center Rent (Provider Audit)	1,580.00	14.50	24,318	21,531		45,849
PHP (Lynn Derman)	205.70	15.34	2,763	3,504	44	6,311
North Central Rent (ROAP)	444.85	10.00	1,911		6,986	8,897
North West Rent (ROAP)	249.70	8.50	979		3,579	4,558
Badland Rent (ROAP)	684.00	12.75	3,734		13,708	17,442
HR Booth & Room Rental			181	69		250
Total			**36,379**	**274,777**	**49,359**	**360,515**

Admin Support - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Service Awards - Admin Support	7,191	4,084	833	12,108
SBAND & CPA Licenses Fees	4,380	3,732	8	8,120
Training Contracts (Succession Planning & Recruitment Issues)	3,617	1,356	27	5,000
MMIS Legal Contract	4,454	3,546	-	8,000
Statewide Indirect Costs		241,684		241,684
Freight & Express	14,482	22,294	19	36,795
County Administration Reviews	6,087	2,341	72	8,500
ROAP Consulting Contracts	2,477	-	9,073	11,550
Record Keepers (Shredding Services)	3,355	1,312	39	4,706
Other Miscellaneous Fees & Services	1,783	1,383	2	3,168
Total	**47,826**	**281,732**	**10,073**	**339,631**

Admin Support - 2011-13 Biennium Budget

Budget Account Code 623000 - Professional Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Office of the State Auditor	166,631	87,768	-	254,399
Interpreter Fees	81	19	-	100
Attorney General's Office	383,607	334,090	72	717,769
Office of Adminstrative Hearings	327,737	353,035		680,772
Total	**878,056**	**774,912**	**72**	**1,653,040**

Department of Human Services 2011 - 2013 Budget to the House (SB 2012)

Subdivision	FTEs (Full Time Equivalents)	Salaries and Wages	Operating Expenses	Capital Assets	Grants	HSCs and Institutions	Grants-Medical Assistance	Total	General	Federal	Other
	32501	32510	32530	32550	32560	32570	32573	32590	32591	32592	32593
00-15 ADMINISTRATION - SUPPORT	74.60	$10,351,992	$5,683,423					$16,035,415	$7,775,396	$7,090,067	$1,169,952
00-20 INFORMATION TECHNOLOGY SRVCS	41.50	$6,161,344	$56,724,715	$138,400				$63,024,459	$23,746,066	$37,243,950	$2,034,443
100 MANAGEMENT Total	**116.10**	**$16,513,336**	**$62,408,138**	**$138,400**				**$79,059,874**	**$31,521,462**	**$44,334,017**	**$3,204,395**
00-01 ECONOMIC ASSISTANCE POLICY - GRANTS	39.80	$5,516,945	$11,703,561		$331,251,570			$348,472,076	$11,439,272	$318,286,921	$18,745,883
00-02 CHILD SUPPORT ENFORCEMENT	165.20	$20,858,604	$4,182,317					$25,040,921	$6,874,824	$15,175,197	$2,990,900
00-03 MEDICAL SERVICES	73.50	$10,139,971	$34,236,842				$665,549,436	$709,926,249	$240,545,012	$434,510,018	$34,871,219
00-10 LONG TERM CARE							$961,386,588	$961,386,588	$427,330,132	$530,781,396	$3,275,060
00-42 DD COUNCIL	1.00	$162,095	$132,652		$621,142			$915,889		$915,889	
00-43 AGING SERVICES	10.00	$1,461,314	$13,762,611		$2,896,942			$18,120,867	$4,666,276	$13,174,591	$280,000
00-46 CHILDREN AND FAMILY SERVICES	17.00	$2,555,408	$5,744,630		$126,793,961			$135,093,999	$31,053,237	$82,978,058	$21,062,704
00-47 MENTAL HEALTH AND SUBSTANCE ABUSE	24.00	$3,592,202	$11,687,985		$4,445,584			$19,725,771	$7,128,641	$12,026,270	$570,860
00-51 VOC REHAB	35.00	$4,672,532	$2,049,230		$20,558,631			$27,280,393	$4,859,126	$22,326,268	$94,999
00-52 DEVELOPMENTAL DISABILITIES DIVISION	9.00	$1,387,140	$7,350,535		$438,207			$9,175,882	$3,151,429	$5,874,450	$150,003
00 PROGRAM AND POLICY Total	**374.50**	**$50,346,211**	**$90,850,363**		**$487,006,037**		**$1,626,936,024**	**$2,255,138,635**	**$737,047,949**	**$1,436,049,058**	**$82,041,628**
10-71 NORTHWEST HSC	45.75					$8,749,068		$8,749,068	$4,958,832	$3,321,230	$469,006
10-72 NORTH CENTRAL HSC	117.78					$22,433,884		$22,433,884	$13,410,027	$8,104,420	$919,437
10-73 LAKE REGION HSC	60.00					$11,418,231		$11,418,231	$6,882,190	$4,063,599	$472,442
10-74 NORTHEAST HSC	138.30					$28,182,609		$28,182,609	$13,209,723	$12,967,908	$2,004,978
10-75 SOUTHEAST HSC	182.15					$38,464,720		$38,464,720	$22,185,733	$15,145,044	$1,133,943
10-76 SOUTH CENTRAL HSC	85.50					$16,953,699		$16,953,699	$9,343,547	$6,691,551	$918,601
10-77 WEST CENTRAL HSC	135.30					$26,740,493		$26,740,493	$14,109,532	$11,430,961	$1,200,000
10-78 BADLANDS HSC	72.70					$11,789,654		$11,789,654	$6,529,292	$4,429,122	$831,240
10 HUMAN SERVICE CENTERS Total	[illegible]					[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
20-00 STATE HOSPITAL	381.45					$62,370,125		$62,370,125	$42,223,722	$2,609,783	$17,536,620
21-00 SH SECURED SERVICES	86.06					$11,264,915		$11,264,915	$11,264,915		
30-00 DEVELOPMENTAL CENTER	400.76					[illegible]		[illegible]	[illegible]	[illegible]	[illegible]
Axx INSTITUTIONS Total	**868.27**					**$125,444,287**		**$125,444,287**	**$73,906,067**	**$30,433,243**	**$21,104,977**
Grand Total	**2,196.35**	**$66,859,547**	**$153,258,501**	**$138,400**	**$487,006,037**	**$290,176,645**	**$1,626,936,024**	**$2,624,375,154**	**$933,104,354**	**$1,576,967,153**	**$114,303,647**

-SB2012
-March 7, 2011
-Debra McDermott
-Attachment + FYE

Attachment c

- Attachment TWO
- Debra McDermott DHS

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 3, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Brenda M. Weisz, Chief Financial Officer for the Department of Human Services. I am here today to provide an overview of the Administration / Support area.

Programs

This area of the budget includes the Executive Office, Legal Advisory Unit, Human Resources, and Fiscal Administration. Each of these areas provides the needed support for the divisions within the Department to carry out their programs. This budget area includes centralized costs for department-wide expenditures such as program appeals, audit fees charged by the State Auditor's Office, and the legal work provided by the Attorney General's Office. Also included are the centralized costs for the Central Office divisions such as motor pool expenses, postage for routine mailings such as federally required client TANF notices, along with the telephone services provided by the Information Technology Department. Finally, this area of the budget reflects the Insurance and Risk Management Fees for the Central Office and Human Service Centers.

Major Program Changes

There have not been any program changes in this area.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	9,346,006	1,005,986	10,351,992		10,351,992
Operating	4,913,798	769,625	5,683,423		5,683,423
Total	14,259,804	1,775,611	16,035,415		16,035,415
General Funds	6,727,982	1,047,414	7,775,396		7,775,396
Federal Funds	6,468,144	621,923	7,090,067		7,090,067
Other Funds	1,063,678	106,274	1,169,952	-	1,169,952
Total	14,259,804	1,775,611	16,035,415		16,035,415

FTE	74.60	0.00	74.60		74.60

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item increased by $1,005,986 and can be attributed to the following:

- $553,938 in total funds of which $356,700 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $91,753 to cover an underfunding of salaries from the 2009-2011 budget.
- $206,867 in total funds of which $166,092 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- During the biennium the Department recognized an increased need in assistance from the Legal Advisory Unit and moved an FTE internally to accommodate this priority. Increased appeals, administrative rules and federal requirements especially from the Centers of Medicare and Medicaid have required additional legal expertise within the Department. The additional attorney hired resulted in additional need of $121,237 for salary and fringes.

- The remaining $32,191 is a combination of increases and decreases needed to sustain the salary of the 74.60 FTE in this area of the budget.

The Operating line item increased by $769,625 (15.7%) and is a combination of the increases and decreases expected next biennium. Outlined below are the significant areas of change:

- $602,146 increase in Professional Fees. $298,481 is a result of increased utilization of the services provided by the Attorney General's office coupled with their rate increase of 4.63% - $73.81 per hour to $77.23 per hour. $267,258 is attributed to services provided by the Office of Administrative Hearings. Our utilization in this area has increased along with a rate increase of 33.99% - $93.29 per hour to $125.00 per hour. The remainder of the increase is attributed to the expected increase in audit fees of $36,407.
- $53,737 is attributable to the increase in the Travel category of the budget. $49,025 is related to an increase in state fleet usage partially offset by a rate decrease established by DOT - $0.40 per mile to $0.37 per mile. The remainder of the increase is related to additional travel required by staff for training and to audit cost reports of the additional basic care facilities across the state.
- $52,867 increase in Insurance the majority being a result of a rate increase by OMB for the Department's Central Office and Human Service Center risk management premium, offset by decreases in property and foster care liability insurance.
- $35,120 increase in Building Leases. $26,298 is attributable to rate increases established by OMB – office space from $8.97 to $10.21 (13.8%) per square foot and storage space $1.36 to $1.42 (4.4%) per square foot. The payment to OMB is federal/other funds and contains no general funds. $3,189 is due to a $1 per square foot

rate increase ($13.50 to $14.50) established by Workforce Safety and Insurance for staff located in the Century Center. The remainder of the increase is essentially due to an oversight, as our current budget did not include two years of rent for staff located at the North Central Human Service Center.

- $21,780 increase in Printing costs as a result of a rate increase by OMB of 3% each year of the biennium, and an anticipated 7% increase each year of the biennium for envelopes based upon information provided by current vendor.
- $10,313 increase in the Postage budget due to a 4% postal rate increase anticipated in October 2011 and October 2012.
- A decrease of $16,235 in IT Communications is primarily due to the reduced long distance rates from $0.09 to $0.07 a minute and reduced utilization of blackberry services and rates.

The general fund request increased by $1,047,414 with 58% of the increase ($608,683) associated with the salary changes as indicated above. The remaining increase of $438,731 is associated with the increase in the operating changes described above.

The net change of the federal and other funds is a result of the increases above and the approved cost allocation plan which is the basis for the majority of the funding in this area of the budget.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for Administration / Support area of the Department. I would be happy to answer any questions.

North Dakota Department of Human Services
2011 - 2013 Biennium
Legal Appeals Information Request

NUMBER OF DHS PROGRAM APPEALS THAT WERE REFERRED TO THE OFFICE OF ADMINISTRATIVE HEARINGS FROM JULY 1, 2009 THROUGH MARCH 3, 2011

Division	2009	CY 2010		2011	
Children & Family Services	(7/1/2009-12/31/2009)	1/1/2010-12/31/2010	Pending 1/1/2010-12/31/2010	1/1/2011-3/3/2011	Pending 1/1/2011-3/3/2011
Child Abuse/Neglect	22	60	5	1	14
Early Childhood Services	6	12	0	0	1
Foster Care	2	3	0	1	0
Total Children & Family Services Cases	30	75	5	2	15
Medical Assistance					
Eligibility	24	18	0	9	4
State	11	20	1	0	7
HCBS	4	13	1	5	1
Nursing Home Transfer & Discharge	1	9	2	0	0
Total Medical Assistance Cases	40	60	4	14	12
All Other Cases					
TANF	6	7	0	1	0
SNAP	18	19	0	0	0
LIHEAP	2	3	0	0	3
Child Care Assistance	0	4	0	0	0
Vocational Rehabilitation	1	2	0	0	0
Developmental Disability	1	5	0	0	0
Basic Care	0	1	0	0	0
Total All Other Cases	28	41	0	1	3
Total Cases Referred to OAH	98	176	9	17	30

NUMBER OF DHS PROGRAM APPEALS THAT WERE REFERRED TO ATTORNEY GENERAL'S OFFICE FROM JULY 1, 2009 THROUGH MARCH 3, 2011

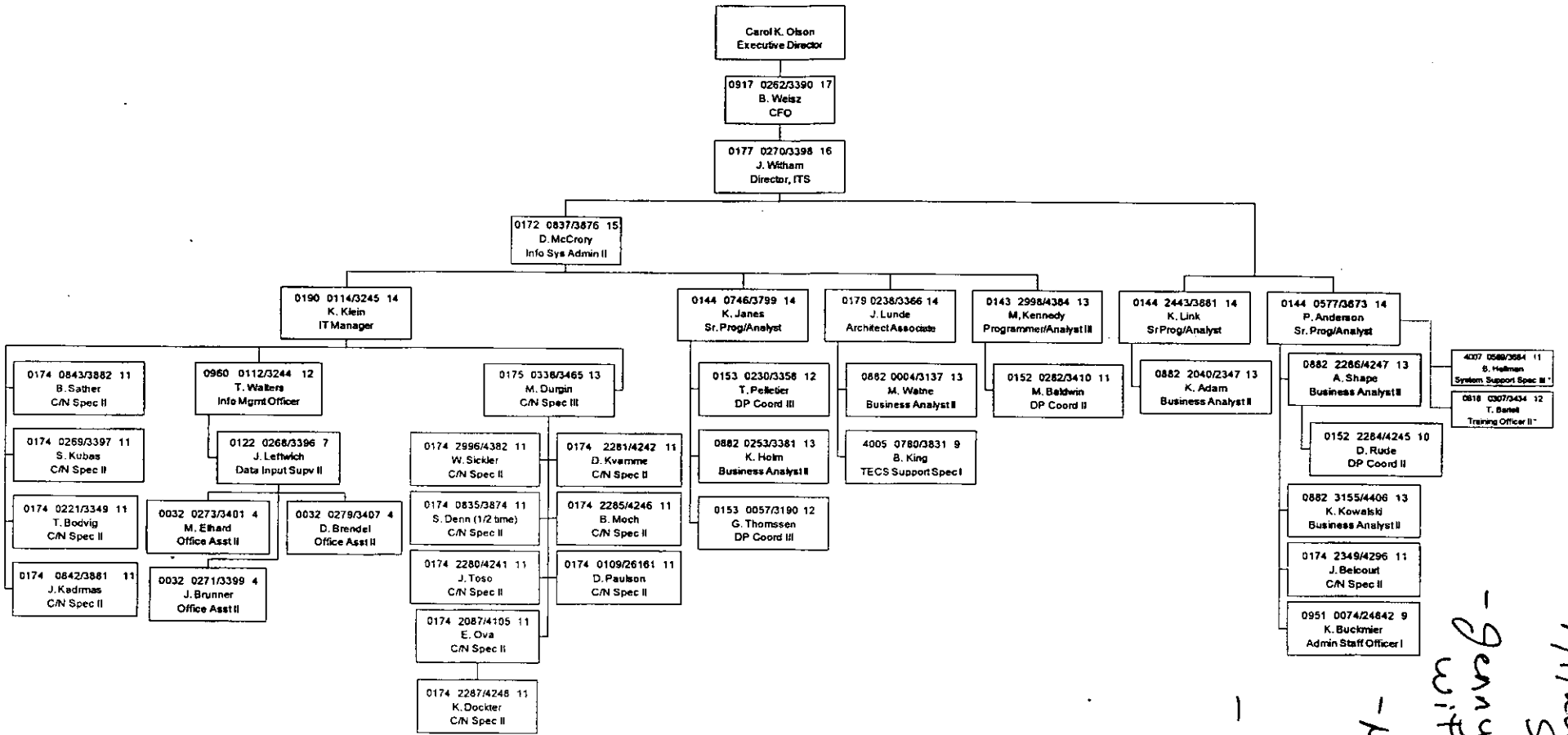
Division	2009	CY 2010		2011	
Children & Family Services	(7/1/2009-12/31/2009)	1/1/2010-12/31/2010	Pending 1/1/2010-12/31/2010	1/1/2011-3/3/2011	Pending 1/1/2011-3/3/2011
Child Abuse/Neglect	22	60	5	1	14
Early Childhood Services	6	12	0	0	1
Foster Care	2	3	0	1	0
Total Children & Family Services Cases	30	75	5	2	15
Medical Assistance					
Eligibility	11	8	0	1	0
State	11	20	1	0	7
HCBS	4	13	1	5	1
Nursing Home Transfer & Discharge	0	0	0	0	0
Total Medical Assistance Cases	26	41	2	6	8
All Other Cases					
TANF	0	0	0	0	0
SNAP	1	3	0	0	0
LIHEAP	0	0	0	0	0
Child Care Assistance	0	1	0	0	0
Vocational Rehabilitation	0	1	0	0	0
Developmental Disability	1	3	0	0	0
Basic Care	0	0	0	0	0
Total All Other Cases	2	8	0	0	0
Total Cases Referred to AG'S Office	58	124	7	8	23

Notes:

1. Due to changes in federal law, an increase in cases that arise outside of program appeals, and the complexity of the cases being referred to both the Office of Administrative Hearings and the Attorney General's Office, the 2011-2013 budget request has increased.
2. Pending refers to those appeals that have been filed with the Legal unit and are either under review by Department program personnel or are awaiting for background information from Department program personnel.
3. ALL Children & Family Services appeals that go to OAH are also referred to the AG's office for representation.
4. ALL Medical Assistance-State and HCBS appeals that go to OAH are also referred to the AG's office for representation as those originate at DHS.
5. No Medical Assistance-NHT&D (Nursing Home Transfer and Discharge) appeals that go to OAH are referred to the AG's office for representation as the Department is not a party in those cases. DHS merely facilitates the process.
6. Medical Assistance-Eligibility appeals that go to OAH are referred to the AG's office for representation if the appealing party is represented.
7. All other program appeals that go to OAH are referred to the AG's office for representation if the appealing party is represented.

- Attachment 1 SB 2012 Debra McDermott - March 7, 2011

North Dakota Department of Human Services
Information Technology Services



* FTE located in EAP

2011-2013 Budget
Authorized: 41.5 FTEs

Revised 2/25/11

- Attachment SEVEN
- Jenny Witham
- March 2, 2011
- SB 2012

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 100-20 INFORMATION TECHNOLOGY SRVCS											
S101		FULL-TIME EQUIVALENTS (FTEs)		34.750	37.500	0.000	4.000	0.000	41.500	0.000	41.500
32510	B	511000	Salaries - Permanent	3,017,489	3,411,420	1,670,956	648,254	0	4,059,674	0	4,059,674
32510	B	513000	Temporary Salaries	468,239	353,518	130,852	(229,726)	0	123,792	0	123,792
32510	B	514000	Overtime	64,189	75,001	47,182	22,753	0	97,754	0	97,754
32510	B	516000	Fringe Benefits	1,101,593	1,379,173	646,235	181,732	0	1,560,905	0	1,560,905
32510	B	599110	Salary Increase	0	0	0	0	184,513	184,513	0	184,513
32510	B	599160	Benefit Increase	0	0	0	0	31,231	31,231	0	31,231
32510	B	599161	Health Increase	0	0	0	0	61,136	61,136	0	61,136
32510	B	599162	Retirement Increase	0	0	0	0	42,217	42,217	0	42,217
32510	B	599163	EAP Increase	0	0	0	0	122	122	0	122
			Subtotal:	4,651,510	5,219,112	2,495,225	623,013	319,219	6,161,344	0	6,161,344
32510	F	F_1991	Salary - General Fund	2,863,740	3,661,787	1,587,513	23,070	211,811	3,896,668	0	3,896,668
32510	F	F_1992	Salary - Federal Funds	1,758,995	1,548,738	905,838	600,650	107,408	2,256,796	0	2,256,796
32510	F	F_1993	Salary - Other Funds	28,775	8,587	1,874	(707)	0	7,880	0	7,880
			Subtotal:	4,651,510	5,219,112	2,495,225	623,013	319,219	6,161,344	0	6,161,344
32530	B	521000	Travel	80,982	90,409	32,638	(38)	0	90,371	0	90,371
32530	B	531000	Supplies - IT Software	68,524	70,352	37,981	37,388	0	107,740	0	107,740
32530	B	532000	Supply/Material-Professional	4,714	1,600	637	0	0	1,600	0	1,600
32530	B	534000	Bldg, Grounds, Vehicle Supply	36	0	0	0	0	0	0	0
32530	B	535000	Miscellaneous Supplies	234	0	0	0	0	0	0	0
32530	B	536000	Office Supplies	5,710	3,194	1,816	380	0	3,574	0	3,574
32530	B	541000	Postage	41	300	70	(112)	0	188	0	188
32530	B	542000	Printing	398,551	463,552	217,184	74,048	0	537,600	0	537,600
32530	B	551000	IT Equip under $5,000	1,144,205	779,187	750,842	180,851	0	960,038	0	960,038
32530	B	553000	Office Equip & Furniture-Under	3,445	2,400	915	(900)	0	1,500	0	1,500
32530	B	561000	Utilities	1,216	961	582	239	0	1,200	0	1,200
32530	B	581000	Rentals/Leases-Equip & Other	6,534	7,200	0	0	0	7,200	0	7,200
32530	B	582000	Rentals/Leases - Bldg/Land	236,694	110,836	179	3,077	0	113,913	0	113,913
32530	B	591000	Repairs	11,303	1,142	1,115	956	0	2,098	0	2,098

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 100-20 INFORMATION TECHNOLOGY SRVCS											
32530	B	601000 IT - Data Processing		32,001,389	27,776,832	15,723,333	11,092,427	0	38,869,259	0	38,869,259
32530	B	602000 IT-Communications		34,338	14,400	7,309	0	0	14,400	0	14,400
32530	B	603000 IT Contractual Services and Re		21,981,775	12,252,793	1,749,723	3,565,881	0	15,818,674	0	15,818,674
32530	B	611000 Professional Development		57,545	68,880	17,940	(2,570)	0	66,310	0	66,310
32530	B	621000 Operating Fees and Services		189,330	129,200	61,834	(350)	0	128,850	0	128,850
32530	B	623000 Fees - Professional Services		158	200	116	0	0	200	0	200
			Subtotal:	56,226,724	41,773,438	18,604,214	14,951,277	0	56,724,715	0	56,724,715
32530	F	F_3991 Operating - General Fund		16,541,697	16,045,724	7,540,990	3,803,674	0	19,849,398	0	19,849,398
32530	F	F_3992 Operating - Federal Funds		37,745,372	23,990,820	10,550,227	10,857,934	0	34,848,754	0	34,848,754
32530	F	F_3993 Operating - Other Funds		376,948	152,498	94,063	(118,487)	0	34,011	0	34,011
32530	F	F_3994 Operating - Retained Funds		147,977	0	0	374,000	0	374,000	0	374,000
32530	F	F_3995 Operating - County Funds		1,414,730	1,584,396	418,934	34,156	0	1,618,552	0	1,618,552
			Subtotal:	56,226,724	41,773,438	18,604,214	14,951,277	0	56,724,715	0	56,724,715
32550	B	683000 Other Capital Payments		285	0	0	0	0	0	0	0
32550	B	693000 IT Equipment Over $5000		399,307	7,022	7,022	131,378	0	138,400	0	138,400
			Subtotal:	399,592	7,022	7,022	131,378	0	138,400	0	138,400
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		58,393	0	0	0	0	0	0	0
32550	F	F_5992 Land & Cptl Imprv - Fed Funds		73,287	7,022	7,022	131,378	0	138,400	0	138,400
32550	F	F_5993 Land & Cptl Imprv - Other Fnds		113	0	0	0	0	0	0	0
32550	F	F_5994 Land & Cptl Imprv - Retained Funds		267,799	0	0	0	0	0	0	0
			Subtotal:	399,592	7,022	7,022	131,378	0	138,400	0	138,400
32551	B	513000 Temporary Salaries		0	232,450	145,800	(232,450)	0	0	0	0
32551	B	514000 Overtime		0	640	319	(640)	0	0	0	0
32551	B	516000 Fringe Benefits		0	19,190	11,783	(19,190)	0	0	0	0
32551	B	521000 Travel		0	1,400	730	(1,400)	0	0	0	0
32551	B	531000 Supplies - IT Software		0	1,242	465	(1,242)	0	0	0	0
32551	B	536000 Office Supplies		0	1,506	658	(1,506)	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 100-20 INFORMATION TECHNOLOGY SRVCS										
32551	B	542000 Printing	0	160	60	(160)	0	0	0	0
32551	B	581000 Rentals/Leases-Equip & Other	0	6,120	3,079	(6,120)	0	0	0	0
32551	B	582000 Rentals/Leases - Bldg/Land	0	118,560	0	(118,560)	0	0	0	0
32551	B	591000 Repairs	0	4,648	2,264	(4,648)	0	0	0	0
32551	B	601000 IT - Data Processing	0	4,626,175	2,787,181	(4,626,175)	0	0	0	0
32551	B	602000 IT-Communications	0	14,030	10,303	(14,030)	0	0	0	0
32551	B	603000 IT Contractual Services and Re	0	25,186,830	2,274,692	(25,186,830)	0	0	0	0
32551	B	621000 Operating Fees and Services	0	21,324	8,419	(21,324)	0	0	0	0
		Subtotal:	0	30,234,275	5,245,753	(30,234,275)	0	0	0	0
32551	F	F_5991 Land & Cptl Imprv - Gen Fund	0	996,035	2,377	(996,035)	0	0	0	0
32551	F	F_5992 Land & Cptl Imprv - Fed Funds	0	26,633,851	4,060,535	(26,633,851)	0	0	0	0
32551	F	F_5993 Land & Cptl Imprv - Other Fnds	0	2,604,389	1,182,841	(2,604,389)	0	0	0	0
		Subtotal:	0	30,234,275	5,245,753	(30,234,275)	0	0	0	0
		Subdivision Budget Total:	61,277,826	77,233,847	26,352,214	(14,528,607)	319,219	63,024,459	0	63,024,459
100-20 INFORMATION TECHNOLOGY SRVCS		**General Funds:**	19,463,830	20,703,546	9,130,880	2,830,709	211,811	23,746,066	0	23,746,066
		Federal Funds:	39,577,654	52,180,431	15,523,622	(15,043,889)	107,408	37,243,950	0	37,243,950
		Other Funds:	405,836	2,765,474	1,278,778	(2,723,583)	0	41,891	0	41,891
		SWAP Funds:	415,776	0	0	374,000	0	374,000	0	374,000
		County Funds:	1,414,730	1,584,396	418,934	34,156	0	1,618,552	0	1,618,552
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	61,277,826	77,233,847	26,352,214	(14,528,607)	319,219	63,024,459	0	63,024,459

Information Technology Services 2011-13 Biennium

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Prairie Hills Training Room			11,155	18,341		29,496
Century Center			3,894	6,401		10,295
NWHSC			1,704	2,801		4,505
Badlands			2,199	3,615		5,814
NCHCS			1,490	2,450		3,940
WCHSC			5,522	9,078		14,600
SCHSC			9,103	14,966		24,069
NEHSC			4,911	8,073		12,984
LRHSC			3,105	5,105		8,210
			$ 43,083	**$ 70,830**	**$ -**	**$ 113,913**

Information Technology Services

2009 - 2011 Budget Account Code 601000 - IT Data Processing	$	27,776,832
Rate Increase for Hosting and Networking: Includes increased hosting and networking costs for Economic Assistance (Vision and TECS), Child Support (FASCES), Children and Family Services (FRAME and CCWIPS), MMIS and the Regional Office Automation Program.	$	2,731,346
Technology Fee: $43.50/FTE to $49.00/ FTE	$	251,900
Software Development: Analyst $63/hr to $67/hr; Senior Analyst $75/hr to $86/hr; Analyst II $69 to $75	$	733,227
Total ITD Rate Increase:	$	3,716,473
Utilization Increase: Increases include MMIS, Cognos licensing, email encryption, additional EDMS users, ITD programming, CPU for Child Support, Connect ND charges, and change in ITD charge back methodology for the Recipient Hub.	$	3,286,728
MMIS Operational Costs: Hardware and Software Hosting Fees, and Software Development	$	3,807,320
One Time Cost: HIPAA Translator Software Licensing	$	252,000
Other Service Categories:	$	29,906
Total Utilization and MMIS Operational Costs:	$	7,375,954
Total Change in 2011-13 Budget Account Code 601000 - IT Data Processing	$	11,092,427
2011-13 Budget Account Code 601000 - IT Data Processing	$	38,869,259

	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget
General Fund	11,312,297	3,317,318	14,629,615
Federal Funds	14,896,554	7,370,953	22,267,507
Other Funds	1,567,981	404,156	1,972,137
Total	27,776,832	11,092,427	38,869,259

Information Technology Services 2011-13 Biennium

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Funds	Funds	Total
Noridian Services	60,892	59,108		120,000
Newspaper Ads	3,255	1,745		5,000
Service Awards	977	523		1,500
Freight & Express	1,530	820		2,350
	$ 66,654	**$ 62,196**	**$ -**	**$ 128,850**

-Jenny Witham -Attachment EIGHT -March 7, 2011 -SB 2012

north dakota department of human services

Full-Time Equivalents (FTEs) People Who Have Been Temporary Employees for Four or More (4+) Years

Positions Involved in Processing Medicaid Claims Submitted by Providers

Information Technology Services Data Entry Office Assistants (3 FTE)

- Handle mail processing of Medicaid claims
- Do the **initial data entry, scanning, and optical character recognition** work that translates handwritten, typed or scanned text into machine-editable text that can be used by a computer system
- **Provide verification services**
  So that Medicaid claims submitted on paper can be processed.
  - About **15%** of the claims (450,000 claims) were **submitted by paper last year**
  - *NOTE: Will always be some paper claims due to provider preferences*
- Work with **paper dental and medical claims, and paper claims submitted by qualified service providers** (in-home caregivers of people who are elderly and disabled and who receive home and community-based long-term care services)
- Provide similar services to other divisions (Two-thirds of their work is Medical services.)
- Have over four years of experience at their jobs.
- Work alongside colleagues who do the same work and are regular benefitted employees (not temps).
- Worked an average of 46 hours per week in 2010 to help assure timely claims processing.
- ***After MMIS Rollout:***
  - Will continue providing these services
  - As electronic document management capacity grows, will **take on added duties** of scanning and indexing incoming Medical Services correspondence and documents.

N.D. Medicaid Program

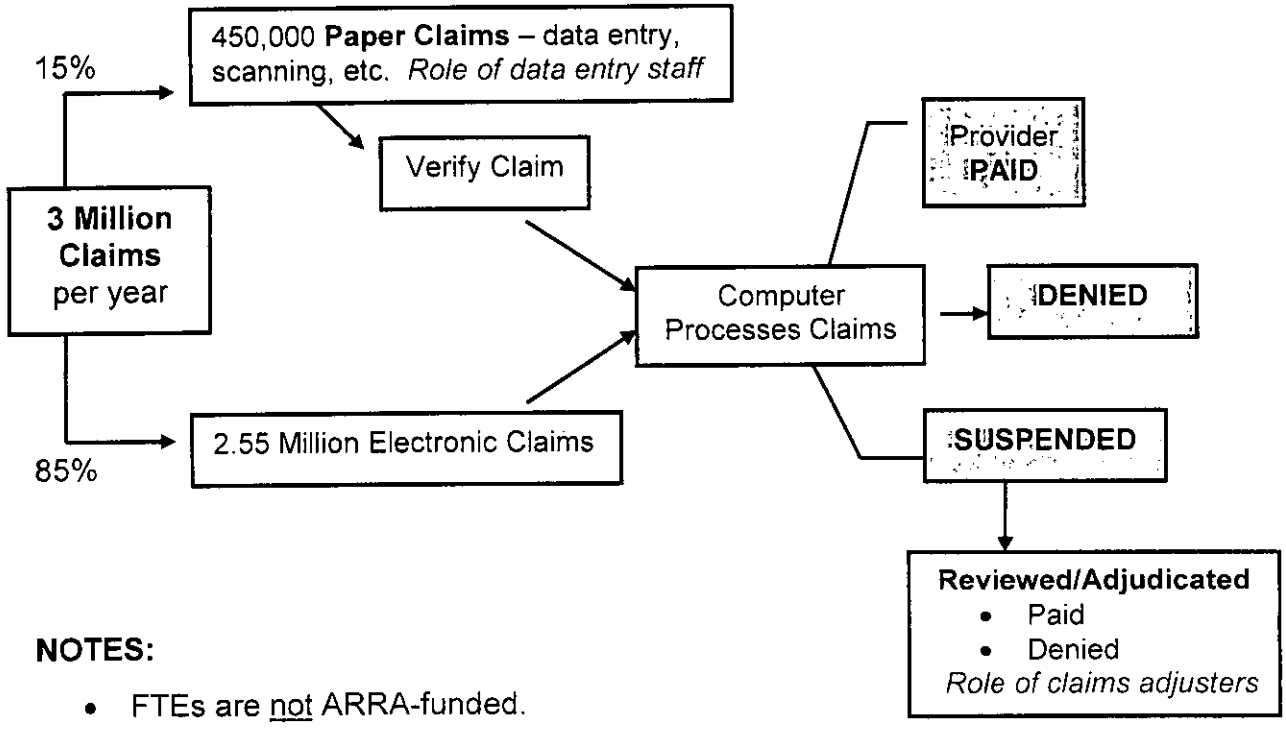
- Processes about **3 million claims/year** to pay clinics, hospitals, doctors, dentists, nursing homes, qualified service providers, and other providers (*85% are submitted electronically and 15% on paper)*
- Has **reduced its claims backlog** from about 100,000 to about 24,000 claims.
- **Pays 96.7%** of clean claims **within 30 days** now and 99.7% within 90 days.

Medical Services Claims Adjuster (1 FTE)

- Reviews and **works to resolve medical claims suspended** by the claims payment system
- Involves **reviewing the reason(s) a claim was suspended and applying** payment and processing **policy to accurately process it** and pay the provider
- **Helps ensure ND claims are processed in a timely manner** (federal requirement)
- Has over four years of experience in DHS.
- ***After MMIS Rollout:***
  - Will assist with **claims review and adjustment**
  - Will provide **customer service to providers *(NEW)***
    - Providers now have to leave a voice mail message if they call about claims. With the new MMIS, DHS expects to be able to answer provider claims questions "live" using staff who are expert on claims issues.

See Medicaid Claims Process & Roles on Page 2 →

Life of a N.D. Medicaid Claim



NOTES:

- FTEs are <u>not</u> ARRA-funded.
- FTEs are <u>not</u> tied to Health Care Reform.
- Their work involves ongoing needs of the Medicaid program to ensure timely and accurate payments to Medicaid providers (*hospitals, nursing homes, QSPs, etc.).*
- North Dakota's Medicaid caseload is growing and even though roles may shift some when MMIS goes live, the positions will still be needed.
- Medical Services Claims Reviewers/Adjusters can and do often seek higher levels of credentialing involving coding, which is essential for the accurate processing and payment of Medicaid claims.

north dakota department of human services

Full-Time Equivalents (FTEs)
State Medicaid Health Information Technology Coordinator

Funding

Under the Federal American Recovery and Reinvestment Act 2009 ("Stimulus Bill"), in a section entitled Health Information Technology and Clinical Health Act (HITECH) dollars were set aside for states to implement state Health Information Exchanges and Medicaid Electronic Health Record Incentive Program.

Incentive Programs

The incentive programs are not increases in reimbursement, but payments over 4-6 years to assist hospitals and eligible providers with adopting, implementing and/or upgrading certified electronic health records so that they can be exchanging health information in a "meaningful way" to improve patient care. Also by 2015, if eligible providers have not met "meaningful use" their Medicare reimbursement will begin to be reduced. States who implement the Medicaid program to assist providers are provided with a 90/10 FFP match for planning purposes and staffing, and a 100/0 match for the incentive payments that go directly to providers.

Oversight

The oversight agencies under the U.S. Department of Human Services for these programs are the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS). ONC is overseeing electronic health record certification standards and the state Health Information Exchanges (HIE), while CMS is overseeing and implementing the Medicare Incentive Program and overseeing states in implementing the Medicaid Incentive Program.

State Medicaid Health Information Technology Coordinator

In order for states to carry out the Medicaid Incentive Program, CMS must follow the final regulation by requiring states to carry out the following activities:

- Submit to CMS a Pre-Planning Advanced Planning Document (P-APD) outlining whether or not the program will be implemented, who has been designated as the staff person or persons to oversee the program and how it will be carried out.

- Once approved the state receives 90/10 funding to begin planning and to create a State Medicaid Health Information Technology Plan (SMHP) and an Implementation Advanced Planning Document (IAPD). These documents are to detail how the state plans to implement the incentive program.

- Once submitted to and approved by CMS, the state may begin to work with providers to assist them in obtaining incentive payments. Those eligible are Prospective Payment System (PPS) Hospitals and Critical Access Hospitals (CAH) and MDs/DOs, Dentists and Dental Surgeons, Nurse Practitioners and Physician Assistants working in a Rural Health Clinic or Community Health Clinic who lead the practice.

- Eligible professionals can obtain incentives each year for six years with the first year's incentive being $21,250 and each subsequent year $8,500 for a total of $63,750. Eligible hospitals must go through a calculation using Total Days, Medicaid Days, Charity Care, etc. and ND Medicaid has projected that large hospitals that qualify could on average receive per facility about $4 million/year, while small hospitals could receive on average per facility $1 million per year. Hospitals and professionals must meet Medicaid volume and Meaningful Use criteria to qualify.

- The staff person implementing this program must oversee and prevent incentive payment fraud and abuse; appropriate payments; Electronic Health Record certification; patient volume threshold; Meaningful Use activities; coordination with the state Health Information Technology Office; coordination with other ND Department of Human Services and Medical Services Programs, CMS reporting requirements; coordination with the CMS electronic registration system (National Level Repository) and assistance, education and outreach to eligible providers.

Department of Human Services OARs for the 2011-2013 Biennium

as of December 9, 2010

Cabinet Priority	IBARS OAR #	Cabinet Category	Description	FTE	General	Federal	Other	Total
01	101	Optional 3% Savings Plan	Optional 3% Savings Plan		(26,964,940)	(34,055,516)	-	(61,020,456)
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			Total Inflation Category		2,692,948	-	-	2,692,948
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04	402	Enhancement of Services	5% Increase - In-home Child Care Providers		902,581		-	902,581
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04	404	Enhancement of Services	Section 13 of 2009 HB 1012		250,000	250,000	-	500,000
04	405	Enhancement of Services	Adult Family Foster Care rate increase		1,134,072	1,172,224	9,103	2,315,399
04	406	Enhancement of Services	Medication Assistance - HCBS		280,568	-	14,010	294,578
04	407	Enhancement of Services	New ICF/MR Beds for DC Transitioning		2,712,968	3,382,849	-	6,095,817
04	408	Enhancement of Services	Guardianship Program Enhancements		65,275	-	-	65,275
04	409	Enhancement of Services	Long Term Care Ombudsman	1.00	135,665	-	-	135,665
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04	411	Enhancement of Services	Post Adoption Services		129,188	66,582	-	195,770
04	412	Enhancement of Services	Sex Offender Community Treatment - MH/SA		498,028	-	-	498,028
04	413	Enhancement of Services	Enhancement of Transitional Youth - MH/SA		500,000	-	-	500,000
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			Report Totals	19.00	36,720,959	27,309,116	738,183	64,768,258

Fully funded in Governor's budget.

Partially funded in Governor's budget.

T:\Bdgt 2011-13\Reports\2011-13 OARs by Cabinet Category.xlsx - With Gov Recs

- Debra HC Dermott
- Attachment NINE
- March 7, 2011
- SB 2012

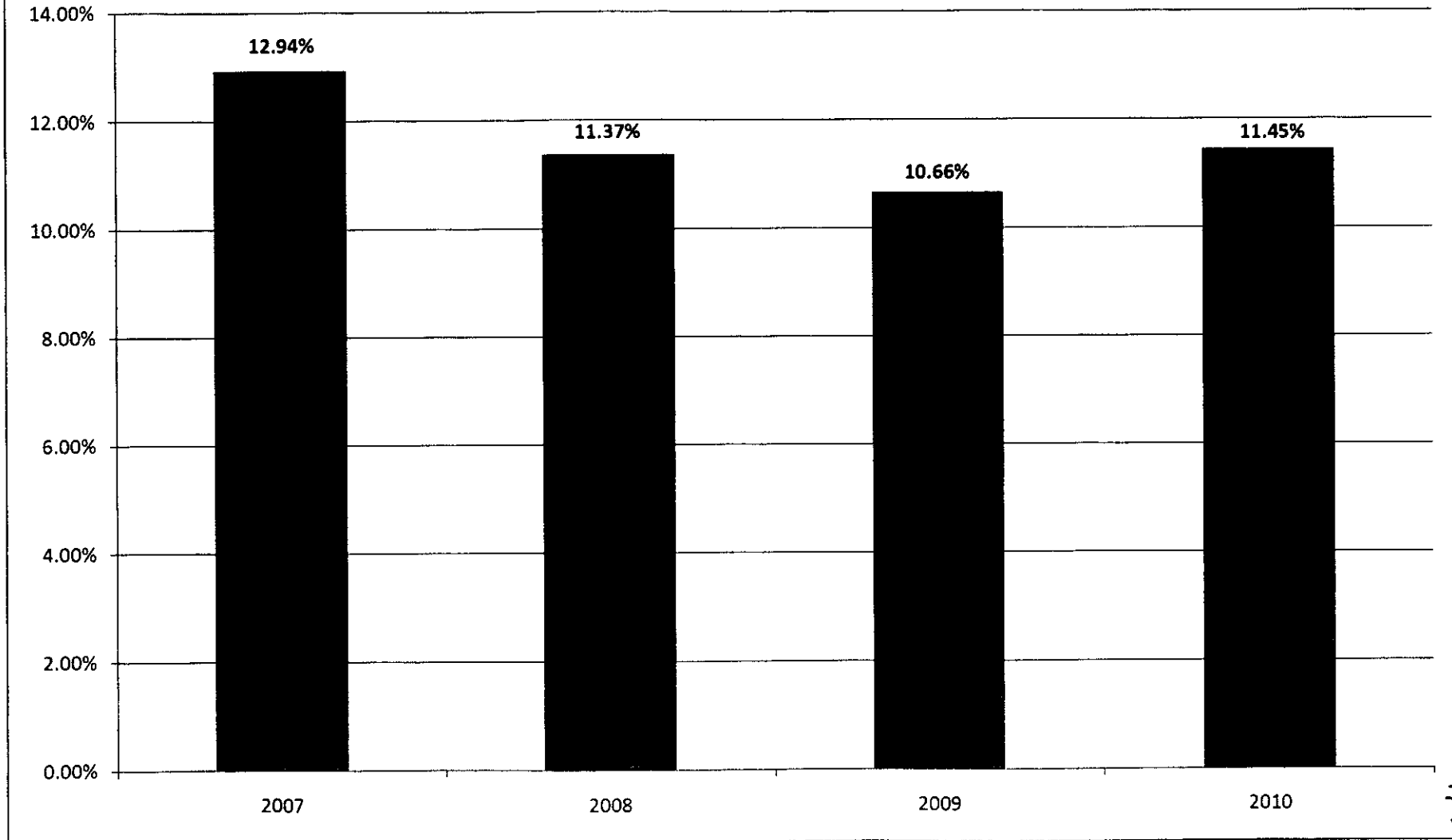
Health Care Trust Fund
Status Statement

	Actual 1999 - 2001		Actual 2001 - 2003		Actual 2003 - 2005		Actual 2005-2007		Actual for 2007-2009		Estimated for 2009-201			
Beginning Balance		$ -		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,9		
Revenue:														
April 2000 pool payment	$ 25,902,739													
Sept. 2000 pool payment	17,340,685													
August 2001 pool payment			$15,398,174											
July 2002 pool payment			19,572,291											
Net interest earnings / (loss)	2,171,632		(1,442,407)		2,313,279		1,808,207		136,644		28,944		7,498	
July 2003 pool payment					13,646,405									
July 2004 pool payment					6,349,417									
Principal and interest repayments			329,314		1,182,277		988,573		1,131,466		1,099,260		1,107,884	
Total Revenue		45,415,056		33,857,372		23,491,378		2,796,780		1,268,110		1,128,204		1,115,382
Expenditures:														
Dept. of Human Services														
SPED	(4,262,410)		(6,898,302)											
Loans	(701,477)		(10,859,661)											
Grants	(445,937)		(8,182)											
Administrative costs	(57,700)		(58,830)											
Special Payment to Govt Facilities	(800,000)													
HIPAA			(2,632,773)											
Nursing home bed reduction			(3,435,874)											
Nursing facility			(8,997,758)											
Basic care facility			(382,080)											
Personal care allowance - ICFMR			(43,200)											
Mill levy			(250,000)											
Targeted case management			(139,542)											
Independent living centers			(100,000)											
QSP training grants			(24,158)											
Long term care needs assessment			(237,285)											
Deficiency appropriation			(5,244,576)											
Transfer to State General Fund					(35,990,650)		(16,900,000)							
Provider Inflationary Increase - 0.65%							(3,001,852)							
DD provider Increase							(198,148)							
Nursing Home Provider Inflationary Increase									(525,597)					
Health Care Trust Funding NH											(3,800,000)			
Nursing Facility Bed Limit											(324,506)			
Remodel of assisted living and basic care grant											(200,000)			
Health Department														
Quick response unit pilot project			(50,000)		(30,000)		(10,000)		(5,000)		(50,000)		-	
Nursing student loan repayment			(489,500)		(489,500)		-							
Evaluate State Trauma System			-		-		-		(73,758)					
Total Expenditures		(6,267,524)		(39,851,721)		(36,510,150)		(20,110,000)		(604,355)		(4,374,506)		-
Ending Balance		$39,147,532		$33,153,183		$20,134,411		$2,821,191		$3,484,946		**$238,644**		**$1,354,026**

Attachment
March 7, 2011
SB 2012

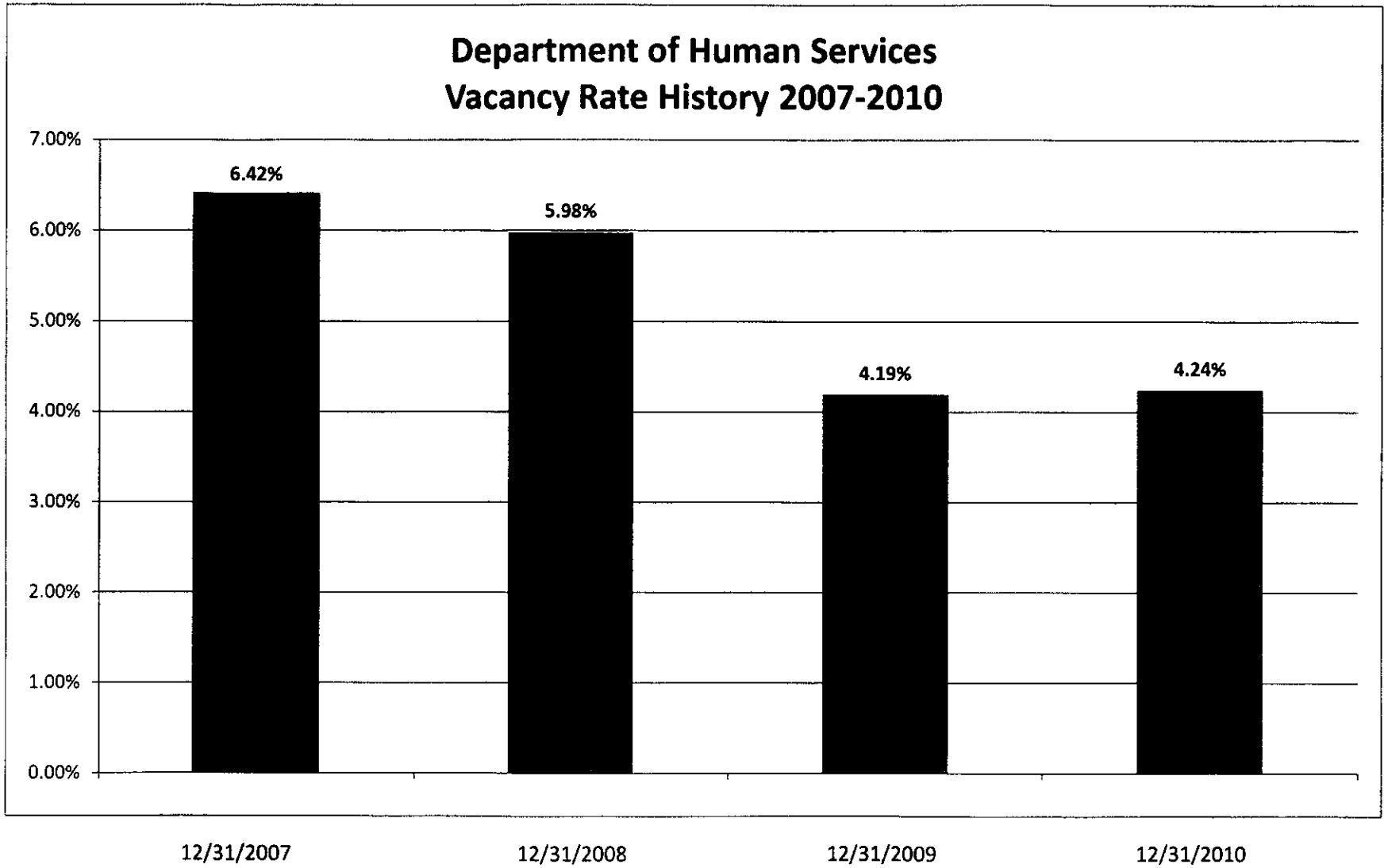
- Attachment Two
- SB 2012
- Debra
- Mc Dermott
- March 7, 2011

Department of Human Services
Turnover History 2007-2010



Prepared by DHS HR Division
March, 2011

-Debra McDermott - SB 2012
- Mar 7, 2011
- Attachment THREE



Prepared by DHS HR Division
March, 2011

North Dakota Department of Human Services
2011 - 2013 Biennium
Legal Appeals Information Request

NUMBER OF DHS PROGRAM APPEALS THAT WERE REFERRED TO THE OFFICE OF ADMINISTRATIVE HEARINGS FROM JULY 1, 2009 THROUGH MARCH 3, 2011

Division	2009	CY,2010		2011	
Children & Family Services	(7/1/2009-12/31/2009)	1/1/2010-12/31/2010	Pending 1/1/2010-12/31/2010	1/1/2011-3/3/2011	Pending 1/1/2011-3/3/2011
Child Abuse/Neglect	22	60	5	1	14
Early Childhood Services	6	12	0	0	1
Foster Care	2	3	0	1	0
Total Children & Family Services Cases	30	75	5	2	15
Medical Assistance					
Eligibility	24	18	0	9	4
State	11	20	1	0	7
HCBS	4	13	1	5	1
Nursing Home Transfer & Discharge	1	9	2	0	0
Total Medical Assistance Cases	40	60	4	14	12
All Other Cases					
TANF	6	7	0	1	0
SNAP	18	19	0	0	0
LIHEAP	2	3	0	0	3
Child Care Assistance	0	4	0	0	0
Vocational Rehabilitation	1	2	0	0	0
Developmental Disability	1	5	0	0	0
Basic Care	0	1	0	0	0
Total All Other Cases	28	41	0	1	3
Total Cases Referred to OAH	98	176	9	17	30

NUMBER OF DHS PROGRAM APPEALS THAT WERE REFERRED TO ATTORNEY GENERAL'S OFFICE FROM JULY 1, 2009 THROUGH MARCH 3, 2011

Division	2009	CY,2010		2011	
Children & Family Services	(7/1/2009-12/31/2009)	1/1/2010-12/31/2010	Pending 1/1/2010-12/31/2010	1/1/2011-3/3/2011	Pending 1/1/2011-3/3/2011
Child Abuse/Neglect	22	60	5	1	14
Early Childhood Services	6	12	0	0	1
Foster Care	2	3	0	1	0
Total Children & Family Services Cases	30	75	5	2	15
Medical Assistance					
Eligibility	11	8	0	1	0
State	11	20	1	0	7
HCBS	4	13	1	5	1
Nursing Home Transfer & Discharge	0	0	0	0	0
Total Medical Assistance Cases	26	41	2	6	8
All Other Cases					
TANF	0	0	0	0	0
SNAP	1	3	0	0	0
LIHEAP	0	0	0	0	0
Child Care Assistance	0	1	0	0	0
Vocational Rehabilitation	0	1	0	0	0
Developmental Disability	1	3	0	0	0
Basic Care	0	0	0	0	0
Total All Other Cases	2	8	0	0	0
Total Cases Referred to AG'S Office	58	124	7	8	23

Notes:

1. Due to changes in federal law, an increase in cases that arise outside of program appeals, and the complexity of the cases being referred to both the Office of Administrative Hearings and the Attorney General's Office, the 2011-2013 budget request has increased.
2. Pending refers to those appeals that have been filed with the Legal unit and are either under review by Department program personnel or are awaiting for background information from Department program personnel.
3. ALL Children & Family Services appeals that go to OAH are also referred to the AG's office for representation.
4. ALL Medical Assistance-State and HCBS appeals that go to OAH are also referred to the AG's office for representation as those originate at DHS.
5. No Medical Assistance-NHT&D (Nursing Home Transfer and Discharge) appeals that go to OAH are referred to the AG's office for representation as the Department is not a party in those cases. DHS merely facilitates the process.
6. Medical Assistance-Eligibility appeals that go to OAH are referred to the AG's office for representation if the appealing party is represented.
7. All other program appeals that go to OAH are referred to the AG's office for representation if the appealing party is represented.

- Attachment SIX
- SB 2012
- Debra McDermott
- March 7, 2011

-Jenny Witham -Attachment EIGHT -March 7, 2011 -SB 2012

north dakota department of human services

Full-Time Equivalents (FTEs) People Who Have Been Temporary Employees for Four or More (4+) Years

Positions Involved in Processing Medicaid Claims Submitted by Providers

Information Technology Services Data Entry Office Assistants (3 FTE)

- Handle mail processing of Medicaid claims
- Do the **initial data entry, scanning, and optical character recognition** work that translates handwritten, typed or scanned text into machine-editable text that can be used by a computer system
- **Provide verification services**
  So that Medicaid claims submitted on paper can be processed.
  - About **15%** of the claims (450,000 claims) were **submitted by paper last year**
  - *NOTE: Will always be some paper claims due to provider preferences*
- Work with **paper dental and medical claims, and paper claims submitted by qualified service providers** (in-home caregivers of people who are elderly and disabled and who receive home and community-based long-term care services)
- Provide similar services to other divisions (Two-thirds of their work is Medical services.)
- Have over four years of experience at their jobs.
- Work alongside colleagues who do the same work and are regular benefitted employees (not temps).
- Worked an average of 46 hours per week in 2010 to help assure timely claims processing.
- ***After MMIS Rollout:***
  - Will continue providing these services
  - As electronic document management capacity grows, will **take on added duties** of scanning and indexing incoming Medical Services correspondence and documents.

N.D. Medicaid Program

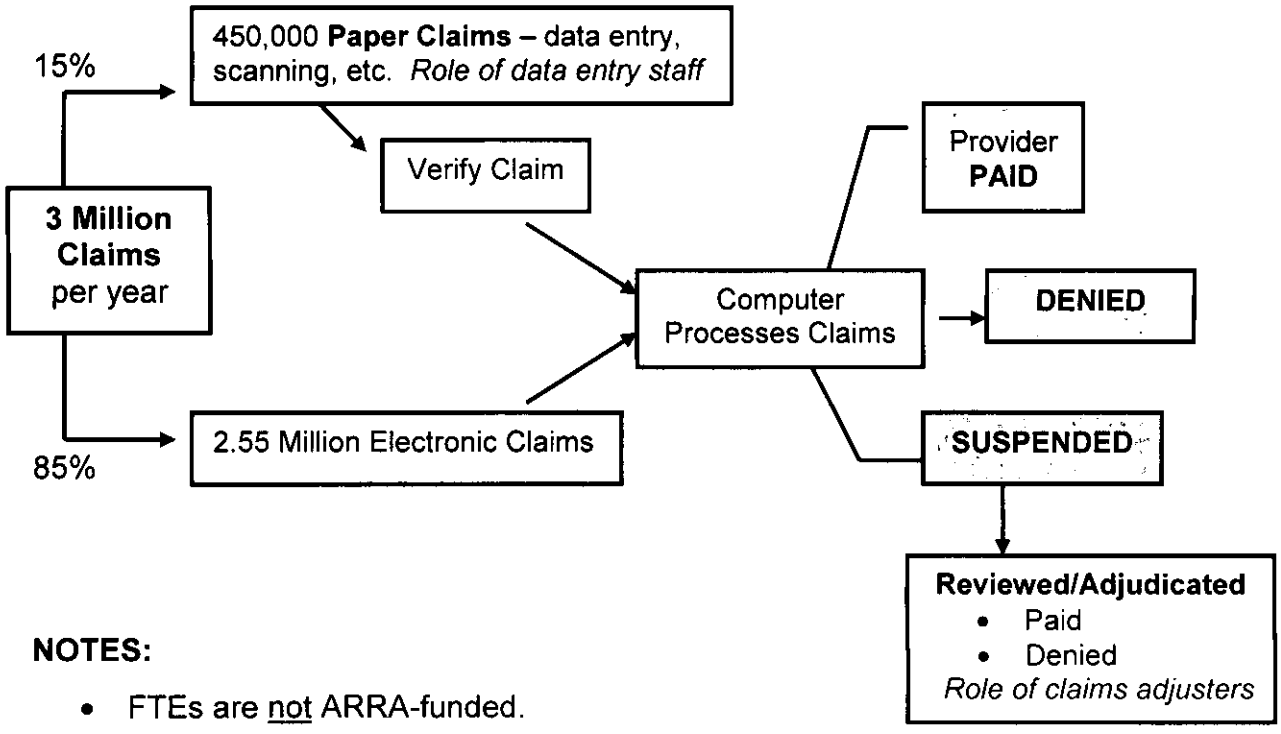
- Processes about **3 million claims/year** to pay clinics, hospitals, doctors, dentists, nursing homes, qualified service providers, and other providers (*85% are submitted electronically and 15% on paper)*
- Has **reduced its claims backlog** from about 100,000 to about 24,000 claims.
- **Pays 96.7%** of clean claims **within 30 days** now and 99.7% within 90 days.

Medical Services Claims Adjuster (1 FTE)

- Reviews and **works to resolve medical claims suspended** by the claims payment system
- Involves **reviewing the reason(s) a claim was suspended and applying** payment and processing **policy to accurately process it** and pay the provider
- **Helps ensure ND claims are processed in a timely manner** (federal requirement)
- Has over four years of experience in DHS.
- ***After MMIS Rollout:***
  - Will assist with **claims review and adjustment**
  - Will provide **customer service to providers *(NEW)***
    - Providers now have to leave a voice mail message if they call about claims. With the new MMIS, DHS expects to be able to answer provider claims questions "live" using staff who are expert on claims issues.

See Medicaid Claims Process & Roles on Page 2 →

Life of a N.D. Medicaid Claim



NOTES:

- FTEs are <u>not</u> ARRA-funded.
- FTEs are <u>not</u> tied to Health Care Reform.
- Their work involves ongoing needs of the Medicaid program to ensure timely and accurate payments to Medicaid providers (*hospitals, nursing homes, QSPs, etc.).*
- North Dakota's Medicaid caseload is growing and even though roles may shift some when MMIS goes live, the positions will still be needed.
- Medical Services Claims Reviewers/Adjusters can and do often seek higher levels of credentialing involving coding, which is essential for the accurate processing and payment of Medicaid claims.

north dakota department of human services

Full-Time Equivalents (FTEs)
State Medicaid Health Information Technology Coordinator

Funding

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Fully funded in Governor's budget.

Partially funded in Governor's budget.

- Debra McDermott



North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: SB 2012
House Appropriations Committee
Human Resources Division
Appropriations for the Department of Human Services
March 8, 2011

- Attachment ONE

Chairman Pollert and Members of the House Appropriations Committee; I am Jerry Jurena, President of the North Dakota Hospital Association (NDHA). I am before you today presenting Testimony in support of SB 2012.

I believe the Governor's recommendation of a 3% inflator each year of the biennium for Medicaid reimbursement for Hospitals is appropriate and fair based on the current increases for supplies, utilities, insurance, equipment upgrades and wages.

I believe the recommendations made by the Governor regarding additional funding for Mental Health Services is long overdue. The additional funding in the proposed budget for the Department of Human Services will enhance reimbursement which will increase access and maintain quality Mental Health Services across the State. Access to Mental Health Services is an ongoing issue for rural Hospitals creating difficultly in placing patients for qualified services. Urban Hospitals do not have the necessary staff to meet the demand in urban areas let alone provide assistance to rural hospitals. The result of not funding Mental Health Services is; patients are being seen repeatedly in Hospital emergency rooms costing more than receiving appropriate treatment.

I believe the Interim Studies completed on Mental Health Services this last year by the Department of Health is right on in addressing the need to increase providers and services. Again I believe the Governor's recommendations to add additional funding is appropriate.

I am In support of SB: 2012. I am here to address any questions.

Jerry E. Jurena, President
North Dakota Hospital Association.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

House Human Resources Division - Attachment TWO
SB 2012
March 8, 2011

Chairman Pollert and members of the House Human Resources Division. I am Paul Ronningen, State Coordinator for the Children's Defense Fund, North Dakota and am here to request an increase in the Children's Health Insurance Program to 250% of poverty.

It seems the 2011 Legislature will do quite a bit for me this session. I will likely benefit from **property tax rebates** on farmland in Steele County, my home in Burleigh County, my lake home in McLean County and my family farm in Ward County. I may enjoy proposed **income tax reductions.** And, who knows, reducing the **oil extraction tax** could also benefit me as drilling begins for oil on the family farm.

But I am embarrassed that little is being done to help my friends and neighbors who are not so fortunate as me.

If there is enough money to pay for tax breaks for those of us doing well, (and we know there is plenty, See Attachment A) then there is more than enough funding to pay for an increase to the Children's Health Insurance Program (CHIP) at 250%. And if someone like me gets tax breaks, shouldn't there be provisions for low and moderate income working families, such as a state earned income tax credit, a proposal killed by the Senate? Fair is fair.

The Legislature's approach to these issues does not fit with my upbringing in North Dakota. My small town minister taught about taking care of those in need as a sacred value. Our community helped each other when illness or death struck a neighbor and we would rally to plant and/or harvest their crops. These are the values most North Dakotan's are raised with. Fair is fair.

I am embarrassed as a citizen of North Dakota that we are lowest in the nation (160%) in providing CHIP, not even coming close to the national *average* of 250% of poverty. The Legislature's choice to give me so many more benefits as a wealthy person, and ignore children in need of health insurance and the working families of the state, seems inconsistent with North Dakota values. Fair is fair.

Why expand health care coverage to more children?

Compared to their insured peers, uninsured children are:

- Almost ten times as likely to have an unmet medical need
- More then eight times as likely to have delayed medical care due to cost;
- More than five times as likely to have an unmet dental need
- More then four times as likely to have gone more that two years without seeing a doctor
- Twice as likely to have gone more than two years without a dental visit
- Children without insurance are 60% more likely to die then their insured counterparts when needing hospitalization.

Investing in children's health is an investment in the future:

- Studies show that increased life expectancy and improved health status results from covering children – in addition to productivity gains for future workers will yield cost-savings for society.

- Lack of health insurance has been shown to impact educational attainment, which in turn impacts income.

It costs less to cover children than any other group of people:

- A year' coverage for a single working adult cost about three times what it costs to cover a child for the same length of time.
- Prevention and early care are cost-effective.
- Primary care doctor visits cost less than emergency rooms.
- Studies show children enrolled in CHIP miss fewer classes and demonstrate better school performance than when they were uninsured.

I therefore request that the Children's Health Insurance Program be raised to 250% of poverty, reflecting similar benefits to the low income working families as I may receive through the income tax reductions, property tax reductions and oil extraction tax reductions.

Thank you! If you have any questions, I would be more then willing to answer them.

Attachment A

North Dakota Total Reserves
2001-2011

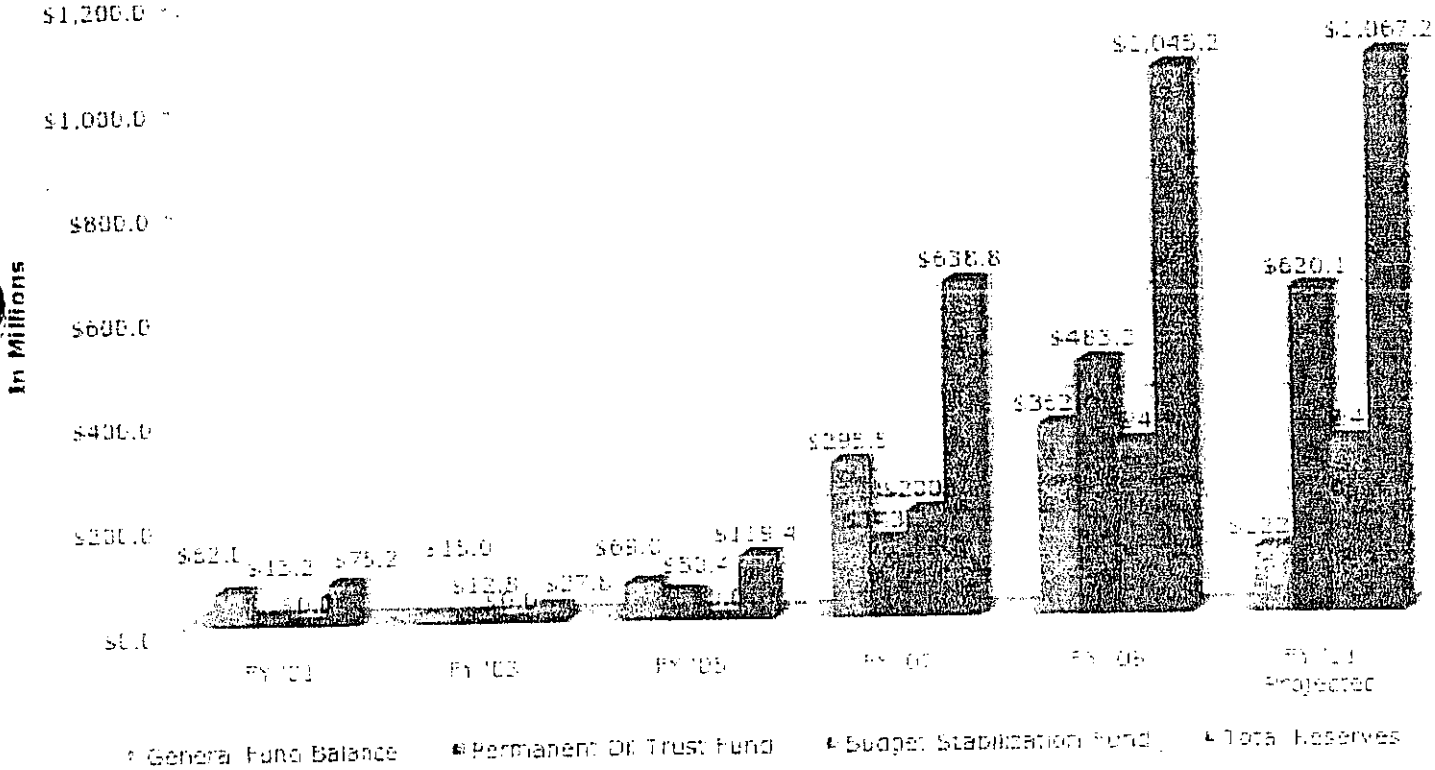


Chart Courtesy North Dakota Economic Policy Project

North Dakota's Children's Health Insurance Program (CHIP) in Perspective...

How does ND compare at a 175% eligibility level?

North Dakota uses "net income" to determine CHIP eligibility. Net income results when you subtract allowable deductions from a family's gross (or total) income.

Most states say they use gross (or total) income to determine eligibility, yet many of these states also allow deductions.

State	Family Income Eligibility Level for CHIP	Common Monthly Deductions (amounts families can subtract from their gross income when calculating their CHIP income eligibility level)				
		Earnings ($$ per worker, per month)	Child Care Expenses	Child Support Received	Child Support Paid	Medical Premiums and Medical Expenses for Other Family Members
Iowa	300% of poverty	0	0	$50	0	0
Minnesota	275% of poverty	0	0	0	0	0
Montana	250% of poverty	$120	up to $200	0	0	0
South Dakota	200% of poverty	0	up to $500	$50	full amount	0
Wyoming	200% of poverty	0	0	0	0	0
North Dakota	**175% of poverty**	**$90***	**full amount**	**$50**	**full amount**	**full amount**

*Or the sum of state income tax, federal income tax, FICA, and any union dues, whichever is greater. In addition to these common deductions, see a complete list of deductions at www.state.nd.us/humanservices/policymanuals/healthysteps-508/healthy_steps.htm.

Meet the Johnson Family...



The Johnsons have two children (ages 12 and 14). Their combined annual employment income is $44,100. Neither parent has health care coverage at work. They do not have child care costs. Would the Johnson children be eligible for children's health insurance coverage in North Dakota or in nearby states?

While North Dakota allows many deductions, the Johnsons do not have enough deductions to enable their children to benefit from CHIP at 175%.

State	Johnson Family annual income (two workers)	Amount of annual deductions allowed the Johnson Family by CHIP	Johnson Family annual income after deductions	CHIP Family Income Eligibility Level in 2010 (for family of four)	Are the Johnson children eligible for CHIP?
Iowa	$44,100	0	$44,100	$66,150	Yes
Minnesota	$44,100	0	$44,100	$60,638	Yes
Montana	$44,100	$2,880	$41,220	$55,125	Yes
South Dakota	$44,100	0	$44,100	$44,100	Yes
Wyoming	$44,100	0	$44,100	$44,100	Yes
North Dakota (at 175%)	**$44,100**	**$4,887***	**$39,213**	**$38,588**	**No**

*Deductions for state taxes, federal taxes, and FICA assuming the Johnsons take 4 exemptions on their W-4.

St. Alexius Medical Center
PrimeCare

-March 8, 2011
-Jackie Bugbee
-Attachment THREE

Chairman Pollart and Members of the House Human Services Appropriations Committee.

RE: SB 2012

I would like to submit this letter regarding the three percent inflationary increase for medical services proposed in SB 2012 for each year of the biennium. As I understand, this increase was included in the Governor's budget.

In the last biennium, the Legislature provided a rebasing for all PPS healthcare facilities in the state of North Dakota. Although the process used the "Medicare step-down method for cost finding" to determine cost for Medicaid patients, it failed to recognize that Medicare was being under-funded by approximately 10 percent at that time and the Medicare process does not pay operational costs. The "step-down" process eliminates many costs providers feel are necessary to operate effectively. The rebasing was an excellent start towards improving Medicaid reimbursement to North Dakota providers, but it left providers with a 12-18 percent shortfall in Medicaid payments to actual operational cost.

I hope you will take into consideration the fact that it will require an inflationary increase of six to eight percent per year to bring Medicaid reimbursement for services closer to actual cost. The total amount needed to bring Critical Access and Tertiary facilities to actual cost is estimated to be $30 million per year. An increase of this amount would cover our actual cost for services provided to Medicaid patients and restore fairness to the payment system.

St. Alexius Medical Center greatly appreciates the Governor's budget including a 3%/3% increase. I hope you will support SB 2012 and those percentage increases per year and recognize that an additional increase would positively impact the services provided to North Dakota Medicaid patients. Medicaid reimbursement is a very important and a very complex issue. Thank you for the time you devote not only to this issue but also to all the issues we face as members of the North Dakota community.

Sincerely,

Gary P. Miller

Gary P Miller
Interim President / CEO
St. Alexius Medical Center

The Arc

The Arc of North Dakota

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Testimony
Senate Bill 2012 – Department of Human Services - Attachment Four
House Appropriations/Human Resources Division
Representative Chet Pollert, Chairman
March 8, 2011

Chairman Pollert, members of the House Appropriations/Human Resources Division, thank you for the opportunity to provide commentary on Senate Bill 2012 – Department of Human Services' budget request for the 2011-2013 biennium.

My name is Dianne Sheppard. I am Executive Director for The Arc, Upper Valley in Grand Forks and an official spokesperson for The Arc of North Dakota. Our mission is to ensure that children and adults with an intellectual disability have the supports, benefits, and services they need, and are accepted, respected and fully included in their communities.

The North Dakota Department of Human Services' budget is a good budget as it relates to programs and services for people with an intellectual disability. We would like to see it adopted as presented along with other critical items that were identified as an OAR, and in particular OAR 407, but failed to be included in the budget or were not fully funded.

Please consider the following:

1. The North Dakota legislative effort to increase staff wages and benefits for DD providers is commendable and should be continued.

   This biennium, DD community service providers are budgeted to receive an equity increase of 3% each year of the biennium. We are asking you to approve these increases.

   In addition, we are asking you to approve a $1.46 per hour market adjustment for all DD community service provider staff.

This increase will address the wage disparity between DD community service provider staff and what the state provides for staff working in state operated programs. It will also help reduce community staff turnover, currently at 33% annually, which is unacceptably high at 1,200 to 1,500 staff leaving each year. The goal is to reduce staff over to 20% or less.

Many workers find that they can earn higher hourly wages, and receive better benefits, in far less demanding jobs. As a result, people with disabilities experience continuous turnover of staff or they find themselves unable to get workers at all. Unable to obtain adequate assistance, people with disabilities find their health and safety at risk.

A well-trained, adequately compensated workforce is essential to providing the necessary supports and services to our constituents, who constitute a very vulnerable population. Higher wages reduce employment turnover and is correlated with an increase in the quality of services.

We realize this is a big request; however, it is needed to turn the tide on staff turnover and eliminate the gap between wages paid to private employees and wages paid to public employees in the state.

2. **Critical Needs Funding**

We are asking you to approve the continued funding for the critical needs of individuals who are medically fragile and/or behaviorally challenged at $4.2 million and a 3% increase each year of the biennium.

This funding is needed so people can get the support they need to stay in their community and avoid being admitted to the Developmental Center.

3. **Developmental Center Budget**

We ask that you approve the Developmental Center 2011/2013 budget request funded for 95 residents, which is the current goal of the Transition to the Community Task Force.

The net decrease of 40.53 FTEs at the Developmental Center should only be approved if the quality of care for those individuals remaining at the institution during the closing and reorganizing of units can be guaranteed and not negatively impacted.

Any cost savings from reorganizing and downsizing the institution should be reallocated to DD community programs and services.

4. **Restore OAR 407 Downsizing the Developmental Center**

Institutions: We are asking you for a commitment to steadily reduce reliance on and ultimately close the North Dakota Developmental Center at Grafton.

Most professionals, family members and persons with an intellectual disability believe that large group settings are no longer acceptable living arrangements because of the difficulty of personalizing services. Virtually every credible research study supports the assertion that people are well served in small community settings, including those with behavior issues, or people with complex medical needs.

As such, institutional placement cannot be justified on the programmatic needs of the people who are forced to reside in an institution in order to receive services. The long-term future of services to persons with an intellectual disability in North Dakota is in community settings.

The **Transition to the Community Task Force**, chaired by Alex Schweitzer, Superintendent of the Developmental Center, has put together a transition goal for July 1, 2013 for a maximum of 67 people residing at the Center. This is a reasonable goal and should be supported with a budget that will meet that goal. **Restoring OAR 407** will help to meet that goal. Without those funds, transitions to the community will happen at a slower pace and make the goal of 67 residents at the institution by the target date difficult to reach.

These funds also address the need for dual funding during the transition process. The resident per diems for those residents remaining at the Center during the downsizing process will increase due to fixed costs being spread over fewer residents. Conversely, as people move to the community the related costs will also increase.

General Funds: $2,712,968
Federal Funds: $3,382,849
Total Funds: $6,095,817

The closure of a state institution can generate savings for state government over time because it:

1) Eliminates the high fixed cost of operating a state-owned facility, originally built for many more residents than live there at the time of closure;

2) Shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI);

3) Increases the likelihood that individuals will engage in productive employment in a local community because they now live closer to employment markets;

4) Utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expense, specialized services provided in the institution; and,

5) By renting/leasing a residence, the expensive institutional capital construction and remodeling costs necessary for most institutions to remain open and certified for receipt of federal reimbursement are avoided.

5. **Children's Health Insurance Program (CHIP)**

The Arc supports the protection and expansion of CHIP as a dedicated program for insuring currently uninsured children to include dental and mental health benefits.

We ask that you approve an increase in CHIP at 250% of poverty rather than the proposed 175% of poverty.

Conclusion:

North Dakota has a healthy budget surplus, and this would be the ideal time to invest in our community service delivery system. People are confined to the Developmental Center in Grafton in part because of the lack of appropriate resources in the community. When the state has the resources to provide those services in the community and fails to commit the money, it is difficult to conclude that the state has a real commitment to community services and the least restrictive environment as required by state and federal law.

Attached is *Closing the North Dakota Developmental Center: Issues, Implications, Guidelines* where you will find 10 key issues addressed on the closure of the Developmental Center at Grafton.

I would be happy to answer any questions you may have.

Thank you.

Dianne Sheppard
Executive Director

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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

David Braddock, Ph.D.
Professor in Psychiatry, University of Colorado

March 7, 2006

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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

PURPOSE AND FOCUS OF THE PAPER

This paper has been prepared at the request of the Arc-Upper Valley Board of Directors. It is intended to stimulate discussion and further study by the Arc and other interested parties in North Dakota on the possible closure of the North Dakota Developmental Center at Grafton (hereafter "Grafton").

The primary focus of the paper is to identify and discuss 10 key issues, expressed as questions, associated with the potential closure of Grafton, North Dakota's remaining mental retardation and developmental disabilities (MR/DD) institution. The implications of closing Grafton are considered in light of other states' experiences in closing state-operated MR/DD institutions and in light of relevant research. The paper addresses the following ten questions:

1. How did state-operated institutions for persons with mental retardation and developmental disabilities evolve nationally?
2. What are residential and community services trends in North Dakota today and in two groups of "comparison states"?
3. How many states have closed state MR/DD institutions and how many are planning to do so in the near future?
4. What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?
5. How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?
6. How do parents of individuals relocated from state institutions to community settings respond to this process of change?
7. How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

8. Should the State of North Dakota anticipate a need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

9. What are some of the alternate uses to which a closed Grafton facility might be put?

10. What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

Question #1: How did state-operated institutions for persons with mental retardation and developmental disabilities (MR/DD) evolve nationally?

The first state-operated MR/DD institutions were opened in the Northeastern U.S. in the 1850s. They were developed to provide a temporary residential placement for individuals who, after a relatively brief period of education and training in these facilities, returned to community life. Early success at several schools led to the opening of additional state-operated MR/DD institutions across the U.S. (Braddock & Parish, 2003). The first state MR/DD institution in North Dakota was opened as the State Institute for Feeble-Minded in Grafton in 1904. In addition, the San Haven facility, opened originally as a tuberculosis hospital in 1922, was converted to MR/DD use in 1973, and closed in 1987 (Braddock & Hemp, 2004).

As the country industrialized and urbanized, state institution populations expanded much faster than facilities' capacities to provide appropriate training and educational services. By 1930, more than 100,000 persons with mental retardation were institutionalized across the U.S., and most residents received minimal custodial care. This trend toward custodial care and "warehousing" of persons with mental retardation increased after the Second World War and throughout the 1950s. Media exposés about deficient conditions were commonplace (Blatt & Kaplan, 1974).

In 1967, the nation's institutional census peaked at 195,000 residents in 240 state mental retardation facilities. Since 1968, the number of individuals with mental retardation served in state institutions has declined every year and, on average, four percent annually for 37 consecutive years. In 2004, the residential census of the nation's state institutions was 41,214 persons. If present trends continue, there will be fewer than 20,000 residents in state institutions in 10 years (2016). Costs for residential care, however, are climbing rapidly. Based on previous trends, in 10 years they are projected to reach an average of approximately $193,000 for each resident per annum ($530/day), in constant 2004 dollars. The per diem cost in the Grafton facility in 2004 was $392/day and $143,000 annually (Braddock, Hemp, Rizzolo, Coulter, Haffer, & Thompson, 2005).

Current trends promoting community services in the mental retardation field evolved out of the parent movement in the 1950s and 1960s. At that time, parents began insisting upon both a higher quality of institutional care and greater opportunities for community living. Federal legislation was enacted in 1963 (Pub. L. 88-156 and Pub. L. 88-164) that authorized the establishment of an initial, but incomplete, network of community centers and services across the country (Braddock, 1987). Segregating individuals with MR/DD in large, often remote institutions and providing substandard care became prominent civil rights issues in the 1970s and 1980s. Class action lawsuits (e.g., *Wyatt v. Stickney* in Alabama, *Ricci v. Okin* in Massachusetts, *New York State Arc v. Carey, Association for Retarded Citizens of North Dakota v. Olson*) were filed and such litigation continues in Federal District Courts throughout the U.S. (Braddock, 1998). By 1980, however, many states had begun implementing community services initiatives involving the development and funding of

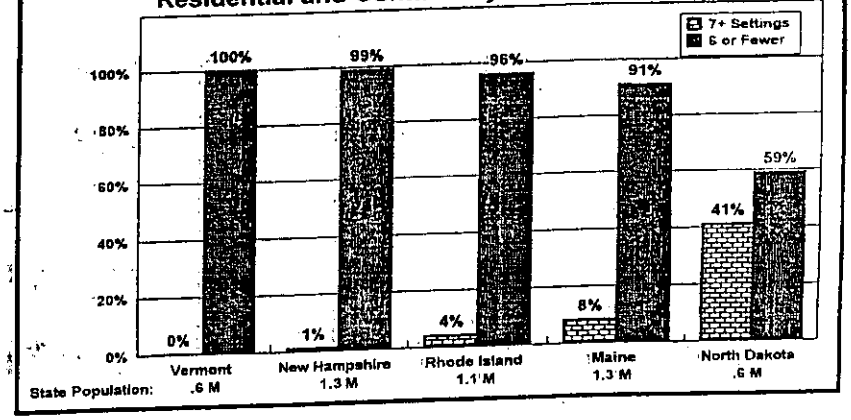
small group homes, supervised apartments, in-home family support programs, and supported employment.

Question #2: What are residential and community services trends in North Dakota today and in two groups of "comparison states"?

Today, institutional settings are being replaced by smaller, more individualized community placements and family support services. There are now more than 140,000 supervised living settings in the U.S. for six or fewer residents with MR/DD (Prouty, Smith, & Lakin, 2005). The total residential population of these small living environments was approximately 335,000 and this figure represented 68% of all out-of-home residential placements in 2004. In contrast, 86% of all persons with mental retardation in out-of-home residential placements nationally were living in large, 16 beds or more, publicly and privately-operated institutions in 1977 (Braddock et al., 2005).

North Dakota, however, significantly lags the dominant national trend in this regard. The State ranked 39th in 2004 in the percentage of persons with MR/DD living in smaller (six person or fewer), family-scale out-of-home environments, and 44th in the proportion of its total spending allocated to six-person or fewer settings. ***Figure 1*** compares North Dakota to four New England states with roughly the same state general population as North Dakota (Braddock et al., 2005).

Figure 1
Percentage of Total State Spending for 6-Person or Fewer Residential and Community Services: FY 2004



Another analytically useful comparison group of states includes South Dakota (.8 million population), Wyoming (.5 million), Montana (.9 million), and Idaho (1.4 million). Each of these "mountain west/plains states," like North Dakota, has one remaining institution. The 2004 MR/DD institutional censuses were 90 (MT), 92 (WY), 94 (ID) and 176 (SD), compared to 146 in North Dakota. Although South Dakota's census in 2004 was larger than North Dakota's, all four of these states had lower institutional utilization per capita rates (per 100,000 of the state general population).

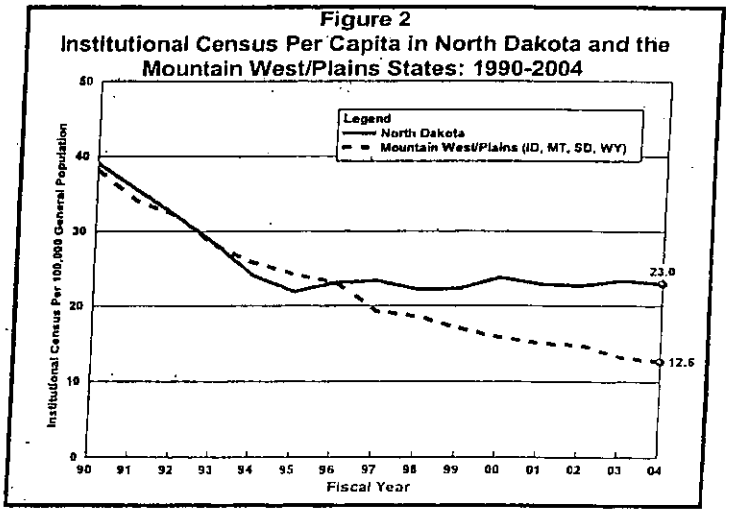


Figure 2 illustrates how the MR/DD institutional utilization per capita (of the state general population) for the four mountain west/plains comparison states began diverging from North Dakota in 1996. In 2004, North Dakota's institutional utilization exceeded the aggregate of the four comparison states by 83% (23.0 vs. 12.6). Moreover, South Dakota, Wyoming, Montana, and Idaho each committed a considerably larger share of total MR/DD spending to six-person or fewer residential and community services (70-77%) compared to only 59% in North Dakota. North Dakota's utilization rate for state-operated institutional care has been stable for the past 12 years, through 2006.

*Question #3: **How many states have closed state MR/DD institutions and how many are planning to do so in the near future?***

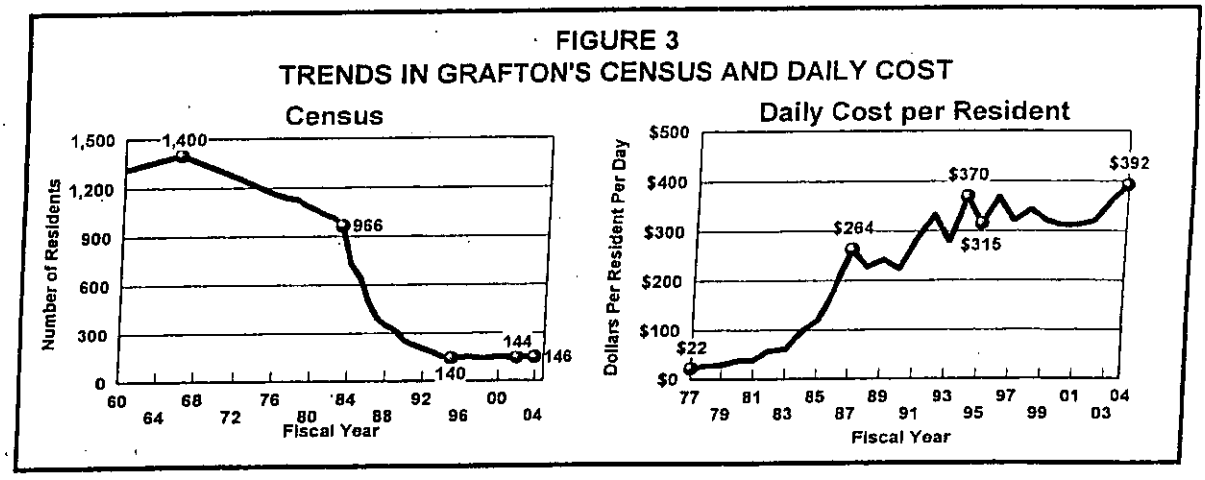
Since 1970, on a national basis, 39 states have closed, or are planning to close, 139 state-operated MR/DD institutions (*Appendix I*). This is more than one-half the 240

institutions that existed in 1970. (The average institutional census in 1970 was about 800 persons, compared to an average of 206 residents for the 200 facilities open in 2004.)

Sixty of the 139 completed and in-progress closures have occurred in the past 10 years. In January 1991, New Hampshire closed the Laconia State School and became the first contemporary American state to operate an institution-free service delivery system. The District of Columbia, Vermont, Rhode Island, New Mexico, West Virginia, Hawaii, and Maine became institution-free from 1991 to 1999. Michigan has closed 12 state institutions and in 2004, its only remaining facility, Mt. Pleasant, had a census of 162 persons. Minnesota has only one "institutional" program for persons with MR/DD. This is an intensive behavioral treatment program for seven consumers, located in a state psychiatric hospital.

Providing community-based services for persons with MR/DD and their families has gained considerable public support in recent years. Between 1977 and 2004, the annual growth of total community spending in the United States averaged 10% per year, after adjusting for inflation. Total state institution spending, however, actually declined 1% annually during 1977-04, and the average annual census of residents in institutions dropped by five percent per year.

The census of Grafton and San Haven in North Dakota (***Figure 3***) declined by an average of two percent per year from 1966 to 1983, one-half of the U.S. institutional rate over that period. Following the implementation of the consent decree in *Association for Retarded Citizens of North Dakota v. Olson* (1982), the North Dakota institutional census dropped by 15% per year from 1983 to 1995, from 966 to 140 persons. San Haven closed in 1987. In the past 12 years, through early 2006, there has been essentially no further decline in Grafton's institutional population. In fact, it has increased slightly since 1995.



Question #4: What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?

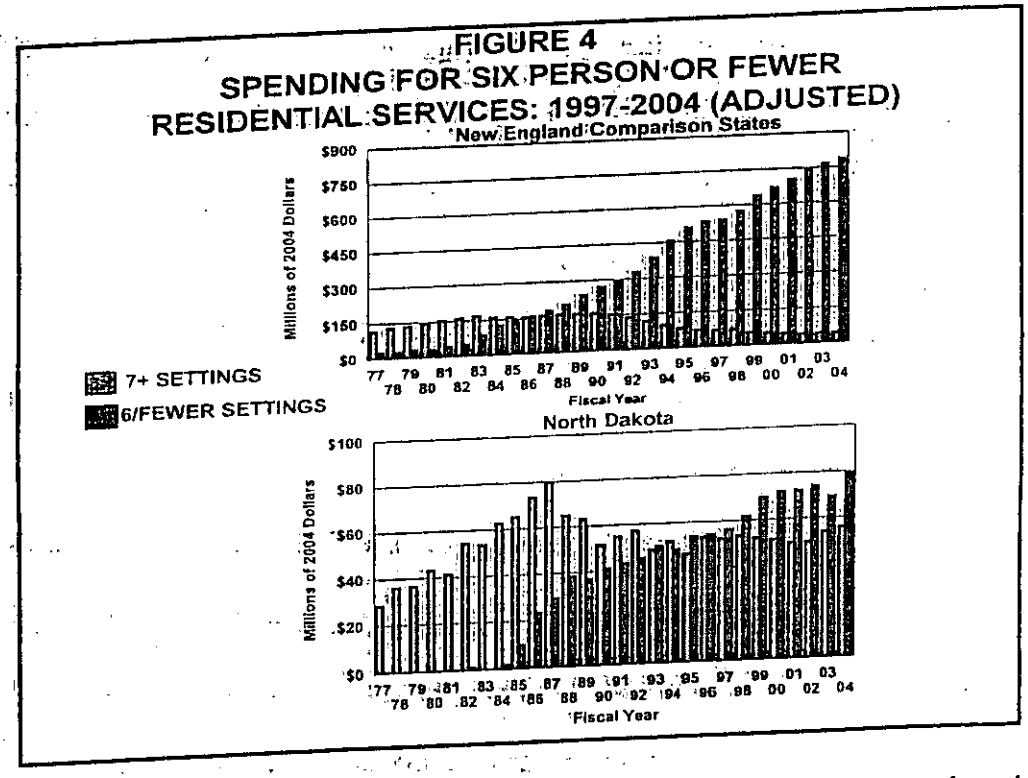
If present trends continue, an average of $193,000 per year, or $530 per day in constant 2004 dollars, is expected to be spent in the year 2016 for each institutional resident in the United States. From 1977 to 2004, average per diems grew nearly nine-fold, from $45/day to $400/day, and in 2004 per diems exceeded $500/day in 15 states, $400/day in 21 states, and $300/day in 35 states (Braddock et al., 2005).

Since 1995, the cost for each Grafton resident has advanced from $315 to $392 per day (***Figure 3***). The average cost of care in North Dakota's institution is now over $143,000 per year for each resident. Absent a decision to close Grafton, and given the stability of the Grafton census, the Grafton per diem for fiscal year 2016 in constant 2004 dollars may well surpass $600/day for approximately 146 residents. This amounts to $219,000 per year per resident, or $32.0 million per annum for the Grafton facility in 10 years.

An equally significant fiscal consequence of continuing to commit increasingly larger sums of money to institutional operations lies in the fact that, given current spending trends for Grafton, fewer "new" funds would be available to initiate additional or higher quality community services for consumers and families in the State. However, the New England

states of Maine, New Hampshire, Rhode Island and Vermont have all closed their remaining state MR/DD institutions, reallocated institutional funding, and greatly expanded their community services for thousands more individuals with MR/DD and their families (*Figure 4*). In contrast, North Dakota has continued to dedicate funding to persons in Grafton and to larger group living arrangements for seven or more persons. The New England states' decisions to close their MR/DD institutions lead to the development of a range of community housing and supported work options that subsequently received widespread political support (e.g., Covert, Macintosh & Shumway, 1994).

FIGURE 4
SPENDING FOR SIX PERSON OR FEWER RESIDENTIAL SERVICES: 1997-2004 (ADJUSTED)



Question #5: How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?

Larson and Lakin (1989) of the University of Minnesota published a comprehensive review of research on changes in adaptive behavior associated with residents moving from state mental retardation institutions to smaller community living arrangements. Over 50

studies published between 1976 and 1988 were initially identified. After screening them according to six quality standards, 18 studies were subsequently analyzed. Results of the analysis indicated that institutions were "consistently less effective than community-based settings in promoting growth, particularly among individuals diagnosed as severely or profoundly retarded" (p. 330). The 18 studies reviewed involved 1,358 participants. The studies were conducted in 13 different states from all regions of the country. The authors concluded:

> ...it must be recognized that based on a substantial and remarkably consistent body of research, placing people from institutions into small, community-based facilities is a predictable way of increasing their capacity to adapt to the community and culture (p. 331).

In California, Brown, Fullerton, Conroy, & Hayden (2001) evaluated the well-being of more than 2,000 individuals with developmental disabilities who left state-operated California developmental centers from 1993 to 2001. The researchers assessed each individual at the state institution prior to the move, and, during 1994-2001, visited all 2,170 relocated individuals in their new homes in the community.

Data collected included measures of independence, behavioral challenges, choice-making, friendships, integration, person-centered planning, health, service intensity, earnings, and both consumer and family satisfaction. Brown et al. (2001) found that those relocated, compared to their lives in an institution in 1994, experienced improvement in "integrative activities," individualized treatment," "progress toward individual goals," "opportunities for choice-making," "reduced challenging behavior," and "perceived quality of life." Families were reported to be "unexpectedly and overwhelmingly happy with community living, even those who formerly opposed the change" (p. 3).

Brown et al. (2001) acknowledged that individuals relocated lost some of those gains between 2000 and 2001, stating that a plausible explanation was that "low salaries and high turnover rates translate into poorly motivated and poorly trained staff" in the community, an issue confirmed by family members who stressed the "poor quality and the short tenure of direct care staff" (p. 50). The State of California spent only 55% of the previous institutional cost per person, compared to community spending levels in New Hampshire, Pennsylvania, and Connecticut ranging from 80% to 86% of their states' institutional costs (Brown et al., 2001; Conroy, 1996).

Many people with levels of impairment once believed to be manageable only in institutional settings now live satisfactorily in community settings. This includes individuals with health problems (Gaylord, Abery, Cady, Simunds, & Palsbo, 2005; Hayden, Kim, & DePaepe, 2005; Larson, Anderson, & Doljanac, in press) and with challenging behaviors (Hanson, Wiesler, & Lakin, 2002; Kim, Larson, & Lakin, 2001; Stancliffe, Hayden, Larson, & Lakin, 2002). Undeniably, anecdotal reports of instances in which community placements did not work out are occasionally cited by proponents of continuing institutionalization of persons with MR/DD. However, the institutionalization of persons who have committed no wrong against society can only be justified by demonstrating clear benefits accruing to these persons from living in an institution. *Research literature noted above clearly indicates that state institutions do not provide a superior level of care for people with mental retardation.*

Question #6: How do parents of individuals relocated from state institutions to community settings respond to this process of change?

Families often initially oppose the transfer of their relatives from institutions to community settings, but after transfer occurs, the great majority of parents become strong

supporters of community placement (Heller, Bond, & Braddock, 1988). Since the late 1970s several studies have addressed the reactions of parents of institutionalized persons to the community placement of their relative with mental retardation. The studies demonstrated that, after community placement, parents consistently reported lower levels of satisfaction with the earlier institutional placement and higher levels of satisfaction with community placement (Brown et al., 2001; Larson & Lakin, 1991).

Initial family dissatisfaction with closure often bears little relationship to family attitudes toward closure a year later. The relative's medical status and the family's worry over "transfer trauma" have often both played significant roles initially upon the announcement of the closure, but not in determining longer-term parent reactions. The primary variables affecting both parent satisfaction with closure and parent stress levels is the family's current appraisal of the quality of the new community placement. Frequent staff consultation with the family members during the closure process was related to higher parent satisfaction with closure one year later (Heller et al., 1988).

Given that some families might resist institutional closure and the relocation of their relative, it is important to assure families that increased consumer health and adjustment problems are now uncommon during and following institutional closures. This is due to implementing the relocation process with sensitivity to the consumer's needs and preferences and involving families directly in the process. The literature on family reaction to institutional closure and relocation may be summed up as follows:

> ...the clearest message in these studies is that the overwhelming majority of parents become satisfied with community settings once their son or daughter has moved from the institution, despite general predisposition to the contrary (Larson & Lakin, 1991, p. 36).

Question #7: How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

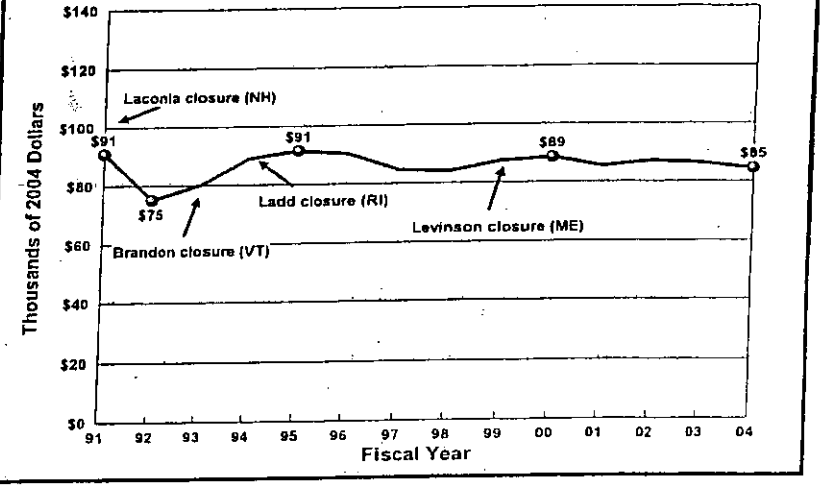
The closure of a state institution can generate savings for state government over time because it: 1) eliminates the high fixed cost of operating a state-owned facility, usually built for many more residents than live there at the time of closure; 2) shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI) and, in some cases, to local government sources; 3) increases the likelihood that individuals will engage in productive employment in a local community because they now live there; 4) utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expensive, specialized services provided in the institution; and, 5) by renting/leasing residences it avoids the expensive institutional capital construction and remodeling costs necessary for most older institutions to remain open and certified for receipt of federal reimbursement (Braddock, 1991a, 1991b).

In a relevant study of closure costs and savings, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) retained the services of an independent consulting firm to study the cost implications of its decision to close multiple mental retardation institutions. The study, authored by the Grant-Thornton accounting firm, concluded that the average post-closure per diem operating costs for each client "were approximately 9% lower than the pre-closure costs" (New York OMRDD, 1990). The study found that closure had little effect on state employee levels. Conversion of a state school campus to an alternate use such as a prison or juvenile facility provided substantial new employment opportunities and absorbed much of the economic impact of the state institution closure.

Another perspective on pre- and post-closure costs is afforded by the four New England states (Maine, New Hampshire, Rhode Island, and Vermont). These states, upon the closures of their last remaining institutions during 1991-99, became "institution-free"--like North Dakota would with the closure of Grafton. New Hampshire closed Laconia in 1991, Vermont closed Brandon in 1993, Rhode Island closed Ladd in 1994, and Maine closed Levinson in 1999 (Braddock et al., 2005).

An analysis of pre- and post-closure costs per residential recipient across 1991-2004 was completed. From the dates of the first closure (Laconia in 1991) through 2004, in inflation-adjusted terms, annual spending per statewide residential recipient in the four New England states declined from $91,000 to $85,000 (***Figure 5***). In addition, the number of aggregate MR/DD recipients served in the four states increased by 44% from 1991 to 2004. The number of recipients post-closure increased by 76% in New Hampshire, 50% in Rhode Island, 41% in Vermont and 30% in Maine.

FIGURE 5
AVERAGE ANNUAL RESIDENTIAL SERVICES SPENDING FOR MR/DD RECIPIENTS IN FOUR NEW ENGLAND STATES CLOSING THEIR ONLY MR/DD INSTITUTIONS, 1991-04



Question #8: Should the State of North Dakota anticipate a short-term need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

Without specific knowledge as to how a closure process might be implemented in North Dakota, including the nature of the phase-down of the physical plant and the duration

of the closure's implementation, it is difficult to provide an accurate estimate of "dual" costs associated with the closure. However, the state should anticipate some temporary dual costs. Assuming closure takes three years to implement (i.e., 2007-09), and that approximately 50 residents move to the community each of the three years, "dual" costs were estimated to be $3.1 million in the first year, $5.7 million in the second year, and $1.9 million in the third year. These estimates, totaling $10.7 million for the three year implementation period are based on the following two additional assumptions:

- The annual cost per relocated consumer in the new community settings in FY 2007 was assumed to be equivalent to the projected per diem cost at Grafton in FY 2007. This assumption permitted community direct support staff wages in 2007, the first year of closure implementation, to be comparable with Grafton's wages. Community direct support staff wage costs for FYs 2008 and 2009 were projected to increase at the average annual rate of increase in Grafton's per diem rates during FYs 1977-04 (2.6% per year on an inflation-adjusted basis).[1]
- Consumer per diems for those residents remaining at Grafton during the closure process will increase significantly in the second and third years, due to fixed costs being spread over fewer residents. We estimated the increased Grafton per diem rates based on the average increases in per diems in the New England comparison states to be 17% in year one, 51% in year two and 57% in year three.

However, as noted in the previous discussion for ***Question 7***, average inflation-adjusted statewide costs per resident receiving services in the consolidated four New England comparison states actually declined from 1995 to 2004. This was due to the fact that additional community recipients with lower average support needs were able to be served as well. North Dakota may experience a similar trend in average overall community costs in the long-term as well.

[1] Some studies, however, have indicated that community costs for individuals with MRDD who had comparable needs were only 55-86% of those in institutions (Brown et al., 2002; Conroy, 1996). These lower community cost estimates were not used to generate the community per diem estimates in favor of emphasizing the conservative assumption of equalizing FY 2007 direct support staff wages in community settings with Grafton's projected FY 2007 staffing costs.

Question #9: What are some of the alternate uses to which a closed Grafton facility might be put?

Alternate uses possible for the Grafton physical plant depend upon the facility's proximity to projected population growth areas, the adaptability of the facility to alternate public or private use (e.g., prison, factory, state or industrial warehouse, etc.), and other factors. ***Table 1*** presents a summary of the various alternate uses for 130 developmental disabilities institutional closures in the U.S. See ***Appendix I*** for additional detail on each of the facilities that closed.

TABLE 1: ALTERNATE USES FOR INSTITUTIONAL CLOSURES IN THE U.S.

Alternate Use	Number[1]	Alternate Use	Number[1]
Corrections (including federal corrections)	22	New MR facilities	2
DD or other state/local administrative offices	15	Unoccupied (asbestos)	2
Alternate use not yet known	9	Private institutions	2
Universities/junior colleges	9	Historic preservation	1
Property vacant	9	Housing	1
Various community uses	6	Public health infirmary	1
Community DD programs	5	Retirement program	1
To be sold (including realty, public auction)	5	Reverting to U.S. Department of Defense	1
Commercial uses	4	Veterans' medical center	1
MI facilities	4	Water survey office	1
Demolished	3	Women's prison	1
Juvenile facilities	3	Undetermined	29

[1]Total is 137--7 institutions had two alternate uses

The four New England closures demonstrate the range of possible alternate uses displayed in ***Table 1***. The Laconia State School in New Hampshire was quickly reopened in 1991 as the Lakes Region Adult Correctional Facility. The town of Laconia (population 16,411) is 30 miles from Concord (population, 40,687). Brandon Center in Vermont, closed in 1993, is near Rutland (population 17,292) which is 85 miles from Colonie, New York (population 79,258). The closed facility is currently under development as a manufacturing site, with both private and state ownership.

The Ladd Center in Rhode Island, closed in 1994, was located in Exeter (population

6,045), 13 miles from Warwick (population 85,808) and was also proximal to Providence, a large city. A $6.4 million state fire academy and new state police headquarters is being developed on the Ladd Center site. The Elizabeth Levinson Center in Maine closed as a state institution in 1999 and now operates as a state-run short-term residential and health program for medically fragile children. Levinson, in Bangor (population 31,473) is 129 miles from Portland (population 64,249). Like North Dakota, the institutions in New Hampshire and Vermont were located in small towns, somewhat distant from a larger city. Grafton, a town of 4,516, is located 38 miles from Grand Forks.

Question #10: What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

In 1983, Illinois successfully relocated the 820 residents of the Dixon State School within a single calendar year. More than 90% of the parents were satisfied with the closure process and outcomes. Resident friendship patterns were kept intact by moving small groups of individuals together and by closing down one residential unit at a time (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986).

Guidelines based on state experiences in MR/DD institutional closures are summarized in ***Appendix II.*** They are presented from five perspectives: 1) general guidelines; 2) the individuals with developmental disabilities who are being relocated; 3) their families; 4) the community programs receiving residents from the closing facility; and 5) the staff of the closing facility. The guidelines were revised from Braddock et al. (1983) and Heller, et al. (1986).

CONCLUSION

In three previous analyses of the structure, financing and quality assurance of residential and community services in North Dakota, Braddock & Hemp (2004, 2000) and Braddock, Hemp, & Rizzolo (2002) suggested service and funding priorities for the State. For example, it was noted that North Dakota had fared better than most states fiscally in the recent national economic downturn during 2003-2005, and North Dakota was one of 10 states with the strongest financial outlook for fiscal year 2005. Priority needs for MR/DD services identified in the most recent North Dakota study included: 1) continuing the expansion of the Medicaid Home and Community-Based Services (HCBS) Waiver; 2) reducing reliance on Intermediate Care Facility/Mental Retardation (ICF/MR) programs for 16+ person public and private institutional facilities; 3) increasing family support, supported employment and supported living; and, 4) enhancing direct support staff wages and benefits (Braddock & Hemp, 2004, p. 50).

Nationwide, there are over nine times more individuals with mental retardation and developmental disabilities living in supervised out-of-home community settings than in state-operated institutions. The number of families and persons with disabilities benefiting from community services and supports nationally is growing as well. State-operated institutions are being closed in many states across the country and few families prefer such programs. Thus, given the trends outlined in this paper, the long-term future of services to persons with mental retardation and developmental disabilities in North Dakota is in community settings.

It therefore seems appropriate for North Dakotans to seriously consider expanding community residential services and support programs for people with MR/DD and their families, and subsequently closing the North Dakota Developmental Center at Grafton.

However, if Grafton is slated for closure, the implementation of that closure needs to be planned and executed in a manner sensitive to the needs of Grafton's consumers and their families and considerate of the employees of the facility as well. As previously noted, suggested guidelines specifically addressing closure implementation issues are presented in *Appendix II.*

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APPENDIX I
COMPLETED AND IN-PROGRESS CLOSURES OF STATE-OPERATED 16+ INSTITUTIONS IN THE U.S. (139 CLOSURES IN 39 STATES)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Alabama	Brewer-Bayside	1984	MR Facility	67	2003	Corrections
	Glenn Ireland	1986	MR Facility	20	1998	To be sold
	Tarwater	1976	MR Facility	74	2003	Corrections
	Wallace	1970	MR Facility	80	2003	Corrections
Alaska	Harborview	1964	MR Facility	45	1997	Community Programs
Arizona	Phoenix	1974	MR Facility	46	1988	Commercial
	Tucson	1972	MR Facility	13	1997	Outreach Offices
California	Agnews	1855/1966	MI Facility	411	2007	Undetermined
	Camarillo	1935	MR Facility	497	1998	University
	DeWitt	1942/1947	Army Hospital	619	1972	Placer County Recreation
	Modesto Unit	1943/1948	Army Hospital	1,394	1969	Modesto Co. Comm. College
	Napa	1875/1967	Asylum for MR/MI	30	2001	MI Use Only
	Stockton	1852	Asylum for MI	414	1996	University
Colorado	Pueblo	1935	MI/MR Facility	163	1989	Pueblo Regional Center
Connecticut	John Dempsey Center	1964	MR Facility		1998	Administrative Offices
	Mansfield	1906/1917	Epileptic Colony	146	1993	Corrections/U. of Connecticut
	New Haven	1964	MR Facility	56	1994	Job Corps
	Seaside	1961	MR Facility		1998	Administrative/Storage
	Waterbury	1963/1972	Convent	40	1989	Administrative Offices
DC	Forest Haven	1925	MR Facility	1,000	1991	Private Rehab/PH Infirmary
Florida	Community of Landmark	1965	MR Facility	256	2005	Revert to Dade County social programs
	Gulf Coast Center	1960	MR Facility	306	2010	Undetermined
	Orlando	1929/1959	TB Hospital	1,000	1984	Demolished, land to school, county
	Tallahassee	1928/1967	TB Hospital	350	1983	Unoccupied: asbestos
Georgia	Bainbridge	1967	WW II Air Force School	129	2001	Corrections
	Brook Run	1969	MR Facility	364	1997	Undetermined
	Georgia Regional-Augusta			438	2004	Undetermined
	Gracewood School/Hospital			93	2004	Undetermined
	Rivers' Crossing	1969	MR Facility	37	1994	Undetermined
Hawaii	Kula Hospital (privatized)	1984			1999	
	Waimano	1921	MR Facility	96	1999	Art Center for PWD
Illinois	Adler	1967	MI/MR Facility	16	1982	Water Survey Offices
	Bowen	1965	MR Facility	105	1982	Corrections
	Dixon	1918	MR Facility	820	1987	Corrections/New MR Facility
	Galesburg	1950/1969	Army Hospital	350	1985	Head Start/Community Programs
	Lincoln	1877	MR Facility	153	2004	Vacant*
	Meyer	1966/1970	MI Facility	53	1993	Women's Prison
	Singer	1966	MI Facility	45	2004	Undetermined
Indiana	Central State	1848	MI/MR Facility	83	1994	Undetermined
	Ft. Wayne	1879	MR Facility	120	2007	To be demolished
	Muscatatuck	1920	MR Facility	287	2005	Undetermined
	New Castle	1907	Epileptic Village	200	1988	Corrections
	Northern Indiana	1943	MR Facility	53	1998	Undetermined
Kansas	Norton	1926/1963	TB Hospital	60	1988	Corrections
	Winfield	1886	MR Facility	250	1998	Undetermined
Kentucky	Frankfort	1860	MR Facility	650	1972	Demolition
	Outwood	1922/1962	TB Hospital	80	1983	Demolition/New Campus
Maine	Aroostook	1972			1995	
	Levinson	1971			1999	
	Pineland	1908	MR Facility	265	1996	Undetermined
Maryland	Victor Cullen	1908/1974	TB Hospital	79	1991	Private Juvenile Facility
	Great Oaks	1970	MR Regional Center	273	1997	Private Senior Retire. Community
	Henryton	1928/1962	TB Hospital	312	1985	Undetermined
	Highland Health	1870/1972	General Hospital	88	1989	Sold to Johns Hopkins University
Massachusetts	Belchertown	1922	MR Facility	297	1992	Vacant
	John T. Berry	1900/1963	TB Sanitarium	101	1995	Undetermined
	Paul A. Dever	1940/1946	P.O.W. Camp	294	2001	Undetermined
	Femald	1848	MR Facility	274	2007	Undetermined
Michigan	Alpine	1937/1959	TB Hospital	200	1961	Notsego County Offices
	Caro	1914			1998	
	Coldwater	1874/1939	Orphanage	113	1987	Corrections
	Fort Custer	1942/1956	Army Hospital	1,000	1972	Back to U.S. Dept. of Defense
	Hillcrest	1905/1961	TB Hospital	350	1982	Demolition
	Macomb-Oakland	1967/1970	CDA	100	1989	Reverted to Community Dev.
	Muskegon	1969	MR Facility	157	1992	Vacant
	Newberry	1896/1941	MI Facility	39	1992	Vacant
	Northville	1952/1972	MI/MR Facility	180	1983	Revert to MI Use
	Oakdale	1895	MR Facility	100	1991	Vacant/County Negotiating
	Plymouth	1960	MR Facility	837	1984	County/State Offices
	Southgate	1977	MR Facility	55	2002	Undetermined

APPENDIX I (CONTINUED)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Minnesota	Brainerd	1958			1999	
	Faribault	1879	MR Facility	501	1998	Portion used by Corrections
	Fergus Falls	1888/1960	Asylum for MI	38	2000	Regional MH Center
	Moose Lake	1938/1970	Psychiatric Hosp	34	1993	Corrections
	Owatonna	1895/1947	Orphanage	250	1970	Abuse
	Rochester	1879/1972	MI Facility	150	1992	Federal Corrections
	St. Peter	1868			1996	
	Willmar	1973			1986	
Missouri	Bellefontaine	1924	MR Facility	341	2005	Undetermined
Montana	Eastmont	1960/1979	Residential School	26	2003	Nursing Facility
New Hampshire	Laconia	1903	MR Facility	4	1991	Corrections
New Jersey	Edison	1975/1981	Corrections	70	1988	Sold at public auction
	Johnstone	1955	MR Facility	239	1992	Corrections
	North Princeton	1898/1975	Epileptic Colony	512	1998	Undetermined
New Mexico	Fort Stanton	1964	Army Apache Outpost/TB H	145	1995	Skilled Nursing/Respite
	Los Lunas	1929	MR Facility	252	1997	Community Based Program MR/DD
	Villa Solano	1964/1987	Missile Base	82	1982	Housing
New York	J.N. Adam	1912/1967	TB Hospital	180	1993	Undetermined
	Bronx	1977	MR Facility	217	1992	Plans Not Final
	Craig	1896/1935	Epilepsy Hospital	120	1988	Corrections
	Gouverneur	1982	MR Facility	N/A	1978	Leased site
	O.D. Heck	1972	MR Facility	274	1999	Administrative Offices; non-profit use
	Letchworth	1911	MR Facility	704	1996	Undetermined
	Long Island	1965	MR Facility	682	1993	Undetermined
	Manhattan	1919/1972	Warehouse	197	1991	OMRDD Office
	Newark	1878	Custodial Asylum	325	1991	Community College
	Rome	1825/1894	County Poorhouse	638	1989	Corrections
	Sampson	1860/1961	Naval Base	695	1971	Office of Mental Health
	Staten Island	1942/1952	Army Hospital	692	1987	OMRDD & Community College
	Sunmount	1922/1965	TB Hospital	503	2004	OMRDD Specialty Units
	Syracuse	1851/1972.	MR Facility	409	1997	Undetermined
	Valatie	1971	MR Facility	N/A	1974	Private Holdings and ICFs/MR
	Westchester	1932/1979	MI Facility	195	1988	Office of MH
	Wilton	1960	MR Facility	370	1995	Sold to private industry
North Dakota	San Haven	1922/1973	TB Hospital	86	1987	Vacant
Ohio	Apple Creek	1931	MR Facility	178	2006	Undetermined
	Broadview	1930/1967	TB Hospital	178	1992	City Administration Building/Retirement
	Cleveland	1855/1963	MI Facility	149	1988	Vacant/Negot. with City of Cleveland
	Orient	1898	MR Facility	800	1984	Corrections
	Springview	1910/1975	TB Hospital	86	2005	Undetermined
Oklahoma	Hissom	1967	MR Facility	451	1994	Corrections/Educational
Oregon	Columbia Park	1929/1963	TB Hospital	304	1977	College
	Eastern Oregon	1929/1963	TB Hospital	240	1984	Corrections/Opened New MR Facility
	Fairview	1907	MR Facility	327	2000	Light commercial/housing
Pennsylvania	Altoona	1975	MR Facility	90	2005	Undetermined
	Cresson	1912/1964	TB Hospital	155	1982	Corrections
	Embreeville	1880/1972	County Poorhouse	152	1998	Undetermined
	Hollidaysburg	1974	MR Facility	60	1976	Revert to MI Use
	Laurelton	1920	MR Facility	192	1998	Undetermined
	Marcy Center	1915/1974	TB Hospital	152	1982	Vacant
	Pennhurst Center	1908	MR Facility	179	1988	Veterans' Medical Center
	Philadelphia	1963	MI/MR Facility	60	1989	Vacant
	Western	1962		133	1999	
	Woodhaven	1974	MR Facility	N/A	1985	Became private institution
Rhode Island	Dix Building	1945/1982	WPA	80	1989	Corrections
	Ladd Center	1907	MR Facility	292	1994	Undetermined
South Carolina	Clyde Street	1973	Home for unwed mothers	20	1995	Administrative Offices
	Live Oak	1987	Nursing home	50	1999	To be sold
South Dakota	Custer	1964	TB Hospital	76	1996	Boot camp for delinquent boys
Tennessee	Winston	1979			1998	
Texas	Forth Worth	1976	MR Facility	339	1995	Undetermined
	Travis	1934	MR Facility	585	1997	Undetermined
Vermont	Brandon	1915	MR Facility	26	1993	For Sale, Local Realty
Washington	Interlake School	1946/1967	Geriatric MI	123	1995	Other State Agency
West Virginia	Colin Anderson	1920s	MR Facility	85	1998	Possible Juvenile Corrections
	Greenbrier	1801/1974	Women's College	56	1994	Community College
	Spencer	1893	MI/MR Facility	150	1989	Vacant/Possible Corrections
	Weston	1864/1985	MI/MR Facility	99	1988	Revert to MI Use
Wisconsin	Northern Wisconsin Ctr.	1897	MR Facility	173	2005	Intensive Treatment/Dental

*Four 10-bed "grouphomes" to be built on the Lincoln, Illinois site, to be named "Lincoln Estates."

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

APPENDIX II
SUGGESTED PRELIMINARY GUIDELINES FOR INSTITUTIONAL CLOSURES

Institutional closure affects "sending" facility staff (staff at the institution that is closing), the "receiving" community staff and their agencies, and, of course, the individuals with disabilities and their families who are most affected. These guidelines were primarily adapted from closures at the Dixon and Galesburg Centers in Illinois (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986)

There are five sections in the Guidelines:

I. General Guidelines
II. Individuals Moving from the Institution
III. Families and Guardians
IV. Community Programs
V. Personnel of the Closing Facility

I. GENERAL GUIDELINES

1. Evaluate the Closure Systematically and Longitudinally

Develop a plan to evaluate (study) the closure of Grafton, first from the standpoints of the residents and their families but also from the standpoint of the impacted staff and the local community in which Grafton is situated. Use this evaluative information to help increase the likelihood of positive long-term impacts on consumers, employees, and communities. Announce the study at the same time the closure is announced. It should continue for at least two years after the last resident is moved to the community.

2. Seek Out Knowledge From Other States' Experiences with Institutional Closure

Many states have a great deal of experience with closing institutions for people with MR/DD. Seek out that experience if you choose to close Grafton.

II. GUIDELINES FOR INDIVIDUALS MOVING FROM THE INSTITUTION

1. Minimize Resident Transfer Trauma by Implementing an "Anticipatory Coping Strategy"

- Close Down Institutional Cottages or Units One at a Time;
- Keep Resident Groups and Friends Intact;
- Minimize Internal Transfer of Residents and Staff in the Closing Facility;

- Conduct Preparatory Programs for Consumers. This should include site visits to the new residential settings, as desired by the individuals, and in respect to any support needed based on their level of functioning; and,
- Involve Consumers Personally in Choosing Their Roommate(s) and Their New Community Home and Support Network.

2. Transfer Staff with Those Moving From the Institution

Determine whether institutional staff can be employed at community programs with individuals with developmental disabilities who know them and who are relocating to those programs.

3. Adopt a Relocation Assessment Process with an Appeal Mechanism

- Level One: Identification of an Alternative Plan

  The sending facility and state agency staff recommend a receiving program in the community for each resident based on service and support needs, preferences of the individual and/or the legally responsible persons, and availability of community resources.

- Level Two: Development of an Individual Services Plan

  A service plan is developed by the receiving program staff in collaboration with the sending facility staff. Minimizing internal transfers at the sending facility will improve the quality of information transmitted, as staff most familiar with the individuals moving would be available to provide the necessary input into the plans. The community agency staff has the final discretion in writing the plan.

- Level Three: Conference with Legally Responsible Person

  Prior to relocation, a meeting is offered at the community program with the legally responsible family member or guardian, if desired, to review with the community program staff the individual service plan. Closing facility staff may also participate in the meeting.

- Level Four: Appeal Process Available to Legally Responsible Person

  The legally responsible parent or guardian can object to the transfer plan if he or she believes it does not meet the individual's habilitation, support or medical needs. An appeal process is a necessary "relief mechanism."

III. FAMILY AND GUARDIAN GUIDELINES

1. Consultation with Closing Facility's Parents' Association

If a closure is decided upon, the state agency should promptly request permission to address the facility's parents' association. Meetings should be held, as necessary, to explain the closure process and to deal with problems that might arise during the relocation process. It is wise to acknowledge upfront to parents at both the sending facility, and to the community programs, that the relocations may temporarily disrupt routines at the institution and the community programs and in the lives of the individuals being relocated and their families. Every attempt to minimize this disruption should be made.

The state agency representative should convey to parents her or his willingness to work out solutions. It is also important for community program parents to be engaged to help provide a receptive environment for the relocated individuals and their families.

2. Involve Parents Who Have Been Through the Process

Parents involved in a successful institutional closure from a nearby state with such experience may be invited to the initial closure discussions with state agency representatives and with the closing facility parents' association. This can help reduce family anxiety and build support for the positive opportunities that a well-planned relocation can bring to their relatives.

3. Family/Guardian Notification

Individualized notification of families and guardians can serve to reduce anxiety and build support for individuals' planned relocations. Immediately upon the announcement of closure or phase-down, notification letters are sent to family members or guardians providing the following information.

- A rationale for the closure;
- The approximate time-frame;
- Anticipated positive aspects of the change;
- Types of community programs that will be available;
- Family and guardian options for alternative community programs;
- Reaffirmation of the state's commitment to serve the individual throughout relocation;
- Description of the four-level relocation assessment process--what will happen next; and,

- Name and phone number of a contact person designated by the state agency.

  Follow-up is continued through telephone contact reiterating essential information that was in the letter of notification and soliciting family or guardian participation in the individual's relocation to the community program.

4. Encourage Family Involvement

The following six steps can be employed to involve the families meaningfully in the process:

- Hold Informational Sessions at the Sending Facility

  Invite families to informational sessions at the sending (closing) facility. Representatives of the receiving community programs should also make presentations about their programs for the families.

- Open House at Community Programs

  Most community agencies operate a range of residential, day, work, and other support services. Invite families to an open-house at each receiving agency so that they have access to the appropriate information about the programs their family member is likely to be involved in.

- Parents at the Receiving Community Agencies. Contact families at the sending institution to offer assistance, inviting them for individualized or small group visits.

- Set Up a Family Buddy System at the Community Agency

  This system connects community agency families with the new families before, during and after the relocation.

- Family and Guardians Should be Present During the Actual Relocation if Desired

- The Community Agency Should Contact Families and Guardians to Inform Them When the Relocation is Scheduled and Invite Them to be Present. (The community agency parent buddy should also be present if possible.)

IV. COMMUNITY PROGRAMS RECEIVING RESIDENTS FROM THE CLOSING FACILITY

1. Develop Consistent Entry Criteria

Develop systematic criteria for accepting residents at each receiving program and communicate these clearly with sending facilities and family/guardians. Encourage pre-placement visits to the receiving programs by staff, consumers with disabilities, and families to enable them to evaluate the program's appropriateness.

2. Provide Staff Training

Prepare incumbent staff and personally orient new staff to the consumers who will be moving in. Often the persons coming from closing facilities are lower functioning, medically fragile, or have challenging behaviors. Without sufficient training, staff may lack the specific knowledge and skills to properly support some of the individuals moving.

3. Involve Receiving Programs in Planning

Once closure has been scheduled, involve receiving program representatives early in the planning process and keep them involved and well-informed.

4. Establish Mental Health Back-Up Supports

Mental health back-up supports to community residences should take the form of a troubleshooting group of trained and experienced professionals drawn from the state facility and community agencies. A "behavioral unit" at one of the community programs or at a state mental health center could function as a temporary placement until appropriate, permanent back-up programs are established in the community and/or state mental health center.

5. Develop Public Relations and Education Programs for Communities

Community providers and state agency personnel can enlist community support by attending meetings with persons and groups in the receiving communities. These meetings could be held at churches, schools, or informally with immediate neighbors, to educate and reassure.

6. Establish Relationships with Local Resources

Some new community residences may need to establish relationships with such local resources as the fire department, health providers, and public safety offices. Specific recommendations for local resources include the following topics:

- Testing, counseling and behavioral support for community mental health providers;
- Updated treatment and medication training for physicians and hospitals on topics such as challenging behavior, seizures, and motor problems;

- Dental monitoring and treatment techniques for neighborhood dentists; and,
- General orientation to developmental disabilities for firemen, police, recreation facilities.

7. Provide Financial Incentives for Community Residential Development

Community placements will be greatly facilitated by financial incentives for community programs. The Medicaid Home and Community-Based Services (HCBS) Waiver has been used successfully in most states.

8. Facilitate Development of Needed Support Services in the Community

Closure affords the opportunity for the development of necessary community services "infrastructure." For example, expanded supported living and supported employment programs for individuals moving from the institution will be needed.

V. PERSONNEL GUIDELINES

1. Plan Ahead Beginning Early in the Process

Develop a plan for future staffing patterns as individuals are relocated, conduct surveys of employee desires for transfer, and determine clear personnel policies early in the closure process. Do not promise employees what cannot be delivered.

2. Terminate One Unit at a Time and Minimize Internal Transfers

Close down one unit, wing, ward, or cottage at a time when possible and determine the schedule ahead of time, not during implementation. Closing down one component at a time keeps groups of individuals with developmental disabilities and familiar staff together, and can also result in increased administrative efficiency and cost savings.

3. Minimize Employee "Bumping"

"Bumping" (whereby staff working elsewhere in a state agency have more seniority and can replace less senior employees) should be avoided or at least minimized during the closure process. Bumping destroys program continuity in the closing facility at precisely the moment individuals being relocated need it most, with a deleterious effect on individuals who have developed interdependent relationships with staff over a long period of time.

4. Establish Employee Counseling Service

Establish an employee counseling and job placement service at the closing facility as soon as the closure is announced and becomes evident to staff. This service

would include individual counseling, workshop training, job relocation and transfer planning, job fairs, resume writing, and retirement planning.

5. Conduct Early and Continuing Briefings for Staff

Have a representative of the state agency or the state's personnel department present comprehensive briefings to facility staff when closure is announced. The briefings should announce the initiation of the employee counseling service, and fully discuss employee rights, benefits, and realistic expectations concerning layoffs, employee transfers, and retirement.

6. Develop an Open Door Policy

Develop clear lines of communication between management and all levels of staff at the closing facility.

7. Establish Liaison with Other Departments and Facilities

Establish positive working relationships with the other major employers in the closing facility's community, and in neighboring municipalities.

8. Adopt as Many Staff Incentives as Possible

Consider using one or more of the following incentives for staff in the closing facility:

- Early Retirement Inducements
- Staff Retraining

  In particular, develop staff retraining programs for community-based services employment.

- Extended Health Coverage

  Temporarily extend health insurance benefits for laid-off workers and their families throughout the first year if the workers remain unemployed.

- Adopt a Priority Interviewing Policy at Community Agencies

  Implement a priority for community agencies to interview staff from the closing facility, but give the community agency complete latitude to judge an employee's potential for working at the agency.

- Payment of Moving Expenses

Consider paying a pre-designated sum of money for moving expenses for employees transferring to MR/DD community agencies or to other MR/DD-related employment in North Dakota that is beyond 30 miles from Grafton.

9. Develop/Distribute Newsletter

Develop a periodic newsletter, perhaps monthly, and distribute it to staff at the closing facility and at the community agencies receiving individuals from the closing institution. A newsletter is useful in dispelling rumors and improving communication between the supervisory staff at the closing facility and employees affected by the closure. Rumors breed anxiety in staff and this can be transmitted to individuals who are undergoing the relocation to community agencies. The newsletters should include time tables, administrative policies including changes in policy, information about employees receiving new positions, job search information, and where to obtain counseling or other services.

10. Use a Participatory Management Approach

Involve top management and employee unions (if applicable) in the initial and ongoing planning for the closure. Make it clear to them that they cannot change the fact that closure is going to happen, but that they can and should influence and help make the decisions about the best way to carry out the closure and implement the relocation process.

-Attachment FIVE

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Testimony on SB No. 2012
House Appropriations Committee
March 8, 2011

Chairman Pollert and Committee Members, I'm Courtney Koebele and I serve as the Director of Advocacy of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

First of all, on behalf of North Dakota's physicians I thank you for your efforts last legislative session. Your rebase of Medicaid payments for medical services provided a significant increase in payments bringing those payments closer in line with what it actually costs to provide those services. With respect to physician payments, the rebase accomplished 75% of what it would take to bring payments to 100% of cost, using the methodology adopted prior to the last session by the ND Department of Human Services. Since 2002, we had expressed the concern of North Dakota's medical community that the Medicaid payment methodology had resulted in payments being substantially less than the actual cost of providing medical services to our Medicaid patients.

Our physicians in North Dakota provide the safety net medical services for the most vulnerable of our population – a population of Medicaid patients who present unique, and often some of most difficult, challenges. Our Medicaid patients benefit from the services physicians are able to provide them – from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we also have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – and our costs for medical equipment, new technology and supplies continue to increase.

The rebase accomplished in the last session and again reflected in the 2011-13 executive budget provide substantial assistance toward helping to address some of these issues.

The North Dakota Medical Association supports the 2011-13 executive budget and the 3% inflationary increases. At the same time, we encourage you to consider further investments that would better reflect the intent to rebase to 100% of cost pursuant to the statement of legislative intent adopted in the Department's 2009 budget bill (2009 HB 1012), and a legislative commitment to ensuring future access to physician services for Medicaid patients. Section 13 of 2009 HB 1012 provided:

> **SECTION 13. LEGISLATIVE INTENT - MEDICAID PROVIDER PAYMENTS.** It is the intent of the legislative assembly that the department of human services establish a goal to set Medicaid payments for hospitals, physicians, chiropractors, and ambulances at 100 percent of cost.

The Department budget included an optional adjustment request for an appropriation of state and federal funds to do additional work to develop methodologies that would support an additional rebase to cost. As one option, NDMA supports the inclusion of the optional adjustment request in the 2011-13 budget.

Physicians in North Dakota continue to do their part in providing good access to quality medical care for Medicaid beneficiaries and showing their ongoing commitment to the long-term sustainability of the Medicaid program. We look forward to working with the Committee in addressing the future needs for Medicaid medical services. Thank you.

-Attachment SIX

Testimony on SB 2012
House Appropriations — Human Resources Division
March 8, 2011

Good Morning Chairman Pollert and members of the House Appropriations — Human Resources Division. My name is Shelly Peterson representing the North Dakota Long Term Care Association. We represent assisted living facilities, basic care facilities and nursing facilities in North Dakota. I am here to testify in support of SB 2012.

I am here to testify in support of the three percent inflator recommended for providers in SB 2012. This will help us address rising costs, recruit and retain quality caregivers and maintain outstanding quality service.

SB 2012 is a comprehensive budget that provides care and services to North Dakota's poor, frail, disabled and elderly population. This budget proposed a 3% annual increase on rates/services to care for this at risk population.

The cost to provide the 3% for basic care residents on Medicaid is $800,000 in state general funds and $4.9 million for nursing facility residents on Medicaid.

Before I outline why the 3% is desperately needed, I would like to outline a fact sheet on long term care.

At the conclusion of my testimony I would like to introduce Mitch Leupp, the Administrator of Mountrail Bethel Home in Stanley, North Dakota. Mitch represents the full continuum of acute care and long term care and would like to give the committee the real life perspective of operating a health system in rural west-central North Dakota.

Why is the 3% Annual Inflator Needed?

1. Rising Costs

Overall nursing facility costs increased from June 30, 2009 to June 30, 2010 by 10.2%. This increase is based upon nursing facility cost reports filed with the North Dakota Department of Human Services. For the past three years, the actual cost to provide care to nursing facility residents has averaged 7.8% annually. Our costs are increasing at a greater rate than the inflationary adjustments provided by the legislature. Why?

- Annual increases in wages, health insurance and pension plan (70% of costs).
- More use of agency/contract nursing.
- Increased property, general and professional liability insurance.
- Increased cost of heating and cooling facility.
- Increased cost of food, medical supplies, OTC drugs, pharmacy consultant and medical director.

2. Recruit and Retain Quality Caregivers

The top issue facing nursing facilities is staffing. It is estimated long term care facilities employ a total of 14,434 people. On October 1, 2010 we estimated basic care and nursing facilities had 894 vacant positions.

CNA turnover in nursing facilities is the second highest ever recorded at 62%. Nursing is the highest ever recorded at 32% for LPNs and 40% for RNs. Dietary is also at the highest ever recorded at 57% annually.

In northwestern North Dakota, staffing is a major crisis and facilities are finding it nearly impossible to secure sufficient staff. Statewide 34% of nursing facility staff are age 50 or older, with the oldest staff person being a 97 year old dietary aide. Almost two out of five nursing facilities contracted with nursing agencies in 2010 to deliver daily resident care. In the current biennium, it is estimated that $6 million will be spent on contract staff.

3. Maintain Quality Service

We believe and data shows North Dakota providers give some of the most outstanding quality of care in the United States. According to satisfaction surveys of residents and families and quality measures of key outcomes, North Dakota ranks in the top.

On average our staffing ratios exceed national averages and we continually strive to exceed resident and family expectations.

Summary

A number of long term care facilities are experiencing financial stress. In 2010, Westhope Home closed a 25 bed skilled nursing facility and ten days ago the Good Samaritan Society closed Rock View at Parshall, a 30 bed skilled nursing facility.

On behalf of the 85 skilled nursing facilities and 64 basic care facilities and the 16,000 individuals receiving care this past year, we encourage you to fund the 3% annual inflator provided in SB 2012.

Thank you again for the opportunity to testify on SB 2012. I would be happy to answer any questions you may have.

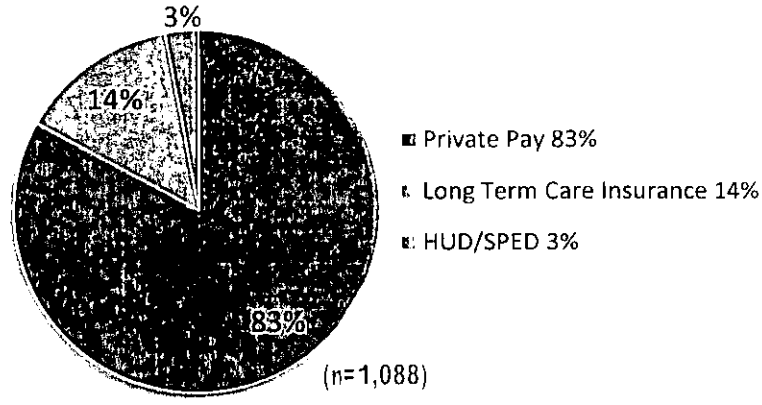
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Assisted Living Facilities

Assisted Living Facilities at a Glance:

- 71 licensed assisted living facilities
- 2,595 licensed units
- 2010 average daily rate is $97
- 2010 average occupancy is 94%

Who Pays the Bill in Assisted Living Facilities



Assisted Living Facts:

- A congregate residential setting with individual private apartments where you contract for specific services.
- Services are contracted for al-carte based upon an agreed upon service plan.
- A basic rental package generally includes three daily meals, housekeeping, activities, transportation, cable TV, laundry and snacks.
- Generally all facilities provide a full range of services from bathing to medication management to hospice care.
- Physical decline is the top issue precipitating the desire to move into an assisted living facility.
- Current tenants range in age from 55 to 106 years old, with the average age being 86.

Care Needs of Assisted Living Tenants:

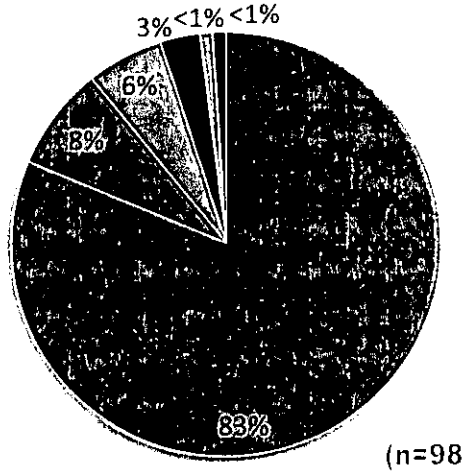
- 30% of tenants have impaired mental status, ranging from confusion/forgetful to a mental health diagnosis.
- 45% of tenants need full assistance with medication administration.
- Most tenants are fully independent in eating (91%), transferring (90%), toilet use (88%) and dressing (70%).
- About one-third of tenants periodically use the assistance of a walker.

Assisted Living Facilities (continued)

When Individuals Move Into an Assisted Living Facility, Where Did They Come From?

Most individuals were living in their own home prior to moving into an assisted living facility.

Living Arrangements Prior to Move-In

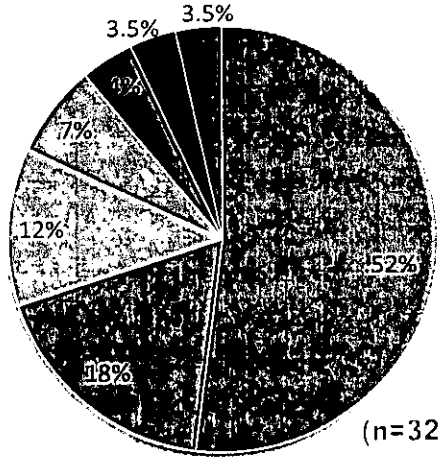


(n=986)

When Tenants Move-Out, Where Do They Go?

Over half of tenants moving out of assisted living facilities are admitted to a skilled nursing facility. Generally, advancing medical needs and growing cognition issues necessitate the move to a higher level of care.

Move-out Destination

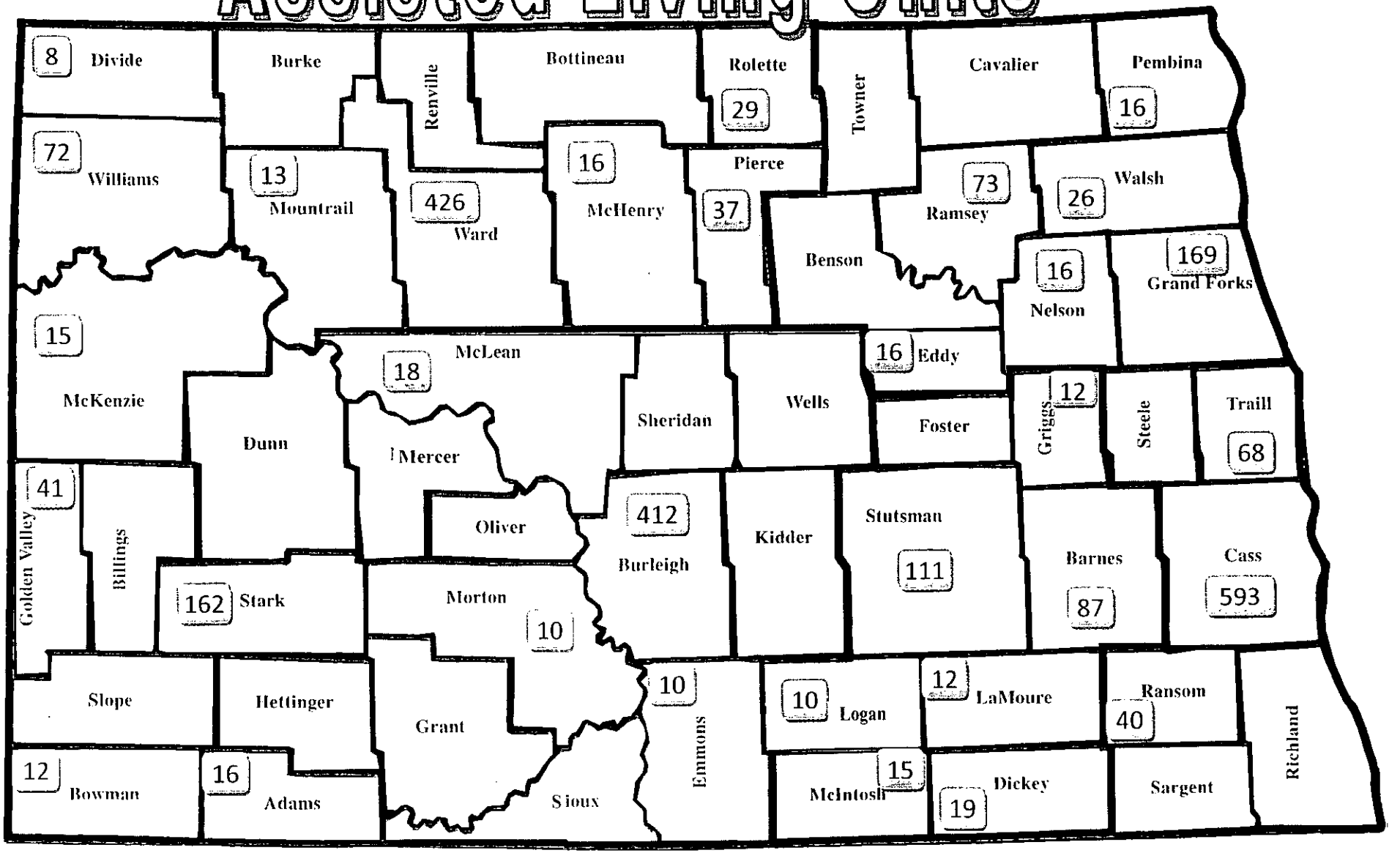


(n=323)

Assisted Living Cost:

- In 2010, the average charge for rent in a one bedroom assisted living facility was $1,776 per month ($21,312/year), with a range of $530-$2,858.
- The average cost for services in an assisted living facility ranged from $300 to $2,350 per month, with an average of $1,162 per month ($13,944/year).
- The cost of a assisted living is highly dependent on the size of the living space, location in North Dakota and the amenities in the rental package.
- Almost 60% of facilities responding to the survey felt rent assistance for low and moderate income individuals should be made available to assisted living tenants.

Assisted Living Units



Seventy-one licensed assisted living facilities as of January 18, 2011

Purple Box – Number of licensed assisted living units as of January 18, 2011 (total licensed units = 2,580).

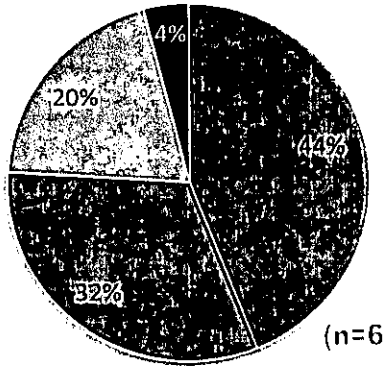
North Dakota Long Term Care

Basic Care Facilities

Basic Care at a Glance:

- 65 licensed basic care facilities
- 1,777 licensed beds
- 2010 average daily rate is $97
- 2010 average occupancy is 83%

Payment Source for Basic Care Bills



(n=669)

Basic Care Facts:

- A congregate residential setting with private and semi-private rooms where you receive 24-hour supervision with a comprehensive service plan to meet your needs.
- Basic care provides an all inclusive rate providing room, meals, personal care services, supervision, activities, transportation, medication administration, nursing assessment and care planning.
- Seventy percent of residents are female and the majority were living in their own home prior to admission.
- Cognitive decline is the top issue precipitating the need for placement.
- Current residents range in age from 23 to 104 years old, with the average age being 78.

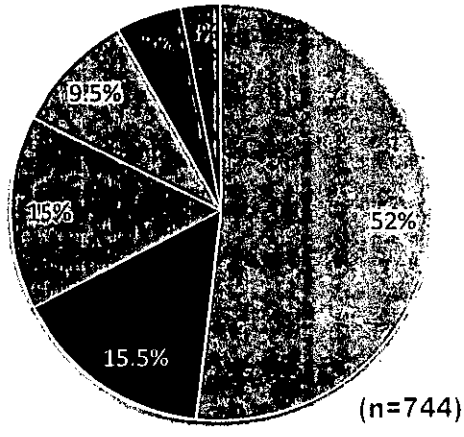
Care Needs of Basic Care Residents:

- 72% of residents have impaired mental status, ranging from early state dementia to significant mental health issues.
- 85% of residents need full assistance with medication administration.
- Over one-third of residents (35%) are receiving psychoactive drugs.
- Most residents are independent in dressing (60%), with less than 10% requiring extensive assistance (8.6%).
- 81% of residents need assistance in bathing.
- Most residents are fully independent in eating (88%), toileting (80%) and transferring (92%).
- 60% are ambulatory and do not need any staff assistance, 48% use a walker and very few use a wheelchair (7%).

Basic Care Facilities (continued)

When Individuals Move Into a Basic Care Facility, Where Did They Come From?

Living Arrangements Prior to Admission



(n=744)

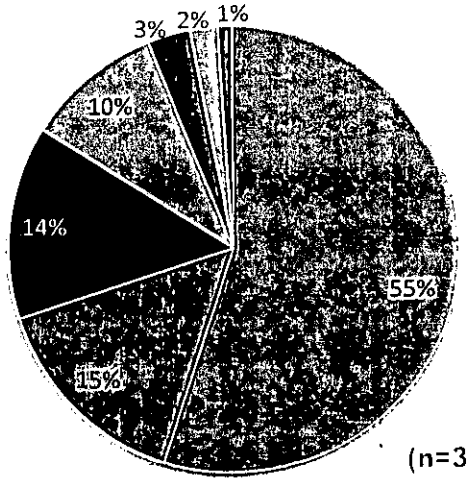
- Home 52%
- Hospital/Swing Bed 15.5%
- Nursing Facility 15%
- Assisted Living Facility 9.5%
- Other Basic Care Facility 5%
- Other 3%

Top three reasons for basic care admission:

1. Cognitive decline
2. Progressive physical decline
3. Social isolation

When Residents Move-Out, Where Do They Go?

Discharge Destination

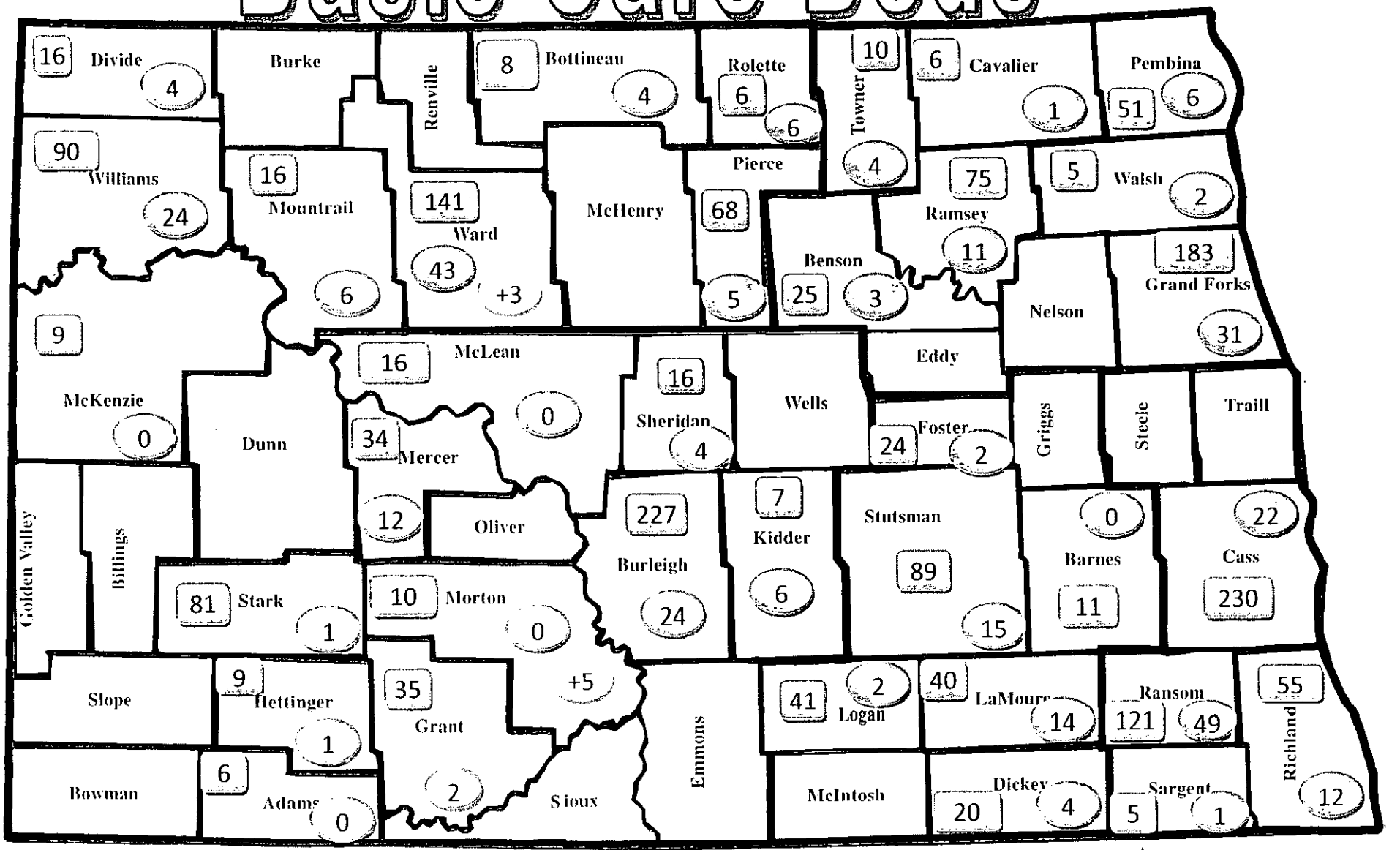


(n=357)

- Nursing Facility 55%
- Home 15%
- Hospital/Swing Bed 14%
- Death 10%
- Assisted Living Facility 3%
- Other Basic Care Facility 2%
- Other 1%

Over half of residents discharged from a basic care facility are admitted to a skilled nursing facility. Generally medical needs, physical limitations and growing cognition issues necessitate the admission.

Basic Care Beds



North Dakota Long Term Care Association

Sixty–five licensed basic care facilities as of March 1, 2011

Purple Box – Number of licensed basic care beds as of March 1, 2011 (total licensed beds = 1,786).

Red Box – Number of vacant licensed basic care beds available on March 1, 2011 (total vacancies = 317).

Green Box – Number of licensed basic care beds expected to increase in the county (purchased or transferred).

Licensed Basic Care Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Arthur	Cass	Prairie Villa	25	4	25	2
Bismarck	Burleigh	Baptist Home, Inc.	10	0	10	0
Bismarck	Burleigh	Edgewood Bismarck Senior Living	73	10	91	16
Bismarck	Burleigh	Good Samaritan Society—Bismarck			18	0
Bismarck	Burleigh	Maple View – East & North	48	4	48	7
Bismarck	Burleigh	The Terrace	40	1	40	0
Bismarck	Burleigh	Waterford on West Century	20	2	20	1
Bottineau	Bottineau	Good Samaritan Society – Bottineau	8	0	8	4
Cando	Towner	St. Francis Residence	10	0	10	4
Carrington	Foster	Holy Family Villa	24	0	24	2
Crosby	Divide	Good Samaritan Society – Crosby	16	5	16	4
Devils Lake	Ramsey	Good Samaritan Society – Devils Lake	10	3	12	3
Devils Lake	Ramsey	Odd Fellows Home	43	0	43	0
Dickinson	Stark	Dickinson Country House LLC	30	3	30	1
Dickinson	Stark	Evergreen	51	0	51	0
Edgeley	LaMoure	Manor St. Joseph	40	1	40	14
Edmore	Ramsey	Edmore Memorial Rest Home	25	14	20	8
Elgin	Grant	Dakota Hill Housing	35	1	35	2
Ellendale	Dickey	Evergreen Place	20	4	20	4
Fargo	Cass	Bethany Towers I and II	33	6	33	1
Fargo	Cass	Edgewood Vista at Edgewood Village	33	1	33	0
Fargo	Cass	Evergreens of Fargo	72	7	54	13
Fargo	Cass	Good Samaritan Society – Fargo	30	0	36	4
Fargo	Cass	Waterford at Harwood Groves	20	0	25	0
Forman	Sargent	Four Seasons Healthcare Ctr Inc.	5	0	5	1
Gackle	Logan	Gackle Care Center	41	1	41	2
Grand Forks	Grand Forks	Maple View Memory Care Community	26	5	36	6
Grand Forks	Grand Forks	Parkwood Place	40	4	40	12
Grand Forks	Grand Forks	St. Anne's Guest Home	54	8	54	10
Grand Forks	Grand Forks	Tufte Manor	40	0	53	3
Hazen	Mercer	Senior Suites at Sakakawea	34	1	34	12
Hettinger	Adams	Western Horizons Care Center	6	4	6	0
Jamestown	Stutsman	Bethel 4 Acres Ltd	16	0	16	1
Jamestown	Stutsman	Rock of Ages, Inc.	53	8	53	13
Jamestown	Stutsman	Roseadele	20	1	20	1
Kenmare	Ward	Baptist Home of Kenmare	60	23	60	41
Lisbon	Ransom	North Dakota Veterans Home	111	43	111	48
Lisbon	Ransom	Parkside Lutheran Home	10	1	10	1
Maddock	Benson	Maddock Memorial Home	25	0	25	3
Mandan	Morton	Dakota Pointe	10	0	10	0
McClusky	Sheridan	Sheridan Memorial Home	16	2	16	4
Minot	Ward	Edgewood Vista Memory Care	22	0	22	0
Minot	Ward	Edgewood Vista Minot Senior Living	31	0	31	0
Minot	Ward	Emerald Court	28	0	28	2

Licensed Basic Care Facility Beds, Locations and Vacancies

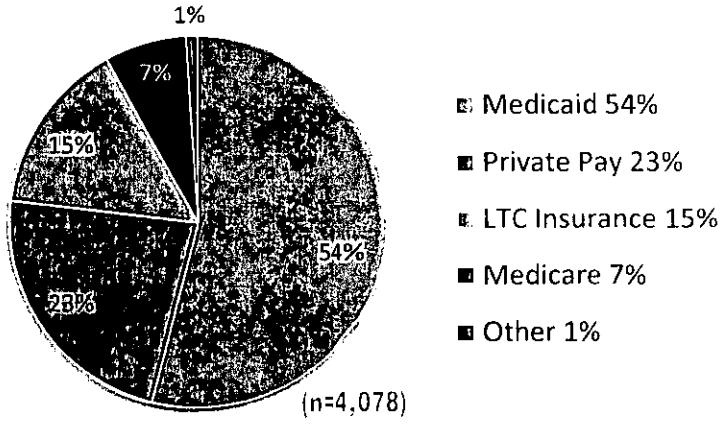
City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Mott	Hettinger	Good Samaritan Society – Mott	9	1	9	1
Mountain	Pembina	Borg Pioneer Memorial Home	43	0	43	3
New Town	Mountrail	Good Sam. Society – New Town	16	7	16	6
Osnabrock	Cavalier	Good Samaritan Society – Osnabrock	6	1	6	1
Park River	Walsh	Good Samaritan Society—Park River			5	2
Parshall	Mountrail	GSS – Rock View at Parshall	6	6	CLOSED	
Rolette	Rolette	Rolette Community Care Center			6	6
Rugby	Pierce	Haaland Estates – Basic Care	68	16	68	5
Steele	Kidder	Golden Manor Inc.			7	6
Valley City	Barnes	HI Soaring Eagle Ranch	11	0	11	0
Wahpeton	Richland	St. Catherine's Living Center	16	11	16	10
Wahpeton	Richland	The Leach Home	39	1	39	2
Walhalla	Pembina	Pembilier Nursing Center	10	8	8	3
Watford City	McKenzie	McKenzie Cty HC Systems	9	2	9	0
West Fargo	Cass	Eventide at Sheyenne Crossings	24	2	24	2
Williston	Williams	Bethel Lutheran Nrsng & Rehab Ctr	19	0	19	0
Williston	Williams	Kensington Williston LLC	71	5	71	24
Wilton	McLean	Redwood Village	16	0	16	0
TOTAL			**1727**	**227**	**1786**	**321**

Nursing Facilities

Nursing Facilities at a Glance:

- 85 licensed nursing facilities
- 6,397 licensed beds
- 2010 average daily rate is $196
- 2010 average occupancy is 93%

Payment Source for Nursing Facility Bills



Nursing Facility Facts:

- Resident needs are complex and they are in need of 24-hour nursing care and supervision.
- Most residents are admitted from their own homes, with over half coming directly from a hospital stay.
- The most significant need necessitating the need for admission to a nursing facility is the need for care throughout the day. Residents are unable to meet their own needs for dressing, toileting, eating and remaining safe.
- Current residents range in age from 18 to 106 years old, with the average age being 84.

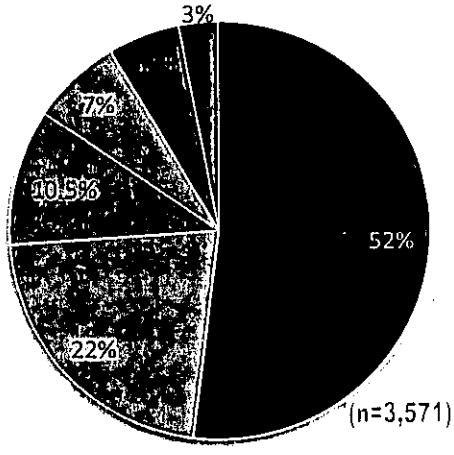
Care Needs of Nursing Facility Residents:

- 75% of residents need help in three or more activities of daily living, such as bathing, dressing, toileting, ambulation, transferring and eating.
- The average resident is on eleven different medications a day.
- Many have cognitive limitations and cannot live safely at home.

Nursing Facilities (continued)

When Individuals Move Into a Nursing Facility, Where Did They Come From?

Living Arrangements Prior to Admission



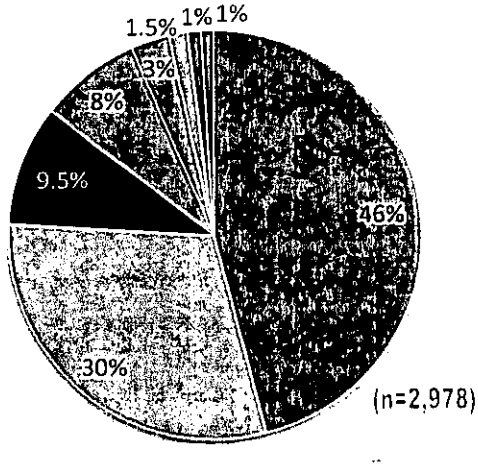
- Hospital/Swing Bed 52%
- Home 22%
- Other Nursing Facility 10.5%
- Assisted Living Facility 7%
- Basic Care Facility 5.5%
- Other 3%

Top five reasons for nursing care admission:

1. Needs assistance with daily care throughout the day
2. Complex medical needs
3. Needs continuous supervision
4. Dementia
5. Falls

When Residents are Discharged from a Skilled Nursing Facility, Where Do They Go?

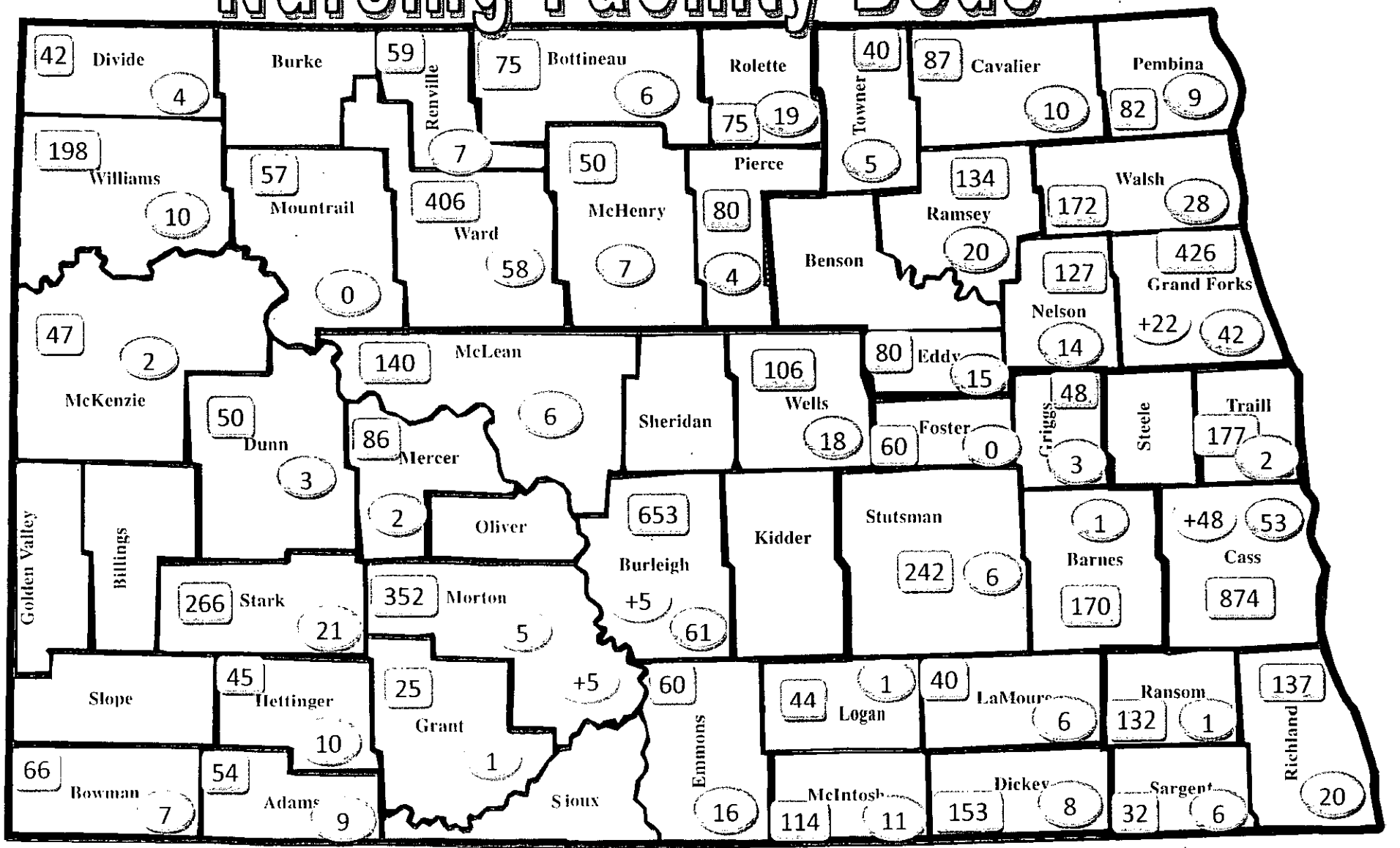
Discharge Destination



- Death 46%
- Home 30%
- Hospital/Swing Bed 9.5%
- Nursing Facility 8%
- Assisted Living Facility 3%
- Basic Care Facility 1.5%
- Family 1%
- Other 1%

- One-third of all residents admitted to a nursing facility are discharged to their own home or a lower level of care.
- Average length of stay in 2010 was 289 days (9.6 months), down 61 days from the 2009 average of 350 days.

Nursing Facility Beds



Eighty-five licensed nursing facilities as of March 1, 2011.

Purple Box – Number of licensed nursing facility beds as of March 1, 2011 (total licensed beds = 6,363).

[illegible] – Number of vacant licensed nursing facility beds available on March 1, 2011 (total vacancies = 537).

Green Box – Number of licensed nursing facility beds expected to increase in the county (purchased or transferred).

North Dakota Long Term Care Association

Licensed Nursing Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Aneta	Nelson	Aneta Parkview Health Center	39	2	39	0
Arthur	Cass	Good Samaritan Society – Arthur	42	3	42	14
Ashley	McIntosh	Ashley Medical Center	44	1	44	0
Beulah	Mercer	Knife River Care Center	86	0	86	2
Bismarck	Burleigh	Baptist Home, Inc.	141	7	141	12
Bismarck	Burleigh	Good Samaritan Society—Bismarck			48	9
Bismarck	Burleigh	Medcenter One St. Vincent's	101	0	101	0
Bismarck	Burleigh	Medcenter One Subacute Unit	22	5	22	6
Bismarck	Burleigh	Missouri Slope Luth Care Center	250	0	250	2
Bismarck	Burleigh	St. Alexius Medical Center – TCU	19	1	19	8
Bismarck	Burleigh	St. Gabriel's Community			72	24
Bottineau	Bottineau	Good Samaritan Society – Bottineau	73	5	75	6
Bowman	Bowman	Southwest Healthcare Services	66	0	66	7
Cando	Towner	Towner County Living Center	45	0	40	5
Carrington	Foster	Golden Acres Manor	60	5	60	0
Cavalier	Pembina	Wedgewood Manor	50	6	50	4
Cooperstown	Griggs	Cooperstown Medical Center	48	1	48	3
Crosby	Divide	Good Samaritan Society – Crosby	42	0	42	4
Devils Lake	Ramsey	Good Samaritan Society – Devils Lake	62	13	60	16
Devils Lake	Ramsey	Heartland Care Center	74	4	74	4
Dickinson	Stark	St. Benedict's Health Center	164	7	164	12
Dickinson	Stark	St. Luke's Home	84	0	84	9
Dunseith	Rolette	Dunseith Comm. Nursing Home	35	7	35	9
Elgin	Grant	Jacobson Memorial Hosp Cr Ctr	25	0	25	1
Ellendale	Dickey	Prince of Peace Care Center	55	11	53	1
Enderlin	Ransom	Maryhill Manor	54	3	54	1
Fargo	Cass	Bethany on 42nd	50	6	78	0
Fargo	Cass	Bethany On University	192	12	172	1
Fargo	Cass	Elim – A Caring Community	136	16	136	15
Fargo	Cass	Manor Care of Fargo ND, LLC	131	34	131	11
Fargo	Cass	Rosewood On Broadway	111	0	111	1
Fargo	Cass	Villa Maria	140	6	140	5
Forman	Sargent	Four Seasons Healthcare Ctr Inc.	32	1	32	6
Garrison	McLean	Benedictine Living Ctr of Garrison	63	14	52	4
Garrison	McLean	Garrison Memorial Hosp & NF	28	4	28	0
Glen Ullin	Morton	Marian Manor HealthCare Center	86	3	86	2
Grafton	Walsh	Lutheran Sunset Home	104	9	104	6
Grand Forks	Grand Forks	Valley Eldercare Center	176	13	202	30
Grand Forks	Grand Forks	Woodside Village	118	2	118	2
Hankinson	Richland	St. Gerard's Com Nrsng Home	37	4	37	5
Harvey	Wells	St. Aloisius Medical Center	106	10	106	18
Hatton	Traill	Hatton Prairie Village	42	6	42	0
Hettinger	Adams	Western Horizons Care Center	54	8	54	9
Hillsboro	Traill	Hillsboro Medical Center	36	0	36	0
Jamestown	Stutsman	Ave Maria Village	100	0	100	1
Jamestown	Stutsman	Eventide at Hi-Acres Manor	142	5	142	5

Licensed Nursing Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Killdeer	Dunn	Hill Top Home of Comfort	50	2	50	3
Lakota	Nelson	Good Samaritan Society – Lakota	49	5	49	9
LaMoure	LaMoure	St. Rose Care Center	40	4	40	6
Langdon	Cavalier	Maple Manor Care Center	63	6	63	4
Larimore	Grand Forks	Good Samaritan Society – Larimore	45	8	45	5
Lisbon	Ransom	North Dakota Veterans Home	38	0	38	0
Lisbon	Ransom	Parkside Lutheran Home	40	1	40	0
Mandan	Morton	Dakota Alpha	20	2	20	2
Mandan	Morton	Medcenter One Mandan Care Center	128	1	128	1
Mandan	Morton	Medcenter One Mandan CC Off Collins	50	0	50	0
Mayville	Traill	Luther Memorial Home	99	6	99	2
McVille	Nelson	Nelson Cty Hlth System Care Ctr	39	1	39	5
Minot	Ward	Manor Care of Minot ND, LLC	114	8	114	12
Minot	Ward	Trinity Homes	292	37	292	46
Mohall	Renville	Good Samaritan Society – Mohall	59	4	59	7
Mott	Hettinger	Good Samaritan Society – Mott	45	1	45	10
Napoleon	Logan	Napoleon Care Center	44	4	44	1
New Rockford	Eddy	Luth Home of the Good Shep NH	80	12	80	15
New Salem	Morton	Elm Crest Manor	68	3	68	0
Northwood	Grand Forks	Northwood Deaconess Hlth Ctr	61	4	61	5
Oakes	Dickey	Good Samaritan Society – Oakes	102	12	100	7
Osnabrock	Cavalier	Good Samaritan Society – Osnabrock	24	5	24	6
Park River	Walsh	Good Samaritan Society – Park River	73	7	68	22
Parshall	Mountrail	GSS – Rock View at Parshall	30	9	CLOSED	
Richardton	Stark	Richardton Health Center	18	0	18	0
Rolette	Rolette	Rolette Community Care Center	46	10	40	10
Rugby	Pierce	Heart Of America Medical Center	80	5	80	4
Stanley	Mountrail	Mountrail Bethel Home	57	3	57	0
Strasburg	Emmons	Strasburg Nursing Home	60	4	60	16
Tioga	Williams	Tioga Medical Center LTC	30	0	30	0
Underwood	McLean	Medcenter One Prairieview	60	5	60	2
Valley City	Barnes	Sheyenne Care Center	170	0	170	1
Velva	McHenry	Souris Valley Care Center	50	0	50	7
Wahpeton	Richland	St. Catherine's Living Center	112	11	100	15
Walhalla	Pembina	Pembilier Nursing Center	37	12	32	5
Watford City	McKenzie	McKenzie Cty HC Systems	47	1	47	2
West Fargo	Cass	Sheyenne Crossings Care Center/TCU			64	6
Westhope	Bottineau	Westhope Home	25	7	CLOSED	
Williston	Williams	Bethel Lutheran Nrsng & Rehab Ctr	168	5	168	10
Wishek	McIntosh	Wishek Home for the Aged	70	11	70	11
TOTAL			**6248**	**450**	**6363**	**537**

NURSING FACILITY PAYMENT SYSTEM

MINIMUM DATA SET FOR PAYMENT

The state adopted the Minimum Data Set (MDS) for its payment system on January 1, 1999. The MDS provides a wide array of information regarding the health status of each resident. The payment system has thirty-four facility specific rates. Each resident is evaluated at least quarterly and the intensity of their needs determines their rate classification.

EQUALIZATION OF RATES

The legislature implemented equalization of rates between Medicaid residents and self pay residents for nursing facilities in 1990. Equalization of rates requires all residents be charged the same rate for comparable services. Minnesota and North Dakota are the only states in the nation with equalization of rates. Nursing facilities are the only providers/private business subjected to an equalized rate system in the State of North Dakota.

RATE CALCULATIONS

The determination of rates is the sum of **four components**: direct care, other direct care, indirect care and property. Today's limits are calculated based on the **June 30, 2006 cost report** inflated forward to 2011. The 2009 legislature allowed rates and limits to be increased by 6% in 2010 and 2011.

Limits (the maximum that will be paid) are set for the direct care, other direct care and indirect care components by utilizing the **2006** cost report of all Medicaid nursing facilities, arraying the facilities from least expensive to most expensive, selecting the facility at mid-point (median facility) and then adding either 10% or 20% to the cost of that median facility. The **direct care** and **other direct care** limit is established by adding **20%** to the cost of that median facility. The **indirect care** limit is established by adding **10%** to the cost of that median facility. The limits are then inflated annually by the legislative approved inflation factor.. In addition, an adjustment was made to the limits in 2011 to recognize the increases for the salary enhancements approved in the 2009 session.

Direct Care Rate. Costs in the Direct Care Category include: nursing and therapy salaries and benefits, OTC drugs, minor medical equipment and medical supplies. On January 1, 2011 the direct care limit was set at $127.76 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities over the limit are spending at least $1,056,229 in nursing that will never be recouped.

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Bismarck, ND 58501 www.ndltca.org

Other Direct Care. Costs in the Other Direct Care Category include: food, laundry, social service salaries, activity salaries and supplies. On January 1, 2011 the other direct care limit was set at $23.95 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities exceeding the limit are spending at least $206,937 in costs that will never be recouped.

Indirect Care. Costs in the Indirect Care Category include: Administration, pharmacy, chaplin, housekeeping salaries, dietary salaries, housekeeping and dietary supplies, medical records, insurance, and plant operations. On January 1, 2011 the indirect limit was set at $60.60 per day. Nineteen nursing facilities currently exceed this limit. The nineteen nursing facilities exceeding the limit are spending at least $1,799,029 in indirect care expenses. These costs will never be recouped.

Property rate includes depreciation, interest expense, property taxes, lease and rental costs, start-up costs and reasonable and allowable legal expenses. The average property rate is $14.34 per resident per day, with a range of $3.39 to $52.40.

Occupancy Limitation – In the June 30, 2010 cost reporting period, twenty-two nursing facilities reported twelve month occupancy averages at less than 90%. Together they incur $1,726,047 in penalty costs because they operate under 90% occupancy.

Incentives – A reward is provided to nursing facilities that are under the limit in indirect care. The incentive is calculated for each facility based upon their indirect costs compared to the indirect limit. Facilities are able to receive 70 cents for every dollar they are below the limit up to a maximum of $2.60 per resident day. In 2011, fifty-five nursing facilities received an incentive, with the average per day incentive at $2.10. Of the fifty-five nursing facilities receiving an incentive, they ranged from $0.07 to $2.60 per resident per day.

Operating Margin - All nursing facilities receive an operating margin of three percent based on their historical direct care costs and other direct care costs (up to limits). The operating margin provides needed cash flow to cover up-front salary adjustments, replacement of needed equipment, unforeseen expenses, and dollars to implement ever increasing regulations. The operating margin covers the gap between the cost report and the effective date of rates (this can be up to 18 months). In 2011, the average operating margin is $3.59 per resident per day.

Inflation – Rates are adjusted for inflation annually. Inflation is a rise in price levels that are generally beyond the control of long term care facilities. Examples of price level increases include the 9.7% increase in health insurance and significant increases in fuel. To attract and retain adequate staff, nursing facilities need to offer salary and benefit packages that reward people. Approximately 75% of a nursing facility's budget is dedicated to personnel costs. Adequate inflation adjustments are critical for salary and benefits so nursing facilities can compete in the market place. Turnover of certified nurse assistants, the largest pool of employees was 62% in 2010.

Annual inflationary adjustments are set every legislative session.

Rebasing – A limit is establish on the maximum that will be paid in each cost category. The 2011 limits are based upon the June 30, 2006 cost report inflated forward to 2011. The next time limits will be rebased is January 1, 2013 using the June 30, 2010 cost report.

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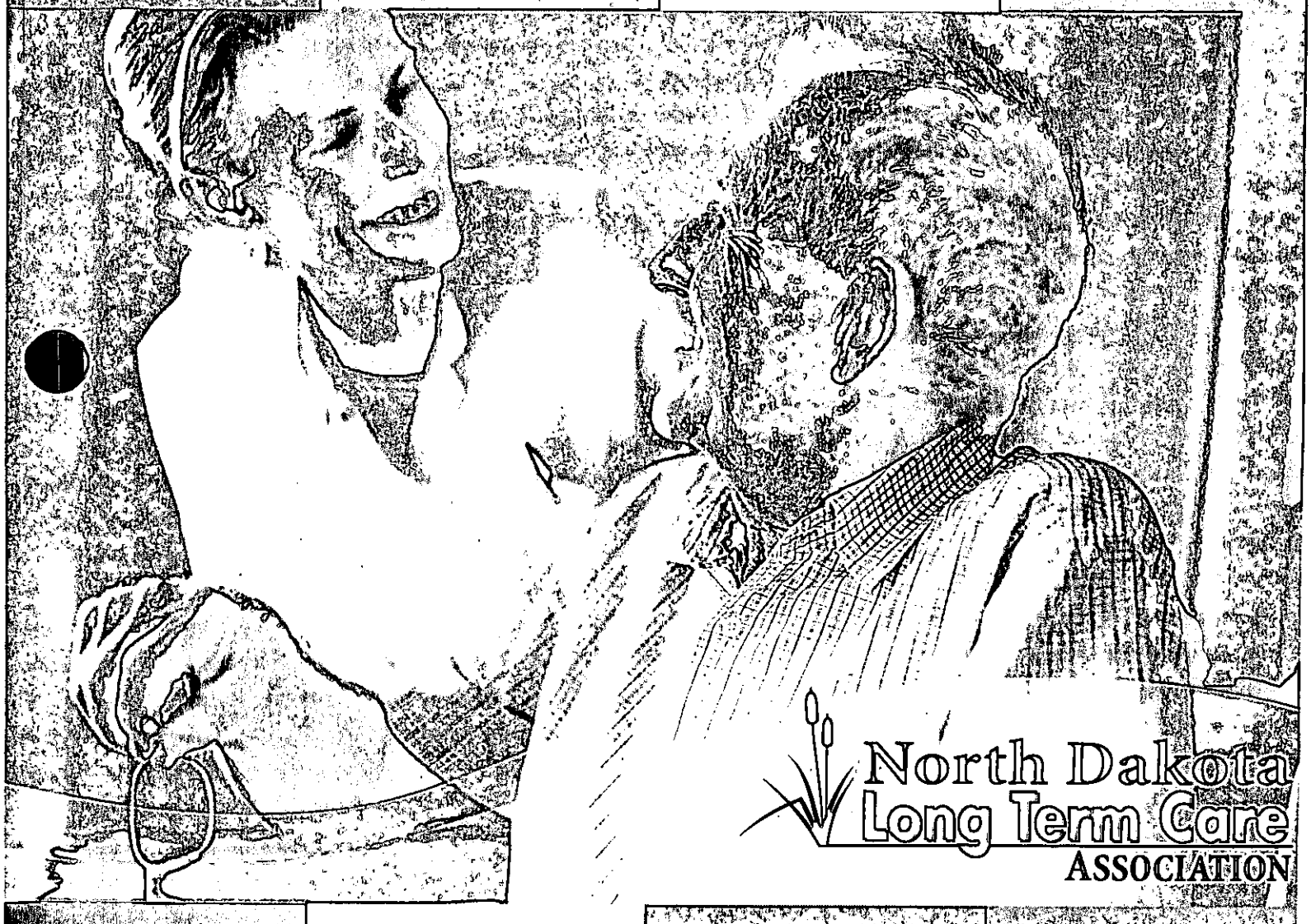
CR #	Facility	Provider	Total Days	Total Operating Costs	Property Costs	Total Costs	2011 Medicaid Rate	Total MA Paid Days Including Bedhold	Cost PPD	Medicaid Allowable Cost	Medicaid Payments
0110	Ashley Medical Center	30188	15,884	2,985,424	81,188	3,066,612	197.83	8,968	193.06	1,731,389	1,774,139
0210	Missouri Slope Lutheran Care Center, Inc.	30004	90,685	20,448,132	1,027,794	21,475,926	224.36	40,395	236.82	9,566,301	9,063,022
0310	Medcenter One St. Vincent's Care Center	30005	36,670	7,974,179	504,286	8,478,465	210.72	21,276	231.21	4,919,221	4,483,279
0410	Towner County Medical Center	30379	13,925	2,388,137	328,543	2,716,680	188.87	6,632	195.09	1,293,862	1,252,586
0610	Golden Acres Manor Nursing Home	30008	21,356	3,562,213	260,168	3,822,381	184.67	10,441	178.98	1,868,772	1,928,139
0710	Cooperstown Medical Center	30095	17,272	3,126,984	140,802	3,267,786	193.40	9,333	189.20	1,765,762	1,805,002
0810	Heartland Care Center	30010	25,840	5,259,108	456,104	5,715,212	216.28	13,654	221.18	3,019,950	2,953,087
0910	Jacobson Memorial Hospital Care Center	30077	9,006	1,676,921	95,406	1,772,327	183.82	4,313	196.79	848,772	792,816
1010	Garrison Memorial Hospital	30134	9,490	1,968,327	123,637	2,091,964	218.87	5,082	220.44	1,120,270	1,112,297
1110	Marian Manor Healthcare Center	30067	30,792	6,004,895	160,024	6,164,919	198.78	17,692	200.21	3,542,146	3,516,816
1310	St. Gerard's Community Nursing Home	30163	11,822	2,199,123	41,235	2,240,358	184.51	5,136	189.51	973,311	947,643
1410	Tri County Health Center	30018	14,116	3,042,958	202,125	3,245,083	221.87	5,082	229.89	1,168,285	1,127,543
1810	Dakota Alpha - HIT, Inc.	30225	5,941	1,971,991	253,742	2,225,733	363.61	3,417	374.64	1,280,143	1,242,455
2010	Trinity Nursing Home	30028	93,799	20,033,120	1,265,853	21,298,973	215.91	47,890	227.07	10,874,400	10,339,930
2210	MCO Mandan Care Center Off Collins	30106	18,007	3,868,682	218,418	4,087,100	216.05	7,979	226.97	1,811,016	1,723,863
2310	Strasburg Care Center	30033	19,253	3,378,007	99,773	3,477,780	189.69	9,867	180.64	1,782,333	1,871,671
2410	Tioga Medical Center	30176	10,806	2,048,783	83,207	2,131,990	201.94	2,217	197.30	437,407	447,701
2510	Prairieview Health Center	30053	20,573	3,950,194	97,056	4,047,250	193.33	10,205	196.73	2,007,592	1,972,933
2610	Wishek Home for the Aged	30039	21,616	4,286,028	100,985	4,387,013	201.13	12,091	202.95	2,453,894	2,431,863
2710	Aneta Parkview Health Center	30322	13,634	2,432,088	103,324	2,535,412	181.31	5,845	185.96	1,086,950	1,059,757
2810	Good Samaritan Society - Arthur	30058	11,413	2,295,775	161,212	2,456,987	191.56	4,071	215.28	876,403	779,841
2910	Baptist Home	30003	49,694	10,645,392	176,237	10,821,629	209.03	23,914	217.77	5,207,640	4,998,743
3010	Good Samaritan Society - Bottineau	30118	25,344	5,075,408	288,188	5,363,596	204.32	12,111	211.63	2,563,073	2,474,520
3110	Southwest Healthcare Services	30403	22,939	4,810,365	333,240	5,143,605	214.79	7,584	224.23	1,700,558	1,628,967
3210	Wedgewood Manor	30424	16,296	3,570,513	172,737	3,743,250	208.38	5,161	229.70	1,185,500	1,075,449
3310	Good Samaritan Society - Crosby	30122	14,336	2,470,473	121,753	2,592,226	175.73	5,742	180.82	1,038,264	1,009,042
3410	Good Samaritan Society - Devils Lake	30115	19,026	3,684,477	158,305	3,842,782	187.35	9,980	201.98	2,015,713	1,869,753
3510	St. Benedict's Health Center	30237	56,314	10,872,126	538,813	11,410,939	189.97	29,824	202.63	6,043,255	5,665,665
3610	St. Luke's Home	30011	30,100	5,878,267	155,584	6,033,851	190.73	14,579	200.46	2,922,509	2,780,653
3810	Prince of Peace Care Center	30012	16,949	2,893,519	232,896	3,126,415	173.01	7,892	184.46	1,455,759	1,365,395
3910	Maryhill Manor	30421	19,057	3,389,788	160,294	3,550,082	191.49	9,232	186.29	1,719,807	1,767,836
4010	Bethany on University	30060	65,796	14,408,426	754,960	15,163,386	217.81	20,492	230.46	4,722,599	4,463,363
4210	Elim Home	30051	45,258	9,541,205	273,791	9,814,996	199.26	15,975	216.87	3,464,461	3,183,179
4310	Rosewood on Broadway	30420	40,040	8,453,532	861,995	9,315,527	216.23	16,080	232.66	3,741,101	3,476,978
4410	Villa Maria Healthcare	30419	47,906	10,068,063	1,173,380	11,241,443	218.11	18,783	234.66	4,407,549	4,096,760
4510	Four Seasons Health Care Center, Inc.	30406	11,180	1,590,404	107,755	1,698,159	149.28	4,762	151.89	723,313	710,871
4610	Benedictine Living Center of Garrison	30247	18,117	3,277,780	167,851	3,445,631	181.30	8,750	190.19	1,664,143	1,586,375
4710	Lutheran Sunset Home	30016	34,579	7,040,976	212,856	7,253,832	212.86	14,760	209.78	3,096,289	3,141,814
4810	Ave Maria Village	30422	36,222	7,118,236	788,172	7,906,408	217.13	15,924	218.28	3,475,833	3,457,578

CR #	Facility	Provider	Total Days	Total Operating Costs	Property Costs	Total Costs	2011 Medicaid Rate	Total MA Paid Days Including Bedhold	Cost PPD	Medicaid Allowable Cost	Medicaid Payments
5010	Good Samaritan Society - Lakota	30097	16,953	2,746,732	216,993	2,963,725	176.89	7,964	174.82	1,392,267	1,408,752
5110	St. Rose Care Center	30119	12,627	2,350,304	146,427	2,496,731	189.21	5,161	197.73	1,020,482	976,513
5210	Maple Manor Care Center	30083	21,567	3,343,889	1,144,646	4,488,535	209.81	5,431	208.12	1,130,303	1,139,478
5310	Good Samaritan Society - Larimore	30113	46,506	2,743,848	192,323	2,936,171	187.78	4,869	63.14	307,406	914,301
5510	Medcenter One Mandan Living Center	30288	46,516	10,058,372	1,592,316	11,650,688	235.83	28,107	250.47	7,039,855	6,628,474
5610	Luther Memorial Home	30024	33,088	6,191,993	252,064	6,444,057	201.65	12,334	194.76	2,402,110	2,487,151
5810	Good Samaritan Society - Mohall	30173	20,038	3,523,999	229,690	3,753,689	185.31	8,917	187.33	1,670,409	1,652,409
5910	Good Samaritan Society - Mott	30142	16,201	2,584,773	88,917	2,673,690	164.38	7,715	165.03	1,273,225	1,268,192
6010	Napoleon Care Center	30114	15,261	2,664,468	124,239	2,788,707	185.30	7,660	182.73	1,399,744	1,419,398
6110	Lutheran Home of the Good Shepherd	30029	26,289	5,139,605	591,563	5,731,168	215.91	13,184	218.01	2,874,195	2,846,557
6210	Elm Crest Manor	30116	22,851	4,301,029	809,666	5,110,695	222.26	11,518	223.65	2,576,035	2,559,991
6410	Northwood Deaconess Health Center	30031	19,670	4,392,478	512,624	4,905,102	241.89	9,208	249.37	2,296,196	2,227,323
6510	Good Samaritan Society - Oakes	30124	33,294	4,984,315	285,660	5,269,975	156.69	14,370	158.29	2,274,570	2,251,635
6610	Good Samaritan Society - Osnabrock	30117	6,892	1,188,382	54,976	1,243,358	171.74	2,123	180.41	383,002	364,604
6710	Good Samaritan Society - Park River	30154	21,582	3,757,075	215,897	3,972,972	181.58	8,328	184.09	1,533,079	1,512,198
6810	Good Samaritan Society - Rock View	30155	8,785	1,807,830	132,887	1,940,717	201.43	3,529	220.91	779,600	710,846
6910	Mountrail Bethel Home	30032	19,776	4,186,642	126,460	4,313,102	207.49	9,747	218.10	2,125,799	2,022,405
7010	Sheyenne Care Center	30418	50,129	11,313,841	810,869	12,124,710	198.60	23,830	241.87	5,763,766	4,732,638
7110	Souris Valley Care Center	30216	17,167	2,873,541	163,777	3,037,318	172.50	6,572	176.93	1,162,769	1,133,670
7210	St. Catherine's Living Center	30034	32,692	5,318,679	476,824	5,795,503	168.52	14,241	177.28	2,524,586	2,399,893
7310	Pembilier Nursing Center	30035	9,245	1,476,954	44,712	1,521,666	164.32	2,709	164.59	445,883	445,143
7410	McKenzie County Healthcare System	30449	16,174	3,432,204	119,368	3,551,572	216.88	6,490	219.59	1,425,108	1,407,551
7610	Bethel Lutheran Home	30038	58,945	11,095,402	527,143	11,622,545	202.34	25,916	197.18	5,110,016	5,243,843
7910	Knife River Care Center	30002	30,651	6,495,605	1,177,838	7,673,443	232.99	16,827	250.35	4,212,620	3,920,523
8010	Heart of America Medical Center	30135	27,039	6,064,914	278,844	6,343,758	213.92	17,422	234.62	4,087,464	3,726,914
8210	Parkside Lutheran Home	30109	14,348	2,899,033	334,381	3,233,414	222.14	4,962	225.36	1,118,219	1,102,259
8310	Rolette Community Care Center	30466	11,843	2,296,549	646,533	2,943,082	225.60	7,989	248.51	1,985,332	1,802,318
8410	St. Aloisius Medical Center	30129	35,833	6,432,234	243,139	6,675,373	188.10	18,952	186.29	3,530,591	3,564,871
8610	Hillsboro Medical Center	30019	12,873	2,755,247	654,877	3,410,124	260.32	4,450	264.91	1,178,828	1,158,424
8710	Valley Eldercare Center	30017	60,049	12,690,290	1,504,441	14,194,731	218.65	20,098	236.39	4,750,882	4,394,428
8810	Woodside Village	30201	42,558	8,636,530	1,229,640	9,866,170	221.54	16,550	231.83	3,836,767	3,666,487
8910	Hill Top Home of Comfort, Inc.	30271	17,561	3,710,483	164,280	3,874,763	210.35	8,994	220.65	1,984,490	1,891,888
9110	Manor Care of Fargo ND, LLC	30478	34,348	7,166,032	505,616	7,671,648	176.79	11,676	223.35	2,607,842	2,064,200
9210	Manor Care of Minot ND, LLC	30479	36,514	6,692,759	328,842	7,021,601	168.36	8,924	192.39	1,716,075	1,502,445
9310	Western Horizons Living Center	30477	17,331	4,012,075	270,458	4,282,533	229.07	5,537	247.10	1,368,206	1,268,361
9410	Richardton Health Center	30487	5,901	1,480,331	91,690	1,572,021	231.92	4,149	266.40	1,105,290	962,236
9510	Bethany on 42nd	30492	8,419	2,768,063	1,316,696	4,084,759	266.22	1,773	485.18	860,230	472,008
			2,008,569		30,091,005	425,357,523		881,357		188,828,783	180,629,652

UPL Above/(Below) of Medicaid Payments for Private Facilities = 8,199,131

Long Term Care

in North Dakota



North Dakota
Long Term Care
ASSOCIATION

2011

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Introduction

Welcome

The North Dakota Long Term Care Association (NDLTCA) is pleased to bring to you the 2011 Long Term Care in North Dakota booklet. This publication provides information about the long term care profession, the challenge of caring for aging North Dakotans and issues facing long term care. This publication is designed to give legislators, association members and the public an overview of Long Term Care in North Dakota.

Our biggest challenge continues to be staffing, with occupancy the second area of concern. Lack of caregivers and continued decreases in census was the chief reason one rural nursing facility announced closure in January 2011. Staff turnover is the highest ever recorded for a number of positions. We must find a solution to address this workforce challenge.

The just released 2010 US Census figures, give us a hopeful outlook. North Dakota hit 672,591 in total population, our second highest recorded population, an increase of 4.7% from a decade ago.

Our 2010 population growth will help us address our workforce challenges however, North Dakota holds one of the highest percentage rates of elderly in the nation. We have the highest proportion of individuals over the age of 85 and are number four for the age category 65 and older. Our age category 55-59, 60-84 and 85 years and older are all expecting growth rates from 20% to 59%, from 2005 to 2020.

Hopefully our out migration and de-population of rural North Dakota has begun to reverse itself. We hope you find this publication helpful. North Dakota is a great place to grow old in and we are proud of the outstanding care provided by the long term care facilities in our state.

Sincerely yours,



Shelly Peterson

Shelly Peterson, President



Rosanne Schmidt

Rosanne Schmidt, Chairman

North Dakota Long Term Care ASSOCIATION

Long Term Care Fact Sheet

What is Long Term Care?

The aging of America, together with extended life expectancy, will result in unprecedented demand for long term care services. Long term care includes a range of services for people who have functional limitations or chronic health conditions. Long term care services are provided in a variety of settings, including nursing facilities, basic care, assisted living, swing beds, adult day care, foster care and home and community based settings.

Aging in America

- According to the United States Census Bureau, the over 85 population is the fastest growing segment of the United States population. This age group is growing six times faster than the rest of the population.

Aging in North Dakota

- North Dakota leads the nation with the highest proportion of individuals aged 85 and older comprising 2.3% of the total population.
- North Dakota is ranked fourth in the nation in citizens aged 65 and older.
- From 2000 to 2030, North Dakota's age 65 and older population is projected to grow by 61%.
- From 2000 to 2010, North Dakota's total population grew from 642,200 to 672,591, a 4.7% increase. This is the second highest recorded population in North Dakota. North Dakota peaked in population in the 1930 census, with 680,845 residents.
- Long term care facilities provide care for over 16,000 North Dakotans annually.



Long Term Care Fact Sheet (continued)

Who Will Need Long Term Care in North Dakota?

- Two out of every five North Dakotans will need long term care sometime during their lives.
- The need for personal assistance with everyday activities increases with age.
- The three top factors impacting the need for nursing home care are being a woman, being 80 or older, and living alone.
- At age 75, 60% of individuals are living alone.
- The most common reasons given for nursing home placement include the need for assistance with daily care throughout the day, complex medical needs, and the need for continuous supervision.

Who Will Care for North Dakota's Aging Population?

- Sufficient staffing is the number one concern facing long term care facilities.
- CNA turnover in nursing facilities is at 62%.
- Nursing turnover has increased significantly with LPNs at 33% and RNs at 40%.
- 34% of caregivers in long term care are age 50 or older.
- The oldest caregiver in long term care is a 97 year-old dietary aide.
- 11% of nursing facilities stopped admissions in 2010 because of insufficient staffing.
- 58 nursing facilities reported 524 open positions in October 2010. Applying the ratio to 85 facilities would show open positions at 768.
- Almost 2 out of 5 nursing facilities contracted with agencies in 2010 to deliver daily resident care. In the current biennium, it is estimated that $6 million will be spent on contract staff.
- 14% of the long term care workforce is at or over retirement age.



Long Term Care Fact Sheet (continued)

Job Service Average Wage Data - 2010

Type of Employment	Average Annual Wage 2010	Percentage Higher than LTC
Nursing, BC/AL, Res. Care, DD	$23,348	—
Adm & Waste Services	$24,544	5.1% Higher
ND Average Wage	$36,972	58.4% Higher
Hospitals	$47,944	105.3% Higher
Amb Health	$58,240	149.4% Higher

Assisted Living Nursing Salaries - 2010

	Nurse Assistant		CNA		LPN		RN	
	Entry	Average	Entry	Average	Entry	Average	Entry	Average
All Assisted Living Facilities	$8.89	$10.86	$10.11	$11.48	$14.81	$17.12	$20.20	$22.80
6 Urban Cities*	$8.67	$10.00	$10.51	$12.27	$15.02	$17.09	$20.75	$23.88
w/o 6 Urban Cities*	$9.00	$11.29	$9.60	$10.49	$13.31	$17.33	$18.00	$18.50

Basic Care Nursing Salaries - 2010

	Nurse Assistant		CNA		LPN		RN	
	Entry	Average	Entry	Average	Entry	Average	Entry	Average
All Basic Care Facilities	$8.37	$9.38	$9.40	$10.52	$14.67	$16.95	$22.23	$23.57
6 Urban Cities*	$8.84	$9.75	$10.34	$11.49	$15.15	$16.86	$21.14	$23.57
w/o 6 Urban Cities*	$8.18	$9.19	$8.93	$10.03	$14.02	$17.33	$25.50	$24.50

Nursing Facilities Nursing Salaries - 2010

	Nurse Assistant		CNA		LPN		RN	
	Entry	Average	Entry	Average	Entry	Average	Entry	Average
All Nursing Facilities	$9.41	$11.14	$11.22	$12.79	$15.45	$18.29	$20.65	$23.49
6 Urban Cities*	$10.53	$12.96	$12.06	$13.38	$15.67	$18.37	$21.69	$23.83
w/o 6 Urban Cities*	$8.90	$10.11	$10.97	$12.63	$15.37	$18.27	$20.30	$23.42

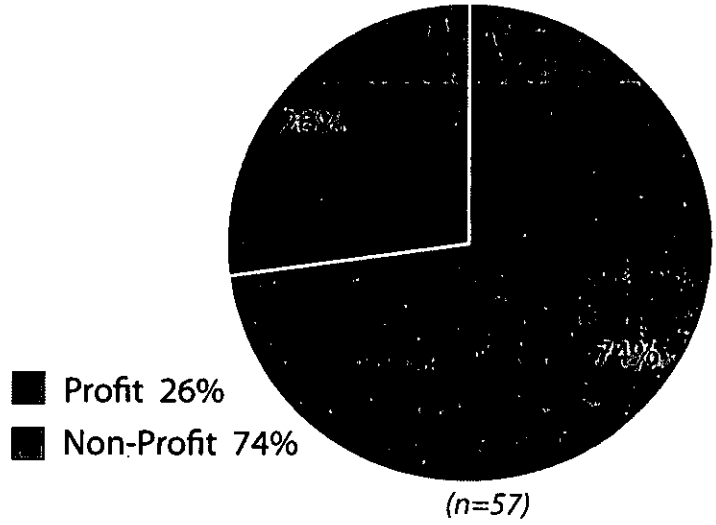
*6 urban cities include: Bismarck/Mandan, Fargo/West Fargo, Grand Forks and Minot

Assisted Living Facilities

Assisted Living Facilities at a Glance:

- 71 licensed assisted living facilities
- 2,595 licensed units
- 2010 average daily rate is $97
- 2010 average occupancy is 94%

Figure 1: Ownership of Assisted Living Facilities

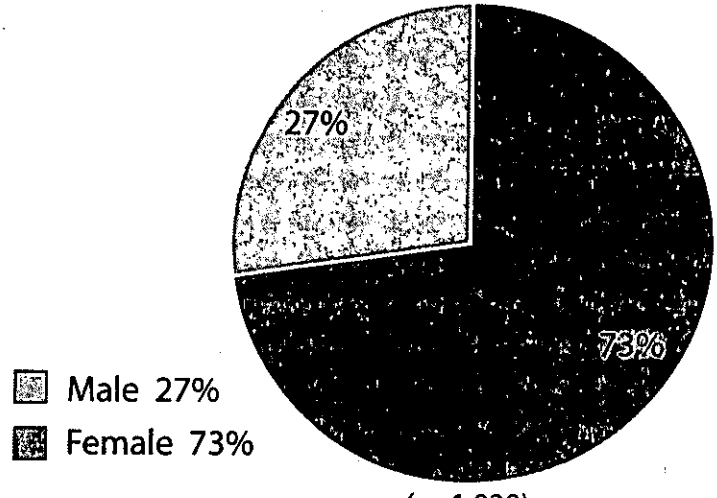


(n=57)

Assisted Living Facts:

- A congregate residential setting with individual private apartments where you contract for specific services.
- Services are contracted for al-carte based upon an agreed upon service plan.
- A basic rental package generally includes three daily meals, housekeeping, activities, transportation, cable TV, laundry and snacks.
- Generally all facilities provide a full range of services from bathing to medication management to hospice care.
- Physical decline is the top issue precipitating the desire to move into an assisted living facility.
- Current tenants range in age from 55 to 106, with the average age being 86.

Figure 2: Gender of Assisted Living Tenants



(n=1,028)

Assisted Living Facilities (continued)

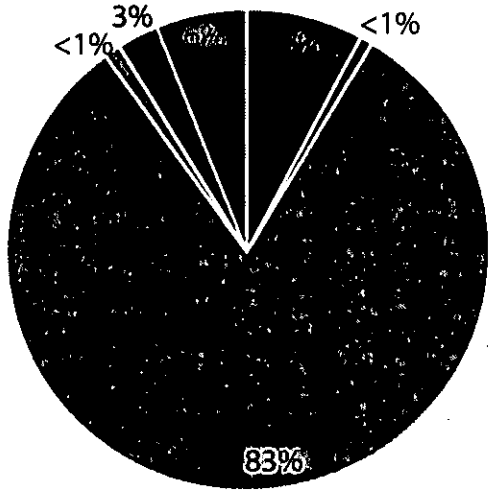
When Individuals Move Into an Assisted Living Facility, Where Do They Come From?

Figure 3: Living Arrangements Prior to Move-In

Most individuals were living in their own home prior to moving into an assisted living facility.

Top three reasons for assisted living move-in:

1. Physical decline
2. Cognitive decline
3. Social isolation



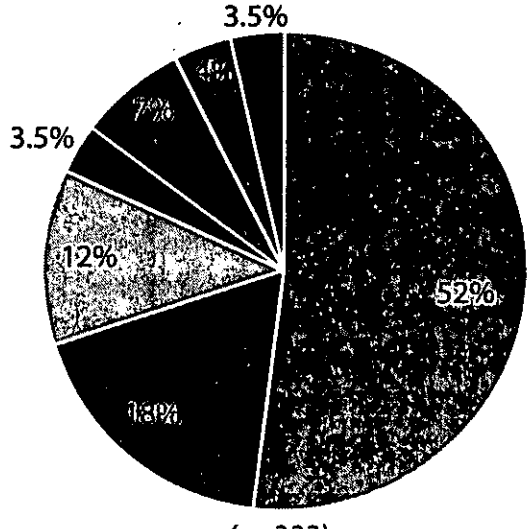
(n=986)

- Home 83%
- Nursing Facility 8%
- Other Assisted Living Facility 6%
- Hospital/Swing Bed 3%
- Basic Care Facility <1%
- Other <1%

When Tenants Move-Out, Where Do They Go?

Figure 4: Move-out Destination

Over half of tenants moving out of assisted living facilities are admitted to a skilled nursing facility. Generally, advancing medical needs and growing cognition issues necessitate the move to a higher level of care.



(n=323)

- Nursing Facility 52%
- Death 18%
- Home 12%
- Other Assisted Living Facility 7%
- Other 4%
- Basic Care Facility 3.5%
- Hospital/Swing Bed 3.5%

Care Needs of Assisted Living Tenants:

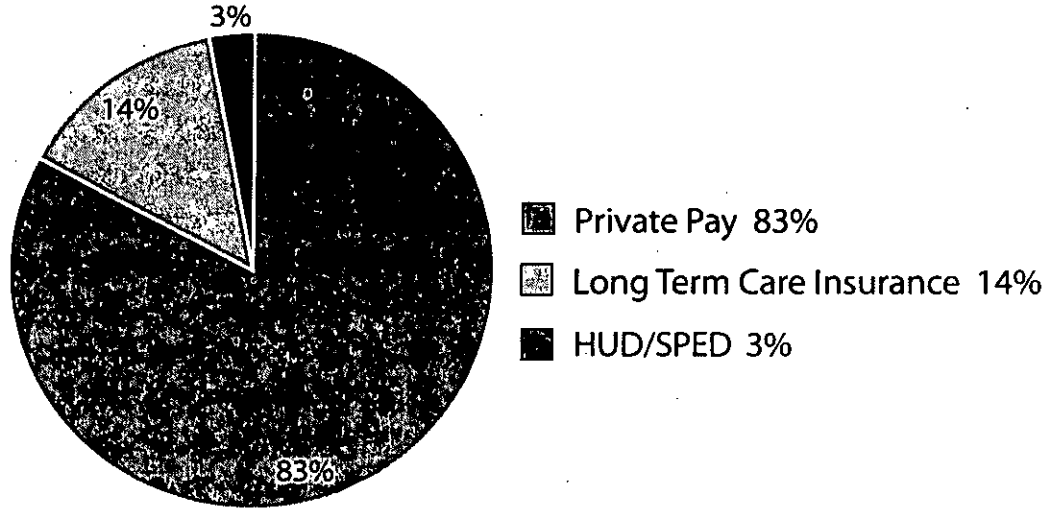
- 30% of tenants have impaired mental status ranging f mental health diagnosis.
- 45% of tenants need full assistance with medication a
- Most tenants are fully independent in eating (91%), tra %) and dressing (70%).
- About one-third of tenants periodically use the assistance of a walker.

Assisted Living Facilities (continued)

Assisted Living Cost:

- In 2010, the average charge for rent in a one bedroom assisted living facility was $1,776 per month ($21,312/year), with a range of $530-$2,858.
- The average cost for services in an assisted living facility ranged from $300 to $2,350 per month, with an average of $1,162 per month ($13,944/year).
- The cost of a assisted living is highly dependent on the size of the living space, location in North Dakota and the amenities in the rental package.
- Most tenants pay for the service from their own private funds, with long term care insurance the payer source in 14% of the cases.
- Almost 60% of facilities responding to the survey felt rent assistance for low and moderate income individuals should be made available to assisted living tenants.
- Less than a handful of facilities are experiencing some tenant account collection issues. This usually occurred when tenant resources were depleted or long term care insurance was behind on paying.

Figure 5: Who Pays the Bill in Assisted Living Facilities



(n=1,088)

Assisted Living Workforce:

- Number of individuals employed in 31 assisted living facilities is 592. Based upon this ratio, total people employed by seventy-one assisted living facilities is estimated to be 1,356.
- October 1, 2010, thirty-five assisted living facilities reported 29 vacant positions. The estimate for all 71 assisted living facility vacancies is 59.
- Assisted living facilities rating of staffing crisis on a scale of 1 to 5, with 5 being a crisis is 1.8.
- 17% (5) of reporting assisted living facilities used contract agency staff in 2010 to staff their facilities.
- The 2010 average salary increase provided was 3.88%.

Figure 6: Assisted Living Staff Turnover

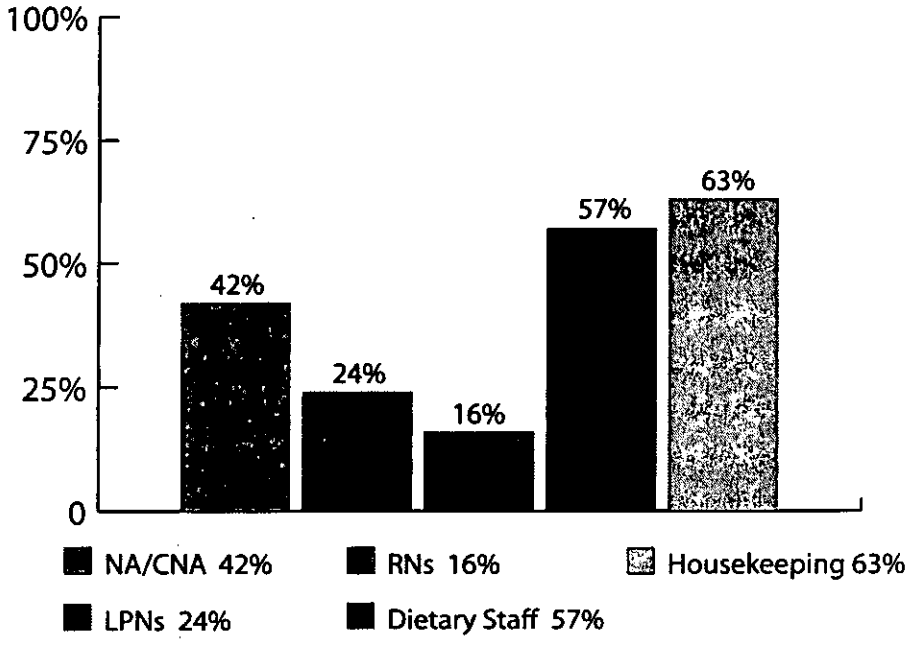
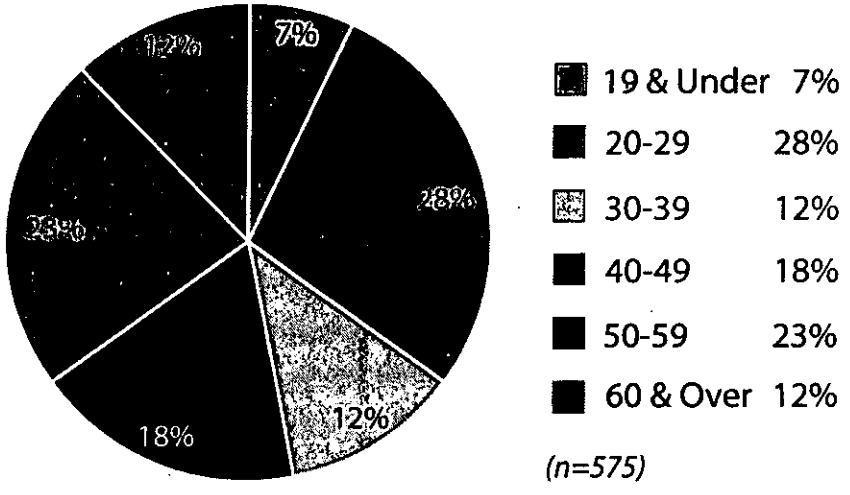


Figure 7: Age of Assisted Living Workforce



- The youngest employee is 16 and the oldest employee is 83.
- One-third of our workforce is age 50 and older.

Compliance with Regulation:

In the 2009 legislative session, HB 1263 was passed requiring administrator and staff training, comprehensive background check prior to employment in assisted living and completion of a consumer satisfaction survey prior to 08/01/11 and every two years thereafter.

All reporting facilities indicated compliance with the training and pre-employment check.

- 61% of assisted living facilities have completed a consumer satisfaction survey by 10/01/10. Of those completing, half used an independent company, My InnerView for the completion of the survey.

Assisted Living Facilities (continued)

ND Long Term Care Association Members

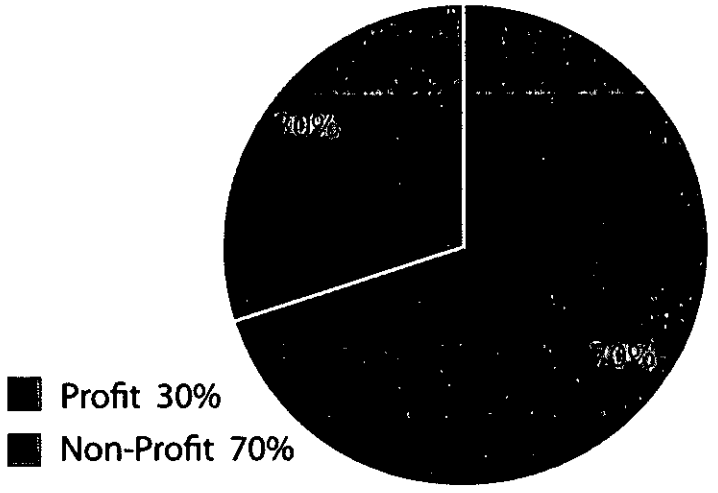
City	Facility Name
Arthur	Prairie Villa
Bismarck	Edgewood Bismarck Senior Living
Bismarck	Edgewood Vista at Edgewood Village
Bismarck	Good Samaritan Society – Bismarck
Bismarck	Primrose Retirement Community
Bismarck	Valley View Heights
Bismarck	Waterford on West Century
Bowman	Sunrise Village
Cooperstown	Park Place
Crosby	Northern Lights Villa
Devils Lake	GSS – Lake Country Manor
Devils Lake	Heartland Courts
Dickinson	Benedict Court
Dickinson	Evergreen
Dickinson	Hawks Point
Dickinson	Park Avenue Villa
Ellendale	Evergreen Place
Fargo	Bethany Gables
Fargo	Bethany Towers
Fargo	Edgewood Vista at Edgewood Village
Fargo	Good Samaritan Society – Fargo
Fargo	Pioneer House Assisted Living for Seniors
Fargo	Riverview Place
Fargo	Waterford at Harwood Grove
Garrison	The Meadows
Grafton	Leisure Estates
Grand Forks	Parkwood Place
Grand Forks	Tufte Manor
Grand Forks	Wheatland Terrace
Hatton	Hatton Prairie Village
Hettinger	Western Horizons Assisted Living
Hillsboro	Hillsboro Medical Center
Jamestown	Heritage Centre of Jamestown, Inc.
Kenmare	Baptist Home of Kenmare
Lakota	Good Samaritan Society – Prairie Rose
LaMoure	Rosewood Court Assisted Living
Larimore	Good Samaritan Society – Larimore
Lisbon	Beverly Anne Assisted Living Center
Mayville	Sun Centers
Minot	Edgewood Vista Minot Senior Living
Minot	The View on Elk Drive
Minot	The Wellington
Napoleon	Napoleon Congregate/AL Apartments
New Rockford	Heritage House
New Salem	Elm Crest Assisted Living
New Town	Good Samaritan Society – New Town
Northwood	Northwood Deaconess Health Center
Oakes	Good Samaritan Society – Royal Oakes
Rugby	Haaland Estates – Assisted Living
Valley City	The Legacy Place, LLC
Velva	Valley View Manor
Walhalla	North Border Estates
Watford City	Horizon
West Fargo	Eventide at Sheyenne Crossings
Williston	Bethel Assisted Living Center
Williston	Kensington Williston LLC
Wishek	Prairie Hills Assisted Living

Basic Care Facilities

Basic Care at a Glance:

- 65 licensed basic care facilities
- 1,777 licensed beds
- 2010 average daily rate is $97
- 2010 average occupancy is 83%

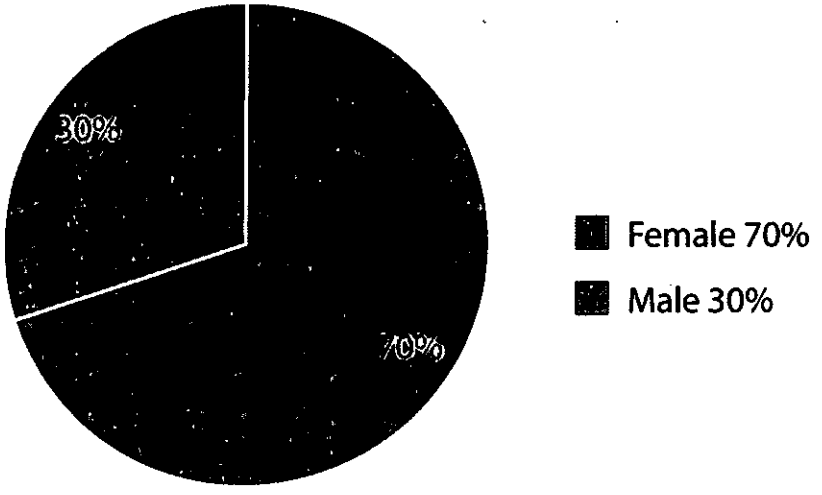
Figure 8: Ownership of Basic Care Facilities



Basic Care Facts:

- A congregate residential setting with private and semi-private rooms where you receive 24-hour supervision with a comprehensive service plan to meet your needs.
- Basic care provides an all inclusive rate providing room, meals, personal care services, supervision, activities, transportation, medication administration, nursing assessment and care planning.
- Seventy percent of residents are female and the majority were living in their own home prior to admission.
- Cognitive decline is the top issue precipitating the need for placement.
- Current residents range in age from 23 to 104 years old, with the average age being 78.

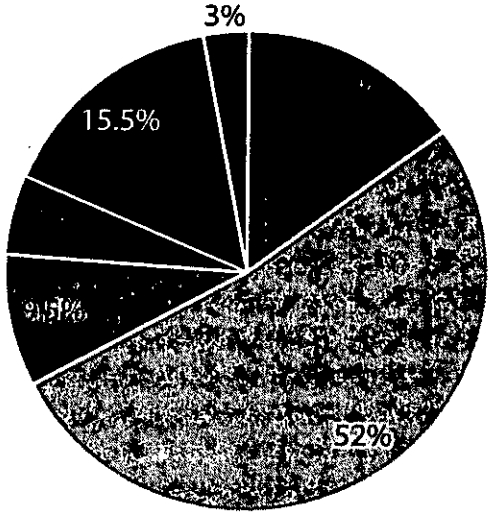
Figure 9: Gender of Basic Care Residents



(n=764)

When Individuals Move Into a Basic Care Facility, Where Do They Come From?

Figure 10: Living Arrangements Prior to Admission



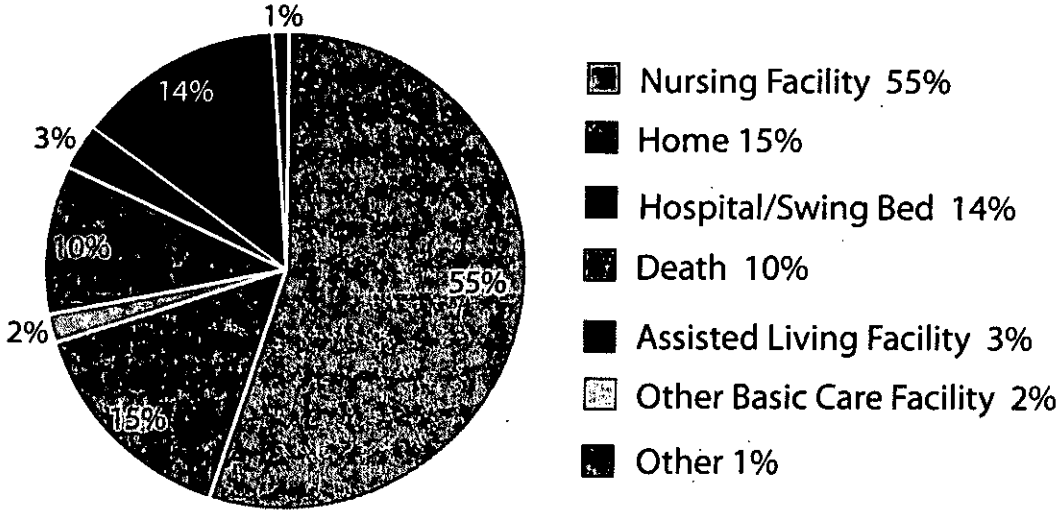
(n=744)

Top three reasons for basic care admission:

1. Cognitive decline
2. Progressive physical decline
3. Social isolation

When Residents Move-Out, Where Do They Go?

Figure 11: Discharge Destination



(n=357)

Over half of residents discharged from a basic care facility are admitted to a skilled nursing facility. Generally medical needs, physical limitations and growing cognitive issues necessitate the admission.

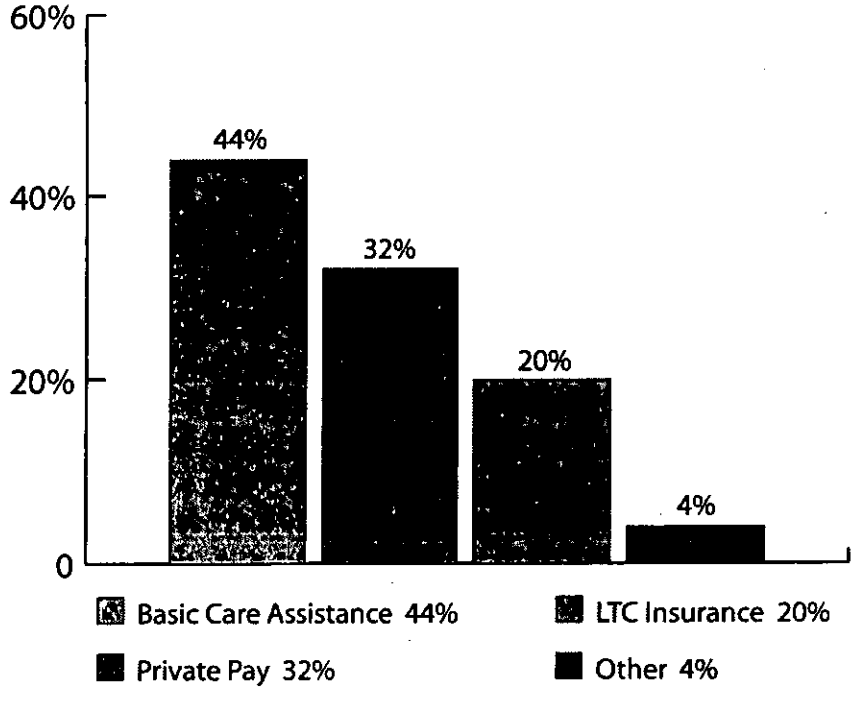
Care Needs of Basic Care Residents:

- 72% of residents have impaired mental status, ranging from early state dementia to a significant mental health issues.
- 85% of residents need full assistance with medication administration.
- Over one-third of residents (35%) are receiving psychoactive drugs.
- Most residents are independent in dressing (60%), with less than 10% requiring extensive assistance (8.6%).
- 81% of residents need assistance in bathing.
- Most residents are fully independent in eating (88%), toileting (80%) and transferring (92%).
- 60% are ambulatory and do not need any staff assistance, 48% use a walker and very few use a wheelchair (7%).

Basic Care Costs:

Slightly more than half of the residents living in basic care pay for the service from their own funds (52%).

ure 12: Payment Source for Basic Care Bills



(n=669)

Cost of a Private Room:

- 55% of basic care facilities charge extra for a private room. The average daily cost for a private room is $16.00 per day or $487 monthly.

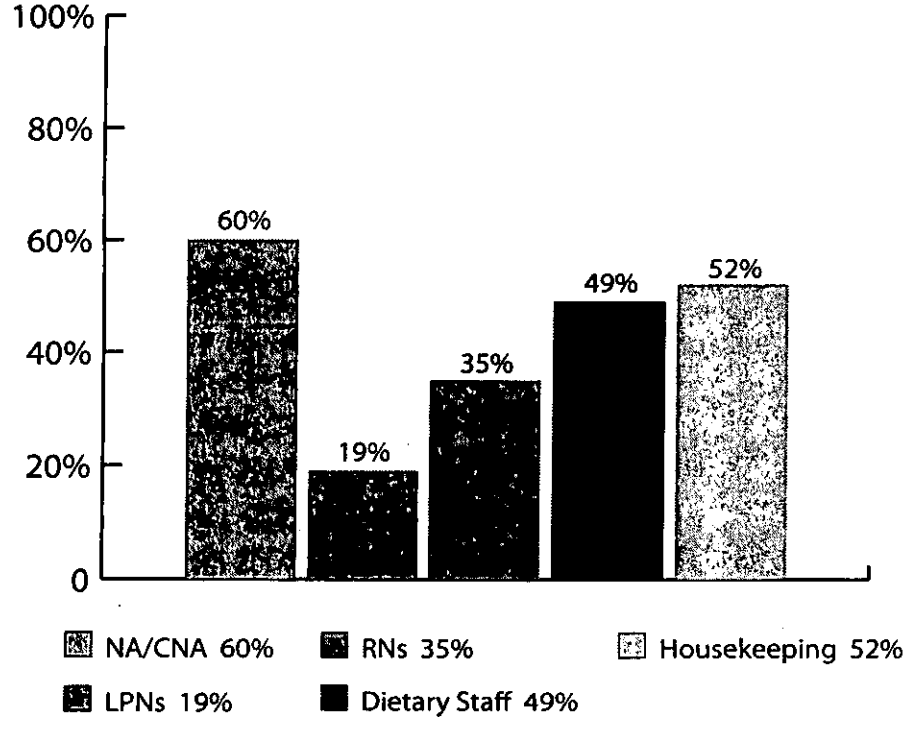
Rate Equalization in Basic Care:

- Today it is allowable to charge private pay residents more than government controlled basic care rates. Even though it is allowable to charge the private pay more, less than two out of five basic care facilities (39%) charge private pay individuals extra. The main reason for charging more is the cost of operation in not fully covered in the basic care rate. For the few (n=12) that charge extra, the average charge is $14.34 daily or $436 monthly.

Basic Care Workforce:

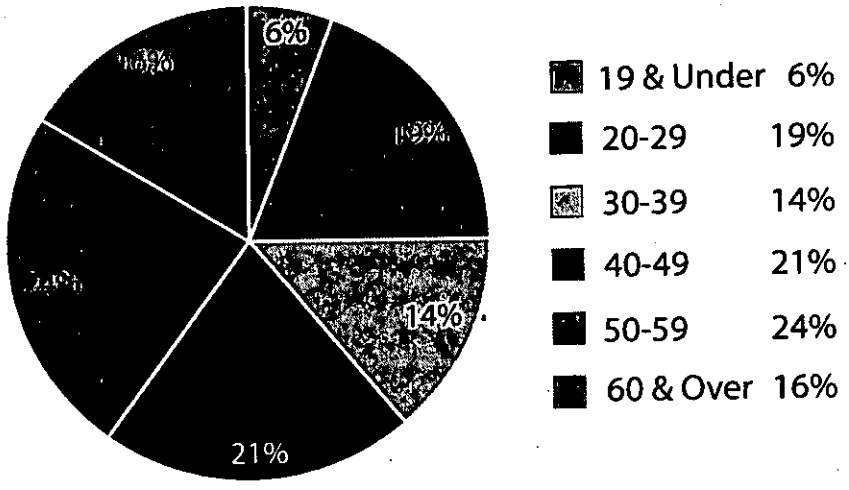
- Top issue facing basic care facilities is staffing.
- Number of individuals employed in 37 basic care facilities was 1,331. Based upon this ratio, total people employed by 64 basic care facilities are estimated to be 2,302.
- October 1, 2010, thirty-seven basic care facilities reported 73 vacant positions. The estimate for all 64 basic care facility vacancies is 126.
- Basic care facilities rating of staffing crisis on a scale of 1 to 5, with 5 being a crisis is 2.76.
- Less than 10% of basic care facilities stopped admissions in 2010 because of a lack of staff.
- 12% (4) of reporting basic care facilities used contract agency staff in 2010 to staff their facilities. The four facilities spent $792,878 on contract staff.
- The 2010 average salary increase provided was 3.64%

Figure 13: Basic Care Staff Turnover



Comparison of Turnover 2000 to 2010		
Position	**2000**	**2010**
NA/ CNAs	56%	60%
LPNs	14%	19%
RNs	36%	35%
Dietary	57%	49%
Housekeeping	16%	52%

Figure 14: Age of Basic Care Workforce



(n=1,170)

- The youngest employee is 14 and the oldest employee is 88.
- 40% of the workforce is age 50 or older.

Basic Care Bad Debt/Collection Issues:

On October 1, 2010 basic care facilities were carrying $64,699 in resident accounts more than 60 days past due. This was due from 32 residents.

On average one out of every twenty residents in a basic care facility e a payment issue associated with their account. This can range om chronic lateness in paying account, children or responsible party refusing to pay the bill or Medicaid denying eligibility and resources do not exist to pay the bill.



Basic Care Facilities (continued)

ND Long Term Care Association Members

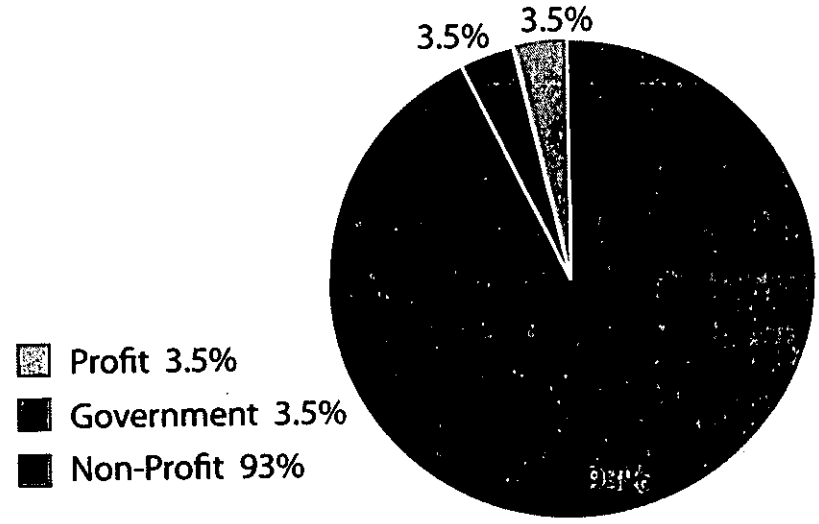
City	Facility Name	City	Facility Name
Arthur	Prairie Villa	Grand Forks	Tufte Manor
Bismarck	Baptist Home, Inc.	Hazen	Senior Suites at Sakakawea
Bismarck	Edgewood Bismarck Senior Living	Hettinger	Western Horizons Care Center
Bismarck	Edgewood Vista at Edgewood Village	Jamestown	Bethel 4 Acres Ltd
Bismarck	Good Samaritan Society – Bismarck	Jamestown	Rock of Ages, Inc.
Bismarck	Maple View – East	Jamestown	Roseadele
Bismarck	Maple View – North	Kenmare	Baptist Home of Kenmare
Bismarck	The Terrace	Lisbon	North Dakota Veterans Home
Bismarck	Waterford on West Century	Lisbon	Parkside Lutheran Home
Bottineau	Good Samaritan Society – Bottineau	Maddock	Maddock Memorial Home
Cando	St. Francis Residence	Mandan	Dakota Pointe
Carrington	Holy Family Villa	Minot	Edgewood Vista Memory Care
Crosby	Good Samaritan Society – Crosby	Minot	Edgewood Vista Minot Senior Living
Devils Lake	Good Samaritan Society – Devils Lake	Minot	Emerald Court
Devils Lake	Odd Fellows Home	Mott	Good Samaritan Society – Mott
Dickinson	Dickinson Country House LLC	Mountain	Borg Pioneer Memorial Home
Dickinson	Evergreen	New Town	Good Samaritan Society – New Town
Edgeley	Manor St. Joseph	Osnabrock	Good Samaritan Society – Osnabrock
Edmore	Edmore Memorial Rest Home	Park River	Good Samaritan Society – Park River
Elgin	Dakota Hill Housing	Rolette	Rolette Community Care Center
Ellendale	Evergreen Place	Rugby	Haaland Estates – Basic Care
Fargo	Bethany Towers	Valley City	HI Soaring Eagle Ranch
Fargo	Edgewood Vista at Edgewood Village	Wahpeton	St. Catherine's Living Center
Fargo	Good Samaritan Society – Fargo	Wahpeton	The Leach Home
Fargo	Waterford at Harwood Grove	Walhalla	Pembilier Nursing Center
Forman	Four Seasons Healthcare Center Inc.	Watford City	McKenzie City HC Systems
Gackle	Gackle Care Center	West Fargo	Eventide at Sheyenne Crossings
Grand Forks	Maple View Memory Care	Williston	Bethel Lutheran Nursing & Rehab Center
Grand Forks	Parkwood Place	Williston	Kensington Williston LLC
Grand Forks	St. Anne's Guest Home	Wilton	Redwood Village

Nursing Facilities

Nursing Facilities at a Glance:

- 85 licensed nursing facilities
- 6,397 licensed beds
- 2010 average daily rate is $196
- 2010 average occupancy is 93%

Figure 15: Ownership of Nursing Facilities

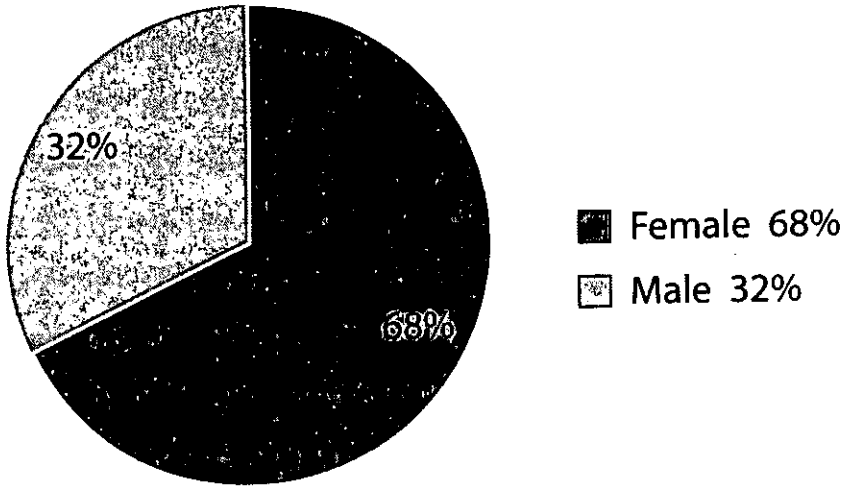


(n=85)

Nursing Facility Facts:

- Resident needs are complex and they are in need of 24 hour nursing care and supervision.
- Most residents are admitted from their own homes, with over half coming directly from a hospital stay.
- The most significant need necessitating the need for admission to a nursing facility is the need for care throughout the day. Residents are unable to meet their own needs for dressing, toileting, eating and remaining safe.
- Current residents range in age from 18 to 106 years old, with the average age being 84.

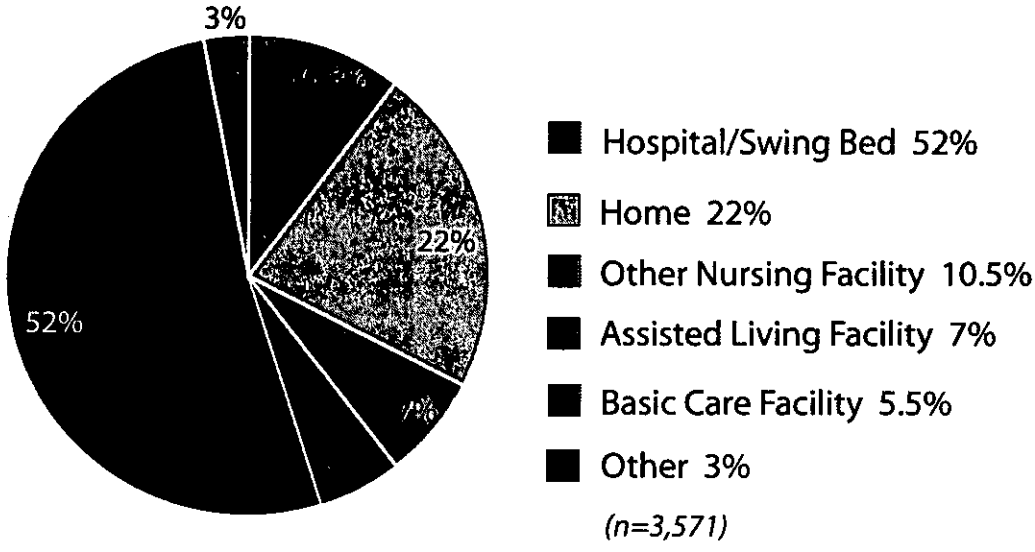
Figure 16: Gender of Nursing Facility Residents



(n=3,857)

When Individuals Move Into a Nursing Facility, Where Do They Come From?

Figure 17: Living Arrangements Prior to Admission

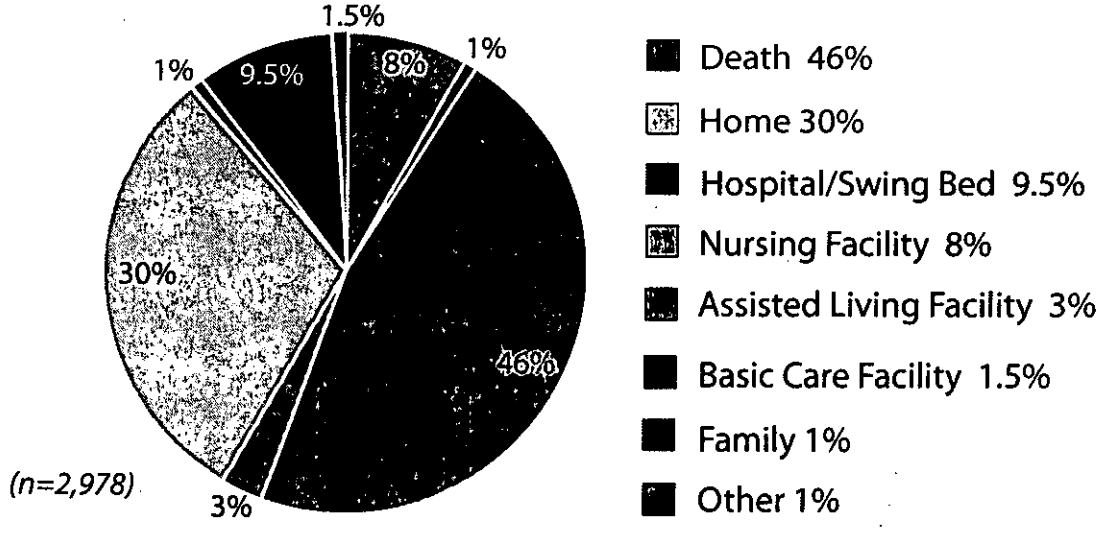


Top Five Reasons for Nursing Care Admission:

1. Needs assistance with daily care throughout the day.
2. Complex medical needs
3. Needs continuous supervision
4. Dementia
5. Falls

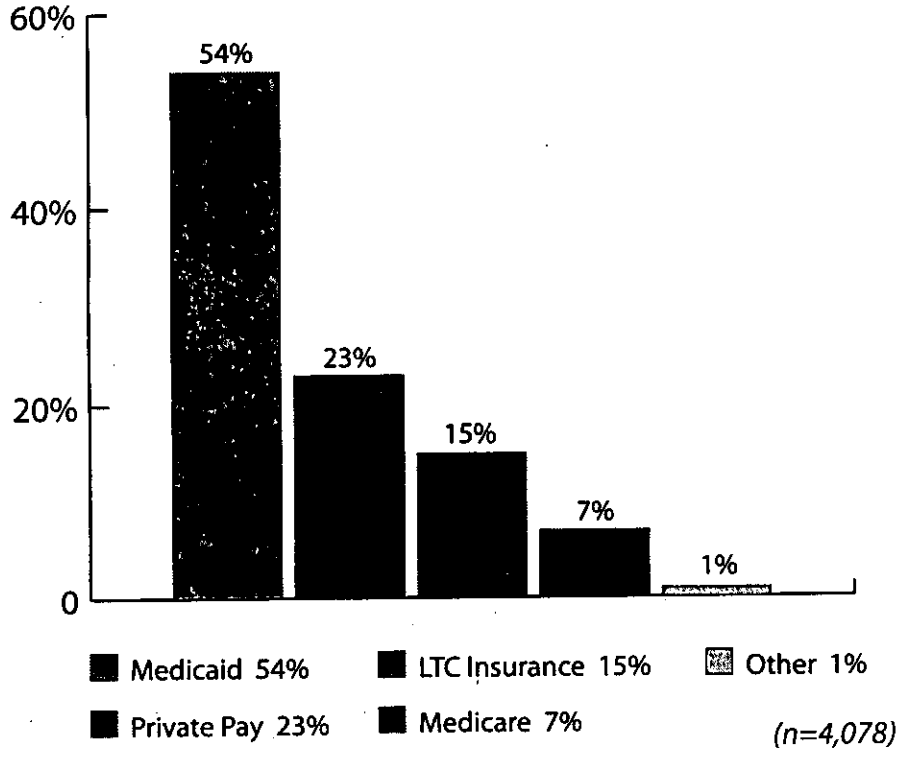
When Residents are Discharged from a Skilled Nursing Facility, Where Do They Go?

Figure 18: Discharge Destination



- One-third of all residents admitted to a nursing facility are discharged to their own home or a lower level of care.
- Average length of stay in 2010 was 289 days (9.6 months), down 61 days from the 2009 average of 350 days.

Figure 19: Payment Source for Nursing Facility Bills



Average cost for one day of nursing facility care:

$195.55 in 2010
$205.04 in 2011

Cost for a Private Room:

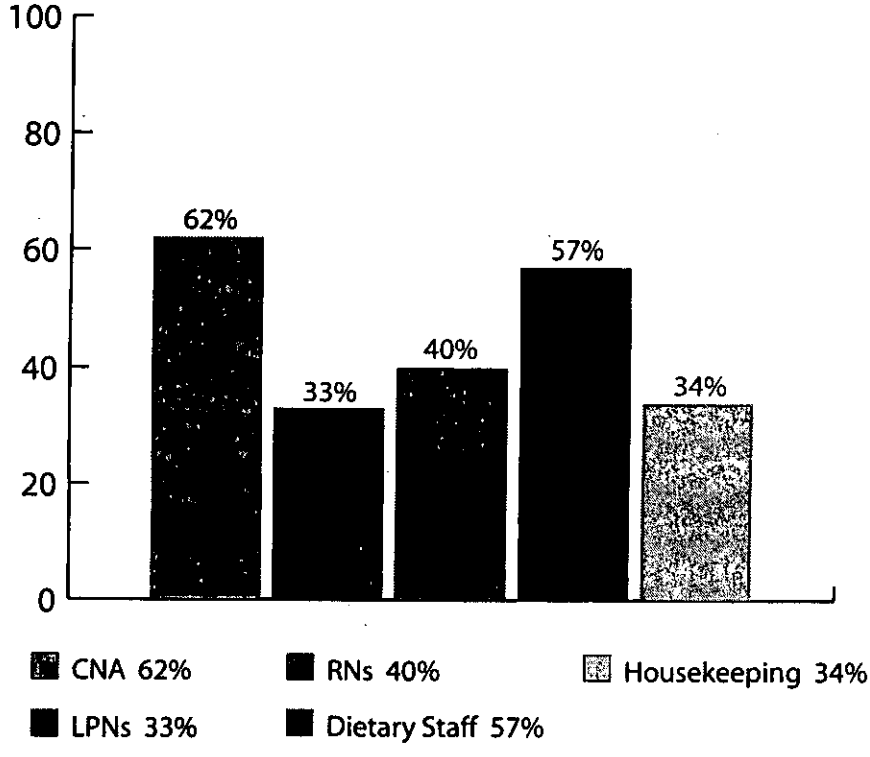
Nursing facilities are allowed to charge extra for a private room. Ninety percent of nursing facilities charge extra for a private room. The average daily private room charge in 2010 was $12.55. The extra private room charge varies based upon size and location of room. Private rooms are growing in numbers to meet the increased demand.

Nursing Facility Workforce

- Top issue facing nursing facilities is staffing.
- Number of individuals employed in 60 nursing facilities was 8,188. Based upon this ratio, total people employed by 85 nursing facilities are estimated to be 11,600.
- October 1, 2010, fifty-eight nursing facilities reported 524 vacant positions. The estimate for all 85 nursing facility vacancies is 768.

- Nursing facility rating of staffing crisis on a scale of 1 to 5, with 5 being crisis is 3.1.
- Seven of 61 reporting nursing facilities stopped admissions in 2010 because of a lack of staff.
- Thirty-eight percent of nursing facilities, almost 2 out of 5 facilities, used contract agency staff in 2010 to staff their facilities.
- The 2010 average salary increase provided was 4.13%.

Figure 20: 2010 Staff Turnover

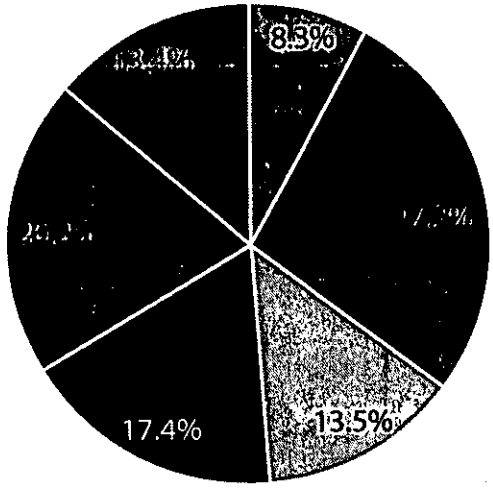


History of Nursing Facility Turnover 1995 to 2010

Position	1995	2000	2003	2006	2010
CNAs	59%	66%	35%	53%	62%
LPNs	22%	24%	17%	21%	33%
RNs	28%	33%	17%	25%	40%
Dietary	43%	54%	N/C*	44%	57%
Housekeeping	40%	27%	N/C*	30%	34%

*N/C = Not Collected

Figure 21: Age of Nursing Facility Workforce



19 & Under	8.3%
20-29	27.2%
30-39	13.5%
40-49	17.4%
50-59	20.2%
60 & Over	13.4%

(n=8,316)

- Turnover and age of our workforce will create an unprecedented demand for employees in the next 10 years.

  The youngest employee is 14 and the oldest employee is 97.

- One-third of our workforce is age 50 and older.

Nursing Facility Bad Debt/Collection Issues:

On October 1, 2010 nursing facilities were carrying $5,342,936 in resident accounts more than 60 days past due. This was due from 613 residents.

On average one out of every six residents in a nursing facility have a payment issue associated with their account. This can range from not paying their bill within 60 days of receipt, responsible party never paying the bill or Medicaid denying eligibility and resources do not exist to pay the bill.

This issue continues to grow. Nursing facilities have been ed to develop aggressive collection plans, deny admissions payment source is not identified and start discharging proceedings when payment is not forthcoming.



ND Long Term Care Association Members

City	Facility Name
Aneta	Aneta Parkview Health Center
Arthur	Good Samaritan Society – Arthur
Ashley	Ashley Medical Center
Beulah	Knife River Care Center
Bismarck	Baptist Home, Inc.
Bismarck	Good Samaritan Society – Bismarck
Bismarck	Medcenter One St. Vincent's
Bismarck	Medcenter One Subacute Unit
Bismarck	Missouri Slope Lutheran Care Center
Bismarck	St. Alexius Medical Center – TCU
Bismarck	St. Gabriel's Community
Bottineau	Good Samaritan Society – Bottineau
Bowman	Southwest Healthcare Services
Cando	Towner County Living Center
Carrington	Golden Acres Manor
Cavalier	Wedgewood Manor
Cooperstown	Cooperstown Medical Center
Crosby	Good Samaritan Society – Crosby
Devils Lake	Good Samaritan Society – Devils Lake
Devils Lake	Heartland Care Center
Dickinson	St. Benedict's Health Center
Dickinson	St. Luke's Home
Dunseith	Dunseith Community Nursing Home
Elgin	Jacobson Memorial Hospital Care Center
Ellendale	Prince of Peace Care Center
Enderlin	Maryhill Manor
Fargo	Bethany on 42nd Skilled Care
Fargo	Bethany on University Skilled Care
Fargo	Elim – A Caring Community
Fargo	Manor Care of Fargo ND, LLC
Fargo	Rosewood On Broadway
Fargo	Villa Maria
Forman	Four Seasons Healthcare Center Inc.
Garrison	Benedictine Living Center of Garrison
Garrison	Garrison Memorial Hospital & NF
Glen Ullin	Marian Manor HealthCare Center
Grafton	Lutheran Sunset Home
Grand Forks	Valley Eldercare Center
Grand Forks	Woodside Village
Hankinson	St. Gerard's Community Nursing Home
Harvey	St. Aloisius Medical Center
Hatton	Hatton Prairie Village
Hettinger	Western Horizons Care Center
Hillsboro	Hillsboro Medical Center
Jamestown	Ave Maria Village
Jamestown	Eventide at Hi-Acres Manor
Killdeer	Hill Top Home of Comfort
Lakota	Good Samaritan Society – Lakota
LaMoure	St. Rose Care Center
Langdon	Maple Manor Care Center
Larimore	Good Samaritan Society – Larimore
Lisbon	North Dakota Veterans Home
Lisbon	Parkside Lutheran Home
Mandan	Dakota Alpha
Mandan	Medcenter One Mandan CC Off Collins
Mandan	Medcenter One Mandan Living Center
Mayville	Luther Memorial Home
McVille	Nelson City Health System Care Center
Minot	Manor Care of Minot ND, LLC
Minot	Trinity Homes
Mohall	Good Samaritan Society – Mohall
Mott	Good Samaritan Society – Mott
Napoleon	Napoleon Care Center
New Rockford	Lutheran Home of the Good Shepherd NH
New Salem	Elm Crest Manor
Northwood	Northwood Deaconess Health Center
Oakes	Good Samaritan Society – Oakes
Osnabrock	Good Samaritan Society – Osnabrock
Park River	Good Samaritan Society – Park River
Parshall	GSS – Rock View at Parshall
Richardton	Richardton Health Center
Rolette	Rolette Community Care Center
Rugby	Heart Of America Medical Center
Stanley	Mountrail Bethel Home
Strasburg	Strasburg Nursing Home
Tioga	Tioga Medical Center LTC
Underwood	Medcenter One Prairieview
Valley City	Sheyenne Care Center
Velva	Souris Valley Care Center
Wahpeton	St. Catherine's Living Center
Walhalla	Pembilier Nursing Center
Watford City	McKenzie City HC Systems
West Fargo	Sheyenne Crossings Care Center/TCU
Williston	Bethel Lutheran Nursing & Rehab Center
Wishek	Wishek Home for the Aged

The Economic Pulse of North Dakota

A summary of the study to determine the contribution of long term care facilities to North Dakota's economy.

A total of 221 long term care facilities provide North Dakota residents with a comprehensive array of services. These health care providers contribute significantly to the overall stability and viability of the state. Long term care facilities provide positive impacts relating to financial, employment and resident care indicators. The research study which follows is titled "The Pulse of North Dakota." It was conducted in the fall of 2010 to assess the contributions made by long term care to the economy of North Dakota. Key research findings include:

- According to the 2010 Pulse Survey, long term care facilities in North Dakota generate an estimated $565.6 million dollars in annual revenue. The revenue was generated by three distinct sectors within the long term care profession; assisted living facilities, basic care facilities and nursing facilities.
- The direct and secondary impact of the long term care industry on the state's economy has reached nearly $1 billion. The total direct impacts, combined with secondary impacts, total $972.9 million annually.
- The vast majority of dollars spent by long term care facilities remain in North Dakota. On average, 87% of the dollars remain in the state, while the remaining 13% go to out-of-state sources.
- According to the 2010 Pulse Survey results, long term care facilities in North Dakota directly employed 7,730 full-time employees and 6,704 part-time employees. Thus, a total of 14,434 people were directly employed by long term care facilities in 2010. This represented an estimated 10,357 full-time equivalent (FTE) jobs.
- Job Service reports the average annual wage for long term care workers to be $23,348 as of the second quarter of 2010. This average wage is considerably lower (36%) than the statewide worker average of $36,972/year.
- Job Service of North Dakota reports the total average level of employment in North Dakota to be 360,251 workers as of the second quarter of 2010. Using statistics from the 2010 Pulse Report, an estimated 4% of all workers in North Dakota are directly employed by long term care facilities.
- According to the 2010 Pulse Survey, long term care facilities reported providing care to over 16,000 residents/tenants in assisted living, basic care and nursing facilities.

About The ND Long Term Care Association

About the North Dakota Long Term Care Association

The North Dakota Long Term Care Association (NDLTCA) is a non-profit trade association representing long term care facilities in North Dakota. Membership includes nursing facilities, basic care facilities, and assisted living facilities. NDLTCA began operating in 1977 and currently represents 163 nursing, basic care, and assisted living facilities. NDLTCA works closely with State and Federal government agencies along with other professional associations in its efforts to advocate on behalf of long term care and promote sound legislative and regulatory policies. NDLTCA is an affiliate of the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL). AHCA and NCAL, located in Washington, D.C., are the largest organizations of long term care facilities in the nation. NDLTCA is governed by a 13 member Board elected by the membership. Overall policy of the NDLTCA is the responsibility of the Board. NDLTCA is dedicated to serving our members who strive to maintain the highest quality of care for the elderly and disabled.

Mission Statement

The North Dakota Long Term Care Association is a professional association of long term care and community service providers who enhance the lives of people we serve through collaboration, education and advocacy.

Vision Statement

The North Dakota Long Term Care Association is recognized as an innovative leader and pioneer in the continuum of care, which has a positive impact on the quality of life of those we serve.

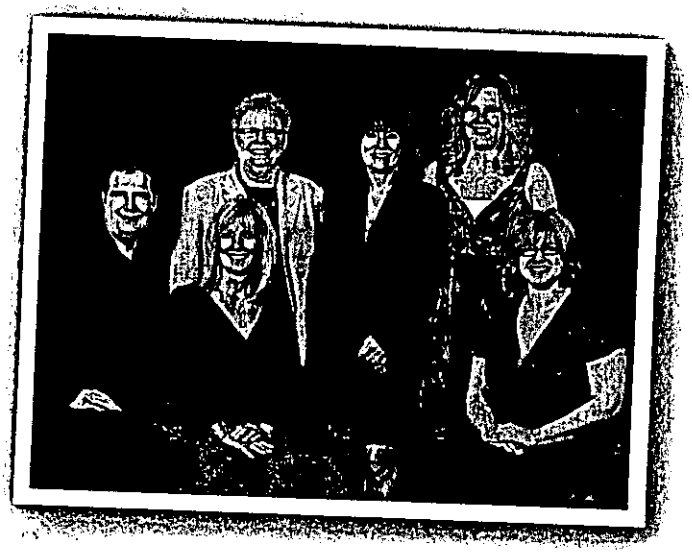
Core Values

- Competence
- Honesty
- Integrity
- Responsiveness
- Trust



Resources

Most of the information provided in this publication was gathered from a comprehensive survey of assisted living, basic care and nursing facility members, completed in the Fall of 2010. Additional information was gathered from the Eide Bailly database on nursing facility costs, the Economic Pulse Report, the North Dakota State Data Center and US Census Bureau.



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Pam Cook, *Education Assistant /Billing*
Pamela Thompson, *Executive Assistant*
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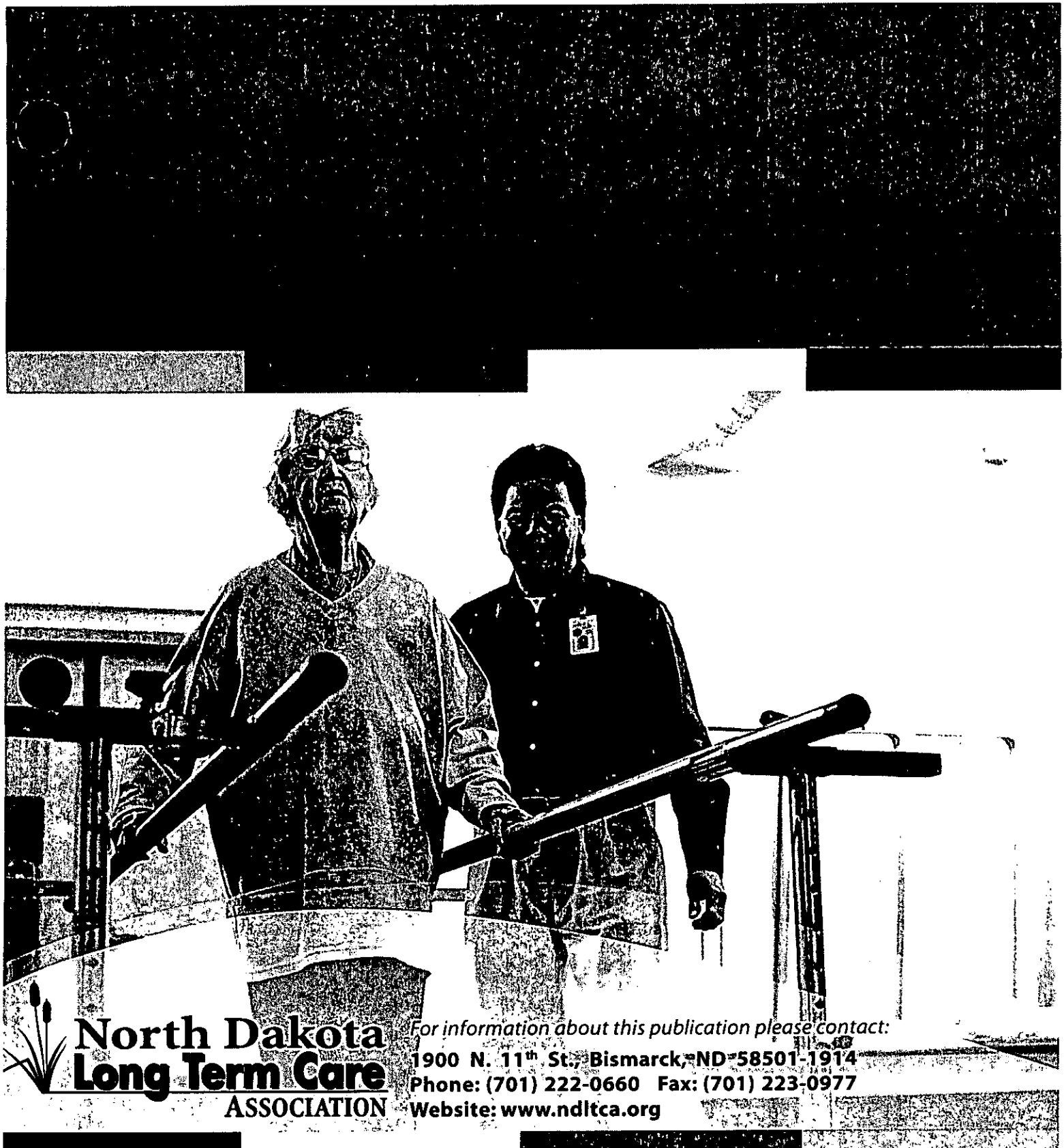
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- Attachment SEVEN

Testimony on SB 2012
House Appropriations-Human Resource Division
March 8, 2011

Good morning Chairman Pollert and members of House Appropriations-Human Resource Division. My name is Mitch Leupp. I am the administrator of Mountrail Bethel Home and Mountrail County Medical Center a 57 bed nursing home and 11 bed Critical Access Hospital with attached rural health clinic and independent living apartments in Stanley, ND. Together we call our campus Mountrail County Health Center.

I am here to testify in support of SB 2012 and share with you why the three percent annual inflator contained in SB 2012 is so vital to our facility.

Thank you for allowing me to share some information on our facilities, community operations and the impact that the oil boom has had on our operations in Stanley.

As you know the oil industry has brought many good things to North West North Dakota and the whole state. As you also know it has created many challenges. For Mountrail County Health Center for the most part it has been challenges.

Some of the challenges we are facing include; difficulty in finding employees, increased costs in housing and increases in cost of living.

Specifically in regard to staffing, Mountrail Bethel Home prior to 2009 had never used traveling or agency Certified Nursing Assistants (CNA's). Today 50% daytime and 90% of our afternoon or P.M. CNA shifts are filled by agency staff. Our employed CNA's in 2008 were 28 FTE's, in 2010 this dropped to about 14.5 FTE's. The rest is covered by traveling CNA's. This comes at a great expense since the contract cost per hour is almost double that of our employed CNA's and we also are paying mileage for them to travel to Stanley and we must provide housing for these traveling CNA's while they are working their shifts for us. It also has a negative impact on how our cost report and how our costs are calculated.

We are also in desperate need for many other positions that are more difficult now than ever to fill. These include dietary, business office and physical therapy, etc. We have gone months without applicants that are native to North Dakota. While this is not necessarily a bad thing, the longevity of those employees moving in to North Dakota from all over the United States is not what we had in the past. Our turnover in positions at Mountrail County Health Center is several times what it was in years past. We also have a much more difficult time in doing background checks on those prospective employees from other states.

Recently we had two resignations in our dietary department. We have been so critically short of staff in that department that our management team as well as numerous other staff has had to help to fill those dietary duties and shifts.

On the hospital side we have had some recent business office openings. Several years ago these jobs would typically produce 20+ applicants. One of the recent posting for a clinic billing person produced 3 applicants, none of whom were qualified or had any experience not only in clinic billing but office work.

We believe there are a number of issues that have impacted the issues with workforce. They include; lack of affordable housing, increased wages for many other jobs in the area, the difficulty of the job compared to other jobs with higher prevailing wages, lack of available workforce in the area due to high demand for employees by every industry.

You can now get a job in a convenience store at and entry level for $13.00/hour, you can clean skid shacks or buildings for the oil companies for $20.00+ dollars an hour, Receptionist and office help are being hired at $18.00 per hour starting wages. We cannot compete in the healthcare arena with these kinds of wages available from other employers in the area.

In regard to housing; a two bedroom apartment in Stanley now rents for $1,700 - $2,000 per month including utilities. Houses that a few years ago sold for $40,000 - $50,000 are now selling for $150,000+. This at a time when financing of housing is in crisis. It takes months to get appraisals. Houses are on the market for well above appraised values and the regular person in Stanley cannot afford to come up with the down payment to purchase the houses that are available. As an example of the high costs in Stanley my son who is living in a single wide trailer in Stanley just had his lot rent increased to $850.00/month. This only includes water/sewer/garbage. I lost a clinic nurse whose rent for a small 2 bedroom house went from $425.00/month to $850.00/month. This was a 1940 vintage house of about 700 sq. feet in significant disrepair. She could not afford as a single mother to live in Stanley.

In regard to salary's Mountrail County Health Center for the past number of years has gauged our salaries by several salary surveys that are done for healthcare in North Dakota. We typically have been toward the top of the salary ranges with most of our jobs compared to the other rural facilities in North Dakota. At this point even being among the best paid rural facilities we are not able to get staff in many positions.

In the recent past we have implemented the following raises and bonuses;
PPE 6 /9/09 - $.50/productive hour bonus
Effective 7/1/09 – Facility wide raise of $.80/hr. for ALL employees (HB 1012-Human Services budget bill.)
Effective 9/1/09 – 19% Market Adjustment for Business Office (Billing Clerks, Business Office Coordinator, CFO, HR Director, Financial Computer Assistant)
PPE 6/2810 - $.15/productive hour bonus
PPE 10/15/10 – Facility Raise of 4% for ALL employees
These raises are in addition to our merit increases which are based on our employee's annual performance evaluation going from 0%- 4% per year.

Also in 2009 we implemented a longevity bonus that recognizes staff for long term service which is given out annually and is in increments from $50.00 – $300.00 starting at 15 years of service through 30 years of service. We implemented this to try and keep our long term employees with us.

We also had in place sign on bonuses for new staff of $1,000 - $2,000 dependant on position. We were also paying a recruitment bonus for staff that referred a new employee to our facility. We have discontinued these at this point, with the exception of the sign on for certain positions that on a position by position basis.

We have also covered the increase in the Blue Cross insurance coverage for our staff for the last 6 years. In doing staff surveys this is one of the most important parts of our retention effort for staff. We currently pay health insurance benefits on the following scale;
Full Time: Single = 89%; SPD = 82%; Family = 65%,
Regular Part Time: Single = 60%; SPD = 47%; Family = 42% for our employees.

The previously mentioned items really just cover our employee issues. The breakdown of our expenses for the nursing home are about 75-80% of our annual expenses are employee's wages and benefits. The remainder (20 – 25%) is for the other costs to operate the facility such as groceries, paper products, utilities, insurance, computer operations etc.

As we look ahead to next year our purchasing group Amerinet is estimating that our inflation for Groceries at 3%- 12% depending on the item, environmental supplies (paper, trash can liners etc.) 5%- 15%, office supplies at 10%. We are seeing significant increase in gas prices. The last time this happened our cost to get supplies increased dramatically.

As you can see from these projections if they are true, and we don't get an inflator factor built in to our reimbursement we will need to be taking money from wages and benefits just to maintain our operations for our supplies. Without an appropriate inflator there would be no way that we can even maintain the current level of quality of care for our residents and patients.

Mountrail County Health Center is a co-located hospital and nursing home. As most of you have heard many of the rural hospitals in North Dakota are losing money. I believe the current statistics show more than 60% are operating in the red with an average operating margin of less that <-2%>. This is certainly the case with Mountrail County Medical Center.

The hospital has been struggling financially for many years. We have focused a lot of attention on gaining as much efficiency as we can. In 2002 Mountrail County Medical Center merged facilities with Mountrail Bethel Home on one campus. We can now share staff and other resources. Even with the significant gains in efficiency we continue to struggle with making ends meet. We are constantly re-evaluating our operations, staffing, services and quality to ensure that we are as efficient as we can be, offering services that make sense and watching our staffing, purchasing and financial operations very closely.

Without Mountrail Bethel Home and the assistance of Trinity Health in Minot Mountrail County Medical Center would probably have had to close its doors. Given the oil industry and the number of new people, increased need for the Emergency Room this would be tragic. Mountrail Bethel Home has assisted Mountrail County Medical Center in regard to operational funds of around $1,000,000.00 in the last 9 years. This along with significant help from Trinity and our foundation, trust and grants that we have received we have been able to keep the doors open.

Without all of these things coming together Mountrail County Medical Center would not be able to continue to operate. We also understand that without Mountrail County Medical Center the Mountrail Bethel Home probably would not be viable either. Without medical services in town it is difficult to operate a nursing facility. The physician and hospital services availability are critical to success in these facilities.

If these Mountrail Bethel Home and Mountrail County Medical Center were to close, that would mean not only the loss of acute care, emergency and clinic services as well as the nursing home services for our elderly but the employment of approximately 143 individuals, and a direct economic impact of over $5,000,000.00 per year and secondary impact of approximately $1,300,000 per year would be gone. (Per impact report of the UND Center for Rural Health based on 2009 statistics).

When we look at the hospital and clinic operations our ER visits are up over 50% over 5 years, our out of state origin of visits to the ER has more than double since 2008, our new patients seen in the clinic has more than doubled since 2007, all while actually increasing our patient satisfaction with our services.

You might ask; why if you have increase in business are you still struggling financially? There are several issues here. Mountrail County Medical Center did have a better year financially than in the previous several years in Fiscal Year 2010. However as I am sure you may have heard – we are not getting our cost paid by our Medicare patients – in fact we only get somewhere between 90-92% of our full costs paid. This then holds true for North Dakota Medicaid. Blue Cross pays on a fee schedule and this does not cover our costs. We are close the Fort Berthold Indian reservation – we provide much of their emergency care and do not get paid for about 85% of that emergency care that we deliver. Much of the oilfield business is Workforce Safety/Workers compensation – they also pay on a fee schedule that does not cover our cost. We have many new people in our area working in the oil field without health insurance. Given the transient nature of these workers they are very difficult to track down to even deliver the bills to. We are having more problems with bad debt since the oil boom has hit than ever before.

As you can see it is a very complex and difficult system for us to navigate. We are dealing with many different reimbursement system issues as well as numerous cost and operational issues on a daily basis. While there is not one single answer to addressing the fragile nature of healthcare in North Dakota, without the inflation factors that are supported by SB2012 the impact on

Mountrail County Health Center, and I am certain many other facilities will certainly have negative consequences. The already stressed healthcare operations in Stanley will suffer at a time when they are greatly needed.

Again thank you for allowing me to share our story with you and your consideration of supporting SB 2012.

I would be happy to answer any questions.

-Attachment EIGHT

Testimony

Senate Bill 2012-Amy Kreidt, ND Association for Home Care

House Appropriations Committee-Human Resources Division

Representative Pollert, Chairman

March 8, 2011

Chairman Pollert and members of the Human Resources of the House Appropriations committee, my name is Amy Kreidt, I am a registered nurse and the Director of Home Health Services for St. Joseph's Hospital, in Dickinson, ND. We are a Catholic Health Initiative Affiliated Hospital. I am here today as a member of the ND Association for Home Care the (NDAHC) and representing the association.

The NDAHC represents Home Health Care Agencies (Hospital-based, County, nonprofit, and proprietary) and their branches, providing care throughout ND, allowing clients to remain in their homes.

Home Health Care provides: Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, Certified Nurse Assistants (CNAs), Infusion Therapy, Medical Social Workers, Pediatric and Psychiatry Programs, as well as Home Health Aides and Homemaker services, or Personal Care Services assisting with activities of daily living and in certain circumstances, tele-health services. Today I will address the Skilled Nursing and Personal Care, or QSP (Quality Service Provider) services provided by Home Health agencies.

QSP services are provided by individuals, proprietary agencies, and Home Health Care Agencies. Home Health agency QSP services are provided within a medical model of care. These agencies are certified by Medicare and licensed by the state of North Dakota. Home Health Agency QSP providers are generally CNAs, or minimally Nurse Assistants registered in the state, who are directly supervised by a registered nurse. These CNAs receive ongoing education and evaluation of their skills and abilities.

In late June of 2010, our hospital was informed that we would need to eliminate QSP services in our hospital.

Originally, the CHI Affiliated Hospitals were planning to eliminate the QSP services at our facility alone, but as of October we were informed that they would be eliminating the QSP services at each of our affiliated hospitals.

As an association, we feel we are facing a crisis as clients are now faced with limited consumer choice for QSP services throughout the state. We feel nurse supervised QSP services provide an important niche for people trying to remain at home longer.

Based on information from our members, it seems the issue is with travel primarily. Essentially, any time the QSP is traveling more than 5-10 miles, the agency loses money on that service.

Our provider association is concerned about the economic viability of providing qualified service provider (QSP) services with access to nursing supervision. We have worked with members of the Department of Human Services as well as several Legislators in an effort to try to address this issue. We have available an analysis for your review which details a possible scenario you may wish to consider for a travel differential for QSP services.

Additionally, it has come to our attention that the Senate Appropriations Committee has included an amendment which would provide the Developmental Disabilities QSP providers with a 50 cent wage and benefit pass-through. We would support that amendment and at the same time respectfully request that Home Health QSP's be included in that increase, as we are ultimately competing for the same employees, so an increase for one specific group would create an inequity for others.

Chairman Pollert and members of the committee thank you for the opportunity to testify before you today - I urge your favorable recommendation for enhanced reimbursement for nurse supervised QSP services in North Dakota. I would be happy to answer any questions you may have.

-Attachment NINE

Testimony delivered to the House Appropriations Committee in support of **SB 2012**, March 8, 2011 – by Lynn Fundingsland, Executive Director, Fargo Housing and Redevelopment Authority.

Chairman Pollert and members of the committee, thank you for the opportunity to speak with you today.

I am here to request your support for an adjustment to the budget for the SEHSC to provide for staff safety at The Cooper House facility in Fargo. The Cooper House supportive housing the homeless facility was opened in May of last year. The project was built in response to Fargo's 10-year plan to end homelessness. One of the plans recommendations was that permanent housing with support services be provided to assist individuals experiencing chronic homelessness.

The last census of the homeless in Fargo counted 347 homeless persons, 160 of whom were categorized as chronic or long term homeless. This means they have been homeless for over a year or, have experienced homelessness at least 4 times in the past 3 years. Cooper House follows the "housing first" model, which means we get people into stable housing first and then work with them on those issues that contributed to their homelessness to begin with. Up to 80% of this population exhibit mental health or substance abuse issues (usually alcoholism) or a combination of both. Many of them have been on the streets and in transitional shelters for several years. One Cooper resident had lived this way since 1969.

Homelessness is a difficult life. Its difficult dealing with the elements and the frequent hunger and the stigma and too, having to be mixed in with others who may have unpredictable and sometimes aggressive behaviors. Sometimes the aggressiveness is adopted as a defense mechanism and a means of protection. So, now we have put 42 of these folks under one roof and they are living in close proximity. There are always a few people in the group that can be pretty tough to work with. They can exhibit some very borderline behaviors and at times they can be frightening or even dangerous.

The project is very successful in a couple of important ways though. As you can see from the hand-out brochure, it's been shown to be more cost effective to house these folks than to provide essential services to them on the street like we have historically. Typical services used are overnight shelters, detox, police intervention, emergency room services, and the court system and rehabilitation programs. The study inventoried the services that had actually been used in the year prior

to being housed - by the first 29 tenants of Cooper House. We found about a 35% reduction in costs to the community. If this information is extrapolated to the 42 people we now house, the savings approaches 45%, since we are saving more in services without a commensurate increase in the cost of operating the facility - even accounting for the addition of another staff. In terms of economics, the housing first model has proven to be a very effective way to work with this population.

On the humanitarian side it works too. People are getting healthy, they are dealing with their addiction issues, they are getting job training and jobs and, they are regaining some dignity and self esteem. Last August one of our tenants celebrated his 100th day of sobriety –in August of the year before he had been admitted to detox 16 times.

In the current 2009-2011 budget, the SEHSC is budgeted for one contracted staff on duty at Cooper 24 hrs. a day. This person provides front door security, admits tenants and guests and keeps track of who is in the building. He also performs searches as needed, monitors the security cameras that are throughout the building, and interacts with tenants.

Since we need to always maintain security at the front door, the on duty staff currently need to call in an off duty supervisor or the police or an ambulance to assist with situations that develop elsewhere in the building and require intervention. Examples are an altercation between tenants, or someone has fallen down or is passed out or obviously needs medical or other assistance, or a smoke alarm has gone off in an apartment. A responder may get there anywhere from 5 to 30 minutes later and, this occurs several times in a typical week.

A lot can happen in that period of time waiting for help – especially if there is an altercation going on or, the (lone) staff is being confronted or threatened by a belligerent and inebriated tenant or guest.

In the SEHSC section of the proposed DHS budget for the 2011-2013 biennium, there is an increase in the grants line, a part of which is there to cover the contract cost of a second 24-hour staff at Cooper House – primarily for the safety of staff and others. We ask that the request for a budget adjustment for this purpose be honored by this committee and, by the greater legislative body.

Thank you for your time and consideration and I will be pleased to answer any questions you may have.

Michael Carbone
Executive Director
North Dakota Coalition for Homeless People
4023 State St North Suite 40
Bismarck, ND 58503
director@ndhomelesscoalition.org
Lobbyist # 504

Cooper House Testimony

Chairman Pollert, committee members, my name is Michael Carbone and I am the executive director of the North Dakota Coalition for Homeless People (NDCHP). Thank you for the opportunity to testify regarding funding for staff at Cooper House, and to thank you for your previous support of Cooper House.

The NDCHP works to coordinate and facilitate the development of housing for North Dakota's poorest citizens. We are responsible for the state's combined Continuum of Care Competitive Grant application to HUD. This application brings 1.7 million dollars per year into ND to provide permanent supportive and transitional housing to North Dakotans with disabilities and other barriers to housing stability who would otherwise be homeless. Currently, 19 housing projects receive funding through the Continuum of Care process, including Cooper House. Additionally, we work with the North Dakota Interagency Council on Homelessness to coordinate and oversee the implementation of North Dakota's 10 Year Plan to End Long Term Homelessness.

Cooper House represents a model of service delivery that has been proven in studies throughout the United States to be the most cost effective way of mitigating chronic homelessness. Studies in Portland Oregon and New York City have shown that there is a system wide savings of $16,000 per year for each unit of supportive housing operating on the housing first model. Preliminary numbers from Cooper House appear to bear this out. Most important are the lives that are impacted by a facility like Cooper House. People suffering with mental illness and other prolonged severely disabling conditions are given the opportunity to get off the street, out of the emergency shelter and into a stable environment where they can be surrounded by services that empower them to address mental illness, chemical dependency, and other developmental and physical disabilities.

A few months agosome of my colleagues and I attended a homeless documentary at the Fargo Theater. After the event we walked a block to a local restaurant to discuss the film. A gentleman entered the restaurant and approached us. He said that he knew we were coming from the documentary and that we had worked to help establish Cooper House. The man told us that he was a resident of Cooper House and that Cooper House represented an answer to his prayers. He thanked us and told us about his work, his sobriety and the new lease he has on life.

In order for Cooper House to continue to make a difference in the lives of people, in the overall health of the community, and to help end chronic homelessness in ND, Cooper House needs to be fully staffed. For this reason the North Dakota Coalition for Homeless People urges continued and expanded support for Cooper House.

Legal & Law Enforcement



Data provided by the Fargo Police Department and the Municipal Court tell us that the average per person per month costs associated with arrests, citations, warrants, incarcerations, and court appearances ran about **$198** prior to Cooper House opening.

In the first three months of operation the average monthly per person cost was **reduced by 51% to $97.**

The average monthly cost associated with **arrests, citations, and warrants** for individuals in the Study Group went **down 82%** from **$45 per person to $8.**

REAL PEOPLE, REAL LIVES: In August of 2009 one future tenant visited Detox 16 times. In August 2010, after moving into Cooper House, that same individual celebrated his 100th day of sobriety.

Emergency Shelter & Detox

The cost of emergency shelter and detox services, as reported by the Gladys Ray Shelter, New Life Center, and both CENTRE, Inc. and ACS detox facilities, for our study group prior to moving in at Cooper House ran **$408** per person in a typical month.

The snapshot of the first three months at Cooper House indicates that these costs have gone down significantly to about **$300.** The cost of 24/7 desk staff is included in the "After" number.

The average number of times this group used **detox services** each month **dropped from 53 times to 8.** The average monthly **cost of detox services** for individuals in this group was **reduced** from **$210** to **$29,** an **86% reduction.**

Cooper House Apartments
414 11th Street North, Fargo, ND

Developed by Beyond Shelter, Inc. (BSI) in partnership with the Fargo Housing & Redevelopment Authority (FHRA), with funding from WNC & Associates, City of Fargo HOME and CDBG programs, Otto Bremer Foundation, FHRA, and BSI.

Operated by the Fargo Housing & Redevelopment Authority; with assistance from the City of Fargo, Southeast Human Services Center, Dacotah Foundation, ND Coalition for Homeless People Continuum of Care, Family HealthCare Center, Sanford Health, and the Great Plains Food Bank.

Beyond Shelter, Inc. · Fargo Housing & Redevelopment Authority · Fargo · north dakota department of human services · Family HealthCare Center · Dacotah Foundation · NDCHP · Great Plains Food Bank · Sanford Health

REAL PEOPLE, REAL LIVES

One new Cooper House tenant had been homeless since 1969

Cooper House has provided the first Fargo home to one man who has lived in Fargo since the late 1970s. Bunking with friends or sleeping on the streets, he has worked all of these years and sent money to his family but never had a home of his own.

For more information contact:
Lynn Fundingsland
Executive Director, FHRA
701-478-2552



Initial Impact Report
August 2010

A snapshot of the ***Impact*** *of* ***Housing*** *North Dakota's* ***Chronically Homeless*** *population*

COOPER HOUSE
Permanent Supportive Housing

for People coming out of homelessness

Background



Cooper House opened in Fargo, ND in May of 2010. The 42 apartments are rented to individuals coming out of homeless shelters or from the streets. Preferences are given for those experiencing chronic or long term homelessness, veterans, and people with disabilities.

Cooper House has a front desk which is staffed 24/7 by Dacotah Foundation through a contract with Southeast Human Services Center. The front desk is the key to Cooper House's success and integration into the community. They check tenants and all guests in and out of the building, monitor the extensive system of security cameras inside and out, interact with tenants daily, do wellness checks, and deal with any situations that arise.

Cooper House employs the "Housing First" model. Meaning, give people a home first and then offer a variety of services to help them improve their lives.

This Study

This study is meant to be an early snapshot of the **impact of housing North Dakota's chronically homeless** population. The data for this study was collected with the consent of the first 29 tenants (the Study Group) who moved into Cooper House. Area service providers, shelters, police, court system, and healthcare providers all cooperated in providing the number of contacts with each of these individuals for the 12 months prior to Cooper House opening, and the subsequent 3 months. The data was consolidated, then an average per person per month cost was calculated. The average monthly per person cost was used to calculate the group average. This study will be done again at the end of 2010 and after the first full year of operations.

Please note that not all of the services accessed are accounted for here so the cost of working with these individuals on the street is understated. For example only two emergency shelters reported for this study. Meals from community based organizations are not accounted for. Court costs reported only include an $80 filing fee for each case and do not consider the time and cost of all of the court personnel involved with a court visit. Also, applicants for Cooper House who had outstanding warrants were required to clear them (schedule court date) prior to being accepted in the building which forced court dates that would have otherwise been avoided thus increasing the "After" costs.

Similarly, clinic visits increased as many of the new tenants were sent to primary care physicians to deal with ailments which had gone untreated while they were homeless. Again these costs get front loaded and as people live there longer and their health stabilizes clinic visits are expected to go down.

The overall **societal cost of housing** this **chronically homeless** population is shown to be **considerably less** than **the cost of continued homelessness.**

Snapshot on the Impact of Housing the Chronically Homeless

before and after opening Cooper House

(Average Monthly Usage of Services for Study Group)

	BEFORE	AFTER	CHANGE
Healthcare & Medical Costs	**$43,355**	**$28,943**	**down 33%**
ER Visits	*14*	*11*	
Ambulance Calls	*8*	*6*	
Clinic Visits/Wellness Visits	*11*	*52*	
State Hospital Days	*12*	*0*	
Legal & Law Enforcement Costs	**$5,745**	**$2,824**	**down 51%**
Arrests/Citations/Warrants	*11*	*2*	
Days of Incarceration	*37*	*22*	
Court Appearances	*4*	*3*	
Detox Costs	**$6,101**	**$840**	**down 86%**
Detox Visits	*53*	*8*	
Emergency Shelter Costs	**$5,756**	**$0**	**down 100%**
Emergency Shelter nights	*207*	*0*	
Cooper Desk Staff Cost	**$0**	**$7,868**	**up 100%**
Total Average Cost per Month for Study Group	**$60,597**	**$40,474**	**DOWN 34%**

Medical & Healthcare



Based on information from Sanford Health, Essentia Health, the Family HealthCare Center, the VA, and the ND State Hospital, the average monthly cost of medical expenses per individual in this group in the one year period prior to opening was **$1,495**.

After moving in to Cooper House the average monthly cost per person of medical expenses has been **$998**, a **33% cost reduction.**

The after move-in cost of medical expenses includes the cost of a part time RN who has an office at Cooper House. This position is expected to further reduce clinic and ER visits.

– Attachment + TEN

Testimony delivered to the House Appropriations Committee in support of SB 2012, March 8, 2011 by Scott Stenerson, Homeless Population Liaison with the Fargo Police Department.

Mr. Chairman and members of the committee, thank you for the opportunity to speak with you today.

I will be speaking today about Cooper House, the permanent supportive housing facility that opened last May in Fargo. I would first like to introduce myself and provide you with some background regarding my current position and past experience. My name is Scott Stenerson. I retired last November from my position as a police officer with the Fargo Police Department. I served as an officer for just over 20 years and spent approximately the last half of my career on special assignment as a Downtown Resource Officer. In this position, I worked exclusively in downtown Fargo to provide enhanced police services to this part of town.

Downtown Fargo is the busiest area of the city in regards to calls for service. There are many reasons for this, but one contributing factor is that the homeless population in Fargo frequent the downtown area. As a Downtown Resource Officer, I dealt with the homeless population on a daily basis and also worked closely with the human service providers that seek to serve this population. After I retired as a sworn officer, I assumed a new position in the Police Department called Homeless Population Liaison. This position allows the Fargo Police Department to continue its collaboration with human service providers in the effort to reduce homelessness. A reduction in homelessness also reduces the workload of the Police Department.

Most people experiencing homelessness have few, if any, dealings with law enforcement. However, we have found that a fairly small group of homeless individuals in Fargo have demanded a significant amount of police resources. Especially in regards to multiple, and sometimes many, admissions to a detoxification facility, and multiple arrests for petty crimes, such as Consuming Alcohol in Public, Panhandling, and Criminal Trespass. These arrests and subsequent prosecution and potential jail time can be quite costly. Many of these "frequent flyers", as they are sometimes referred to, are individuals that have been around Fargo for many years. I know this because, in some cases, I personally dealt with them for much of my career. One thing I learned over the years was that on the rare occasions that one of these "frequent flyers" was able to secure housing for awhile, I almost never dealt with them. Hence, the value of Cooper House, which provides supportive housing for just these types of individuals.

There are a number of reasons why I believe that Cooper House is of value to the City of Fargo in general and specifically to the Fargo Police Department. I would like to give just one example. In my position as a Downtown Resource Officer, I tracked the number of admissions to Centre Detox, Fargo's detoxification facility. I found the number of admissions to Centre Detox to be a barometer of sorts as to the kinds of activities we might be expecting as police officers on the street. Studies have shown that around 60% of all intakes at Centre Detox involve homeless individuals. From 2005 thru 2009 the number of admissions to Centre Detox in Fargo were steadily rising, and there was a corresponding rise police calls for service in the downtown area. Admissions to Centre Detox had nearly tripled in that five year span, up to an all-time high of approximately 3200 in 2009. In 2010, we had over 600 fewer admissions to Centre Detox compared to the previous year. This downward trend is continuing in 2011. I believe that the

opening of Cooper House has contributed greatly to this reduction in admissions to Centre Detox.

I think it is important to point out that all of the residents of Cooper House have been around the Fargo area for a significant period of time and that approximately 40% of these residents have ties to other parts of the state. I am a member of the committee that screens all applicants for Cooper House. The Screening Committee has made a conscious effort to approve applicants who have come to Fargo from all parts of the state. None of the current residents of Cooper House are new to North Dakota.

My experience and training as a police officer also taught me that the chronic offenders and frequent users of Centre Detox, many of whom are now residents of Cooper House, can be very unpredictable and sometimes dangerous, especially if they are under the influence of alcohol. Which, unfortunately, is often the case. Fargo Police Department protocol is to dispatch two officers to any call for service involving an intoxicated person and officers are trained to try to avoid approaching the individual until both officers are on scene. As you are well aware, these officers are well trained and well equipped to deal with a potentially violent subject. For the safety of the staff and residents at Cooper House, I think it is critical that this facility have at least two staff on duty all the times. As a representative of the Fargo Police Department, I was closely involved with the development of Cooper House and continue to be closely involved in my new position. One of the first things I recognized, after the facility opened in May, was the critical need for double staffing, not only for safety reasons, but also to help ensure the success of the entire project.

Thank you very much for your time and consideration. I will be happy to answer any questions you may have.

- Attachment ELEVEN

TESTIMONY
Senate Bill 2012 – DHS/ DD
House Appropriations – Human Resources Division - LTC Continuum
Representative Pollert, Chairman
March 8, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Barbara Murry, Executive Director of the North Dakota Association of Community Providers. I am here today to give brief testimony on the developmental disabilities section of the long term care continuum in SB 2012

The North Dakota Association of Community Providers is made up of 29 organizations across the state. We represent approximately 4,500 staff, 3,900 of whom are Direct Support Professionals, or DSP's. We serve approximately 4,500 individuals with developmental disabilities. Services are most often, lifelong. Ninety-nine percent of the typical provider funding comes through the Department of Human Services.

We are requesting your support in a number of areas of our platform, which I have attached. I will address the wages, turnover, and set aside. Sandi Marshall will discuss critical needs and transition. Jon Larson will testify on benefits. Catholic Charities will discuss the guardianship needs which are under the DD Division operational budget. We have introduced you to some of our staff and the people we support in previous years, and are not repeating that testimony today. I have included a card with a description of a young woman who was earlier served at the Anne Carlsen Center, and is currently served by Enable to give you information on our services.

Wage Increases. We are requesting your support for the Governor's budget, which includes an increase of 3% each year of the biennium. We are also requesting support for the $.50 per hour increase to the budget made by the Senate. Our original request was for a $1.46 per hour market adjustment for all staff in the organizations, which is the differential found in our October wage survey. With the support of the 2009 Legislature, developmental disabilities staff received a 6% increase each year of the biennium, along with a $1.00 per hour increase the first year. This increase, along with strategies put in place by NDACP members, had a profound impact on our turnover, reducing it from 43% to 33%, as of 7-1-10, and we are very appreciative of this increase. While this has stabilized services, it is still a very high turnover rate, and we hope it can be reduced further with your support. I have attached a study of our turnover, "Recruitment and Retention of Direct Support Professionals in ND," completed by the CMS DSW Resource Center Technical Assistance Team out of the U of MN, for your review. I have also attached a graph of our turnover, since 2001, indicating the impact of raises given by the legislature. This report highlights several additional areas that are significant in reduction of turnover. Strategies include improving the capacity of supervisors to know and use effective supervision practices, improving hiring practices by implementing interventions to reduce unrealistic expectations for newly hired staff, and improving the status and image of the direct support profession.

We have been working hard since the last legislative assembly to implement strategies to impact our turnover. We partnered with the Department of Commerce and served as the beta organization to implement a Talent Pipeline Map, as a part of

the Governor's strategies to impact the labor force needs in ND. The strategies selected in this pipeline map match those recommended in current research. We have increased the training for our frontline supervisors, with a training curriculum of approximately 40 hours, as research indicates competent supervisors are a critical factor in reducing turnover. Ninety staff were trained with that curriculum. In a partnership developed through the DHS Money Follows the Person grant, we are in the process of developing a Realistic Job Preview video, which will help us hire those staff who understand the work in the job for which they are applying. Our improved data collection indicates our highest turnover occurs in the first year and this strategy should impact that initial turnover. We are also working with the Center for Persons with Disabilities at Minot State. They have long had a high quality module curriculum, with a career ladder which leads to a certificate, an associate's degree, and a bachelor's degree. They are exploring an accreditation process which will give a nationally recognized certification to ND's DSPs. We have also begun to work with the Labor Department to explore an apprenticeship program with a national credential.

Additionally, almost half of NDACP members provide agency QSP services. NDACP supports the same increases for QSPs, as well as support increased funding for travel.

Chairman Pollert, this concludes my testimony. I would be happy to answer any questions.

NDacp NORTH DAKOTA ASSOCIATION OF COMMUNITY PROVIDERS

North Dakota Association of Community Providers

PUBLIC POLICY PLATFORM 2011 – 2013 BIENNIUM

Priority Items:		Fiscal Impact
1	We support the Governor's request for 3% annual inflator for each year of the biennium.	Total: 397 Million General Funds: 63.5 Million
2	7.65% increase in the benefit multiplier to cover the increasing costs of health insurance.	Total: $19.1 Million General Funds: 8.3 Million
3	$1.46 an hour market adjustment for all staff	Total: $33 Million General Funds: $14.5 Million
4	Continuation of funding for the critical needs of individuals who are medically fragile and / or behaviorally challenged	Contained within priority #1 dollar amount
5	Transition from Developmental Center to the community, including increased community capacity development through use of flexible funding mechanisms (BND collaboration)	Partially managed through DHS (DC & DD Community Services) budget authority
6	State set-aside for employment of people with disabilities	No fiscal note
7	Increased Corporate Guardianship Capacity	Partially Funded within the DHS Budget

For more information, contact: Barb Murry 220.4778
Jon Larson 220.1892

Recruitment and Retention of Direct Support Professionals in North Dakota: Analysis of 2010 NDACP Data

In 2008, North Dakota provided services to 4, 242 persons with Intellectual and Developmental Disabilities living in the community in either Home and Community Based Waiver (HCBS) services or Intermediate Care Facilities (ICF-MRs) (Lakin, Larson, Salmi & Scott, 2009).

Direct support professionals (DSPs) receive monetary compensation to provide supports to people with disabilities so they can live and work in our communities. Finding and keeping qualified DSPs has been a long standing problem in types of long-term supports and service settings (Larson & Hewitt, 2005). These low wage low status careers are often occupied by women, with recent immigrants and racial minority groups disproportionately represented. During the last 30 years services for people with intellectual and developmental disabilities have moved nationally and in North Dakota from institutional to small community settings.

Research on the DSP workforce has reported turnover rates averaging 42% for organizations providing multiple types of services (e.g., residential and vocational, Hewitt & Larson, 2007). High turnover rates disrupt services and create hardships for both the people being supported and their families. Just as concerning are the demographic changes expected in the next decade as Baby-Boomers retire and the number of people living with disabilities increase dramatically. The number of working-age females (aged 25 to 54) is expected to remain constant between 2006 and 2016 (Toosi, November 2007), while the number personal and home care aides are expected to increase 46% and the number of home health aides are expected to increase 50% between 2008 and 2018 (Lacy & Wright, 2009). These national statistics are mirrored by North Dakota's estimates. The U.S. Census estimates that by 2030 North Dakota's elder population will increase by 61.3% while the workforce 25 to 44 years old will decrease by over 27%.

In 2009, the Centers for Medicaid and Medicare Services, Direct Support Worker Resource Center issued a paper recommending that state Medicaid Agencies collect annual data on the direct support workforce. The North Dakota Association of Community Providers (NDACP) has worked with its member organizations that provide supports to people with intellectual or developmental disabilities (IDD) to collect turnover and other workforce data since 2002. This report highlights some of the results from the FY 2010 data collection along with selected historical trends.

2010 Turnover, wage and benefits for North Dakota organizations supporting people with IDD.

In fiscal year 2010, 2,870 direct support professionals were employed by 25 provider agencies of the NDACP. The NDACP collects workforce outcome data for three position types: DSP, Professional, and Administrative. The DSP category consists of all staff whose primary responsibility is the care of a person with IDD. Professional staff includes the titles of Behavioral Analyst, Qualified Mental Retardation Professional (QMRP) and Nurse. The administration category includes all other job titles.

In Fiscal Year 2010, ND turnover rates (calculated here as crude separation rate) were 32.8% for DSPs, 9.8% for professional staff, and 5.4% for administrative staff (See Table 1). Vacancy rates (the proportion of the total positions vacant) at the end of the fiscal year was 2.6% for DSPs, 0.6% for professional staff, and 0.6% for administrative staff. DSPs earned an average of $12.51 per hour while professional staff earned an average $19.82 per hour, and administrative staff earned an average of $22.50 hour.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Table 1 Turnover, Wages and Benefits by Position Type for FY 2010

	DSP	Professional	Administrative
Turnover Stats			
Number of Staff	2,870	208	160
# Separations	964	15	9
# Vacancies	78	1	1
Crude Separation Rate	32.8%	9.8%	5.4%
Vacancy Rate	2.6%	0.6%	0.6%
Wages and Benefits			
Average Hourly Wage	$12.51	$19.82	$22.50
% Full-time	54%	92%	93%
% Earns paid Sick Leave or Vacation	50.2%	84.6%	82.8%
% Provider Paid Health Insurance	33.5%	50.1%	50.3%

In NDACP organizations, 54% of DSPs, 92% of professional staff, and 93% of administrative staff were considered full-time employees. Overall, 50% of DSPs, 85% of professional staff, and 83% of administrative staff were eligible to earn paid time off including sick leave or vacation. Overall, 34% of DSPs, and 50% of professional or administrative staff received health insurance paid for in full or in part by the provider organization.

Characteristics of DSPs who left their job in FY 2010.

The first part of this report summarized workforce outcome data for all employee groups for FY 2010. For the rest of the report, we will focus on workers in the Direct Support Professional job classification. While it is helpful to know the overall turnover and vacancy rates, designing interventions to improve those rates requires additional assessment. The NDACP collected detailed information for 941 DSPs who left their position in FY 2010 ("leavers"; See Table 2) to help with this task. DSP leavers in FY 2010 had worked in their positions an average of 1.8 years before separating. They earned an average of $11.21, were 31 years old, and 33% were considered full-time employees. Overall, 64% of all staff who left were 30 years old or younger. Compared to the current DSP staff contingent, those who left their positions earned $1.30 per hour less, and were less likely to be considered full-time (33% versus 54%). Of all the DSPs who left their position in FY 2010, 39% left within 6 months of hire, and an additional 20% left between 6 and 12 months after hire.

Table 2 Characteristics of ND Staff who left their positions in FY 2010

	Direct Support Professionals	
	Number	Mean
Number of Leavers	941	100%
Years Tenure		1.82
Hourly Wage		$11.21
Mean Age		31.4

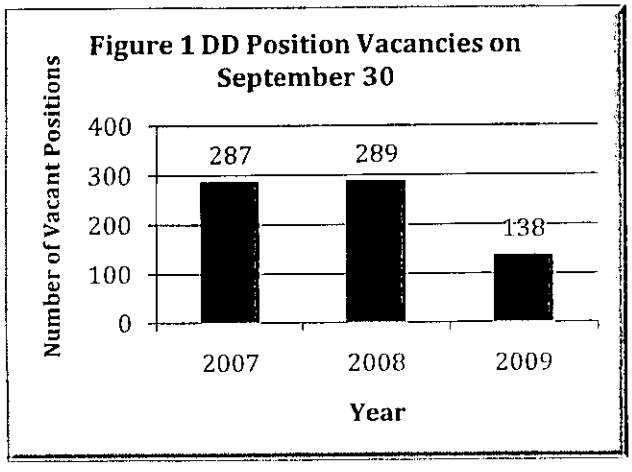
The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

% Full-Time	311	33%
Tenure Category		
0 to 6 months	364	39%
7-12 months	184	20%
13 - 24 months	173	18%
25 months or more	220	23%
Age Group		
18 to 30	600	64%
31 to 40	116	12%
41 to 50	108	11%
51 to 60	68	7%
61 +	49	5%

Together these data show that in ND those who left were younger, newer, more likely to be employed part time, and lower paid than those who remained. This picture, which is very similar to that in other states, suggests that interventions to retain DSPs for a longer period should focus, at least in part, on new employees. Several evidence based interventions are available for this purpose including improving hiring practices by using structured behavioral interviews; reducing unmet expectations by implementing realistic job previews; and better supporting new staff with training and effective supervision (Hewitt & Larson, 2007). The CMS DSW Resource Center technical assistance team has been working with NDACP and the North Dakota Medicaid office to develop a workforce development plan, and to craft specific interventions. One intervention that will be rolled out in 2010 is a North Dakota specific Realistic Job Preview. Additional interventions are also being considered.

DSP Workforce trends over time.

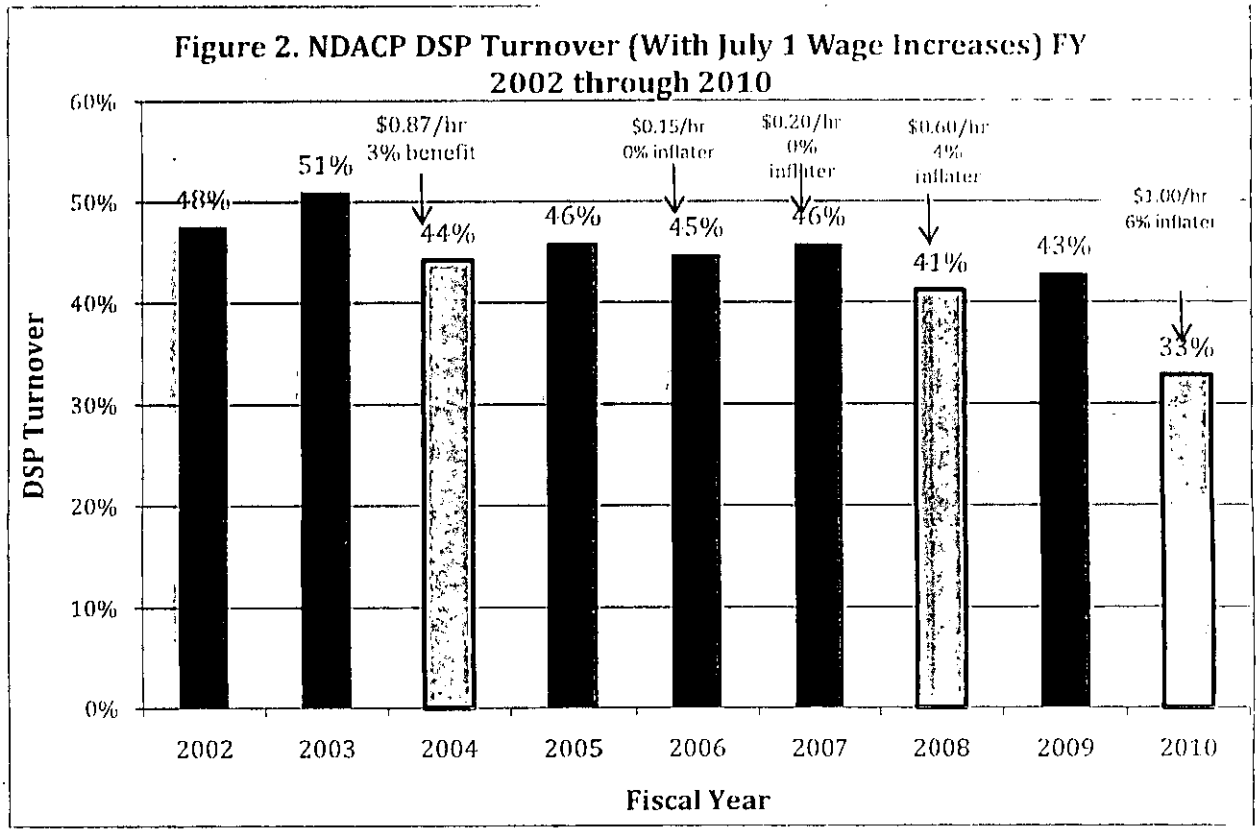
Data have been collected about vacancy rates and turnover for DSPs for several years. Three years of data are available on vacancy rates (See Table 3). While the total number of people with IDD served in ND increased between FY 2006 and FY 2008, the total number of vacant DSP positions at the end of the Fiscal Year declined from 287 on Sept 30, 2007 to 138 on Sept. 30, 2009 (See Figure 1). On June 30, 2010, 78 DSP positions were vacant.



Data about DSP turnover in ND are available for 2002 through 2010 (See Figure 2). Figure two shows two separate trends. The bars reflect the crude separation rate in June 30 of the listed years. The text and arrows above the bars are legislatively authorized wage and benefit changes for DSPs. Overall, the turnover rate for DSPs in ND has declined from 48% in 2002 to 33% in 2010. During this period there were five wage and benefit changes. Three of those wage and benefit changes were for $0.60 per hour or greater (2004, 2008 and 2010). In each of the three years that included a large wage increase, turnover was notably lower than the previous year (44% in 2004 versus 51% in 2003; 41% in 2008 versus 46% in 2007; and 33% in 2010 versus 43% in 2009). The two small wage increases ($0.15 per hour in 2006 and $0.20 per hour in 2007) did not result in notable declines in turnover, and turnover increased in each of the years in which no wage/benefit increases were provided. This pattern of changes in turnover rates during years with large wage increases suggests that those wage increments had a measurable effect on turnover.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Data collected in Wyoming has shown a similar pattern. A decrease in turnover occurred when large wage increase were provided to DSPs supporting individuals with IDD in 2002 (Average wages were increased from $7.38 per hour to $10.32 per hour; turnover declined from 62% to 37%). These findings, together with large research studies showing a robust correlation between wage and turnover for DSPs (See Hewitt & Larson, 2007), support the assertion that wages matter. It is possible to reduce turnover by implementing wage increases.



Note: N of Agencies Reporting in 2010 = 25

Research reviews support the association between wage and turnover rates. However, wages aren't the only thing that matters. Turnover can also be reduced by improving hiring practices, implementing interventions to reduce unmet expectations for newly hired staff, improving socialization and orientation and practices, implementing a robust system of competency based training, improving the capacity of supervisors to know and use effective supervision practices, and improving the status and image of the DSP profession (Larson & Hewitt, 2005).

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Conclusions and Recommendations

North Dakota like most states struggles to find, choose and keep qualified direct support professionals to support people with disabilities in community residential and vocational support settings.

The wage increments provided in FY 2004, FY 2008 and FY 2010 for DSPS supporting individuals with IDD resulted in notable reductions in turnover for this employee group, and the FY 2010 increase also was associated with a reduction in the number of vacant positions.

Continued efforts to measure workforce outcomes including turnover, vacancy rates and wages and benefits will support efforts to measure the impact of interventions chosen by the ND Medicaid authority and the provider organizations.

Efforts to measure workforce outcomes in North Dakota should be expanded include other sectors of the DSP workforce (such as services for people with mental health needs, physical disabilities, and for seniors).

Reducing turnover is one strategy to address the growing challenge of staff shortages in the direct support professional workforce in North Dakota.

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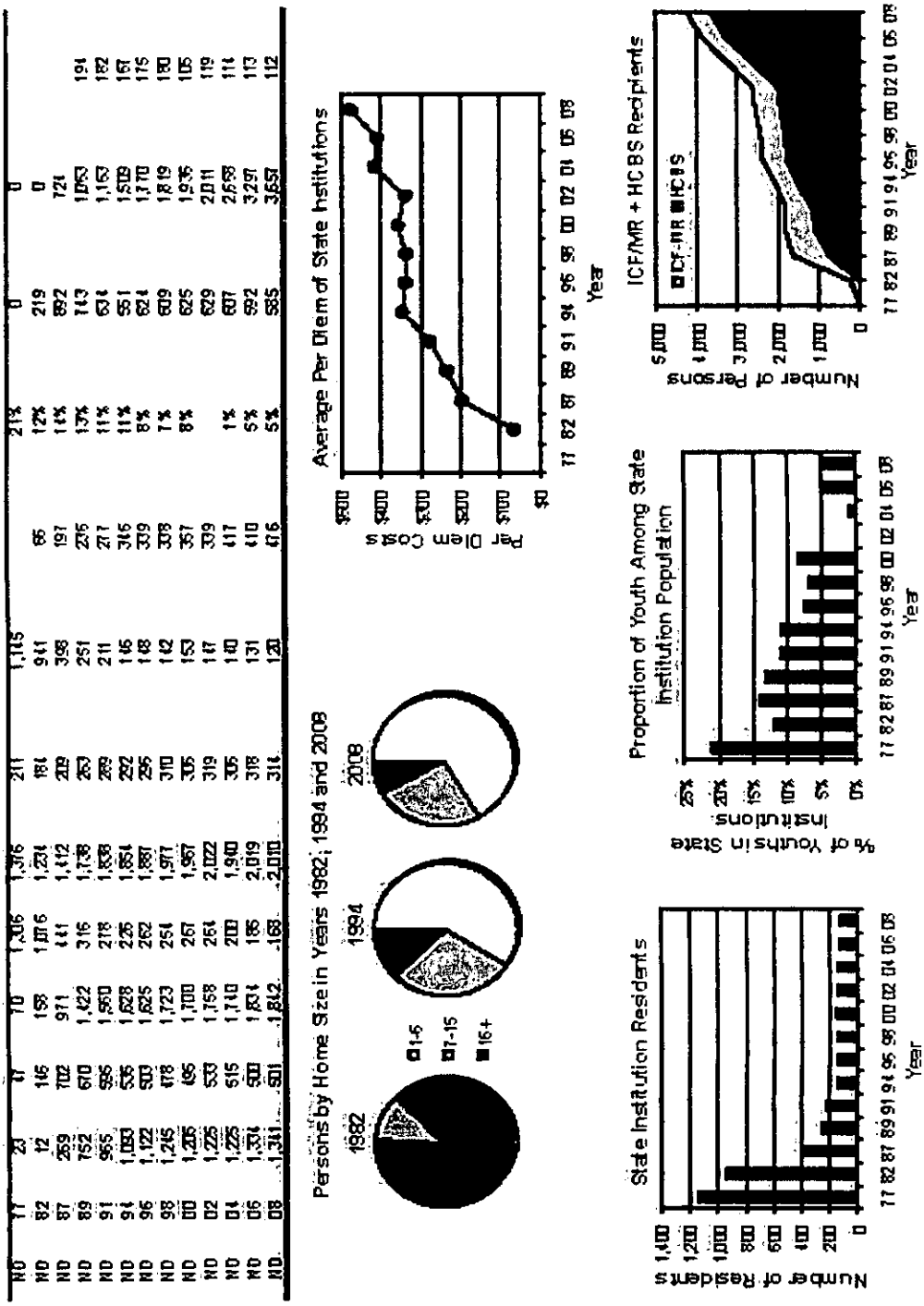
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The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Appendix A: North Dakota's Medicaid Funded Service System in FY 2009

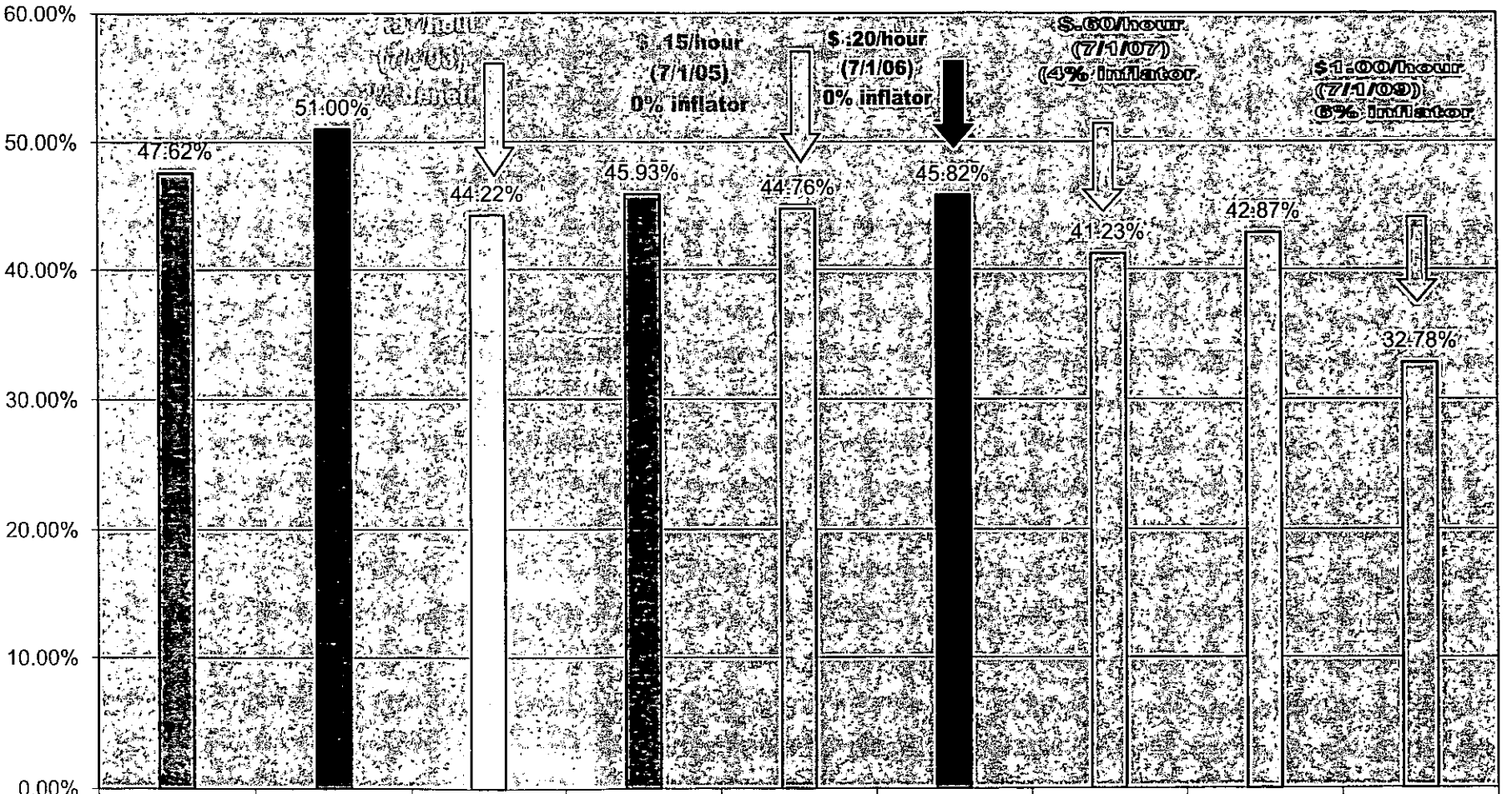
North Dakota

State	Year	Persons with ID/DD by Home Size					Utilization Rate per 100,000 of Population	State Institution Population	Per Diem of State Institutions ($)	0-21 Yr. Olds as % of State Institution Residents	Persons with ID/DD Living in ICFs-MR	Persons with ID/DD Receiving HCBS	Persons with ID/DD Living in Nursing Homes
		1-6	7-15	1-15	16+	Total							
ND	77	23	47	70	1,306	1,376	211	1,115		21%	0	0	
ND	82	12	146	158	1,076	1,234	184	941	66	12%	219	0	
ND	87	269	702	971	441	1,412	219	398	197	14%	892	721	
ND	89	752	670	1,422	316	1,738	263	251	276	13%	143	1053	194
ND	91	965	595	1,560	278	1,838	269	211	271	11%	624	1,163	182
ND	94	1,093	535	1,628	226	1,854	282	146	316	11%	551	1509	161
ND	96	1,122	503	1,625	262	1,887	295	148	339	8%	624	1,770	175
ND	98	1,245	478	1,723	254	1,977	310	142	308	7%	609	1819	180
ND	00	1,205	495	1,700	267	1,967	305	153	351	8%	625	1,936	185
ND	02	1,225	533	1,758	264	2,022	319	167	339		629	2011	179
ND	04	1,225	515	1,740	200	1,940	305	140	417	1%	607	2,658	114
ND	06	1,331	500	1,831	185	2,019	318	131	410	5%	592	3291	113
ND	08	1,311	501	1,842	168	2,010	314	120	476	5%	585	3653	112

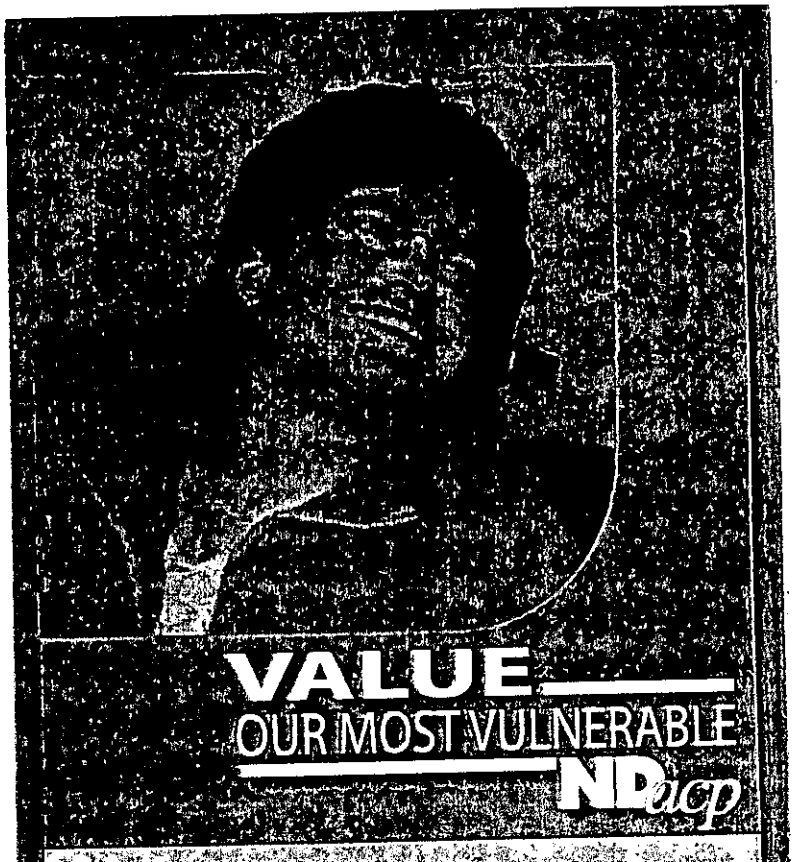


The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

NDACP TURNOVER
FY 2001 - 2010



	7/1/01 - 6/30/02	7/1/02 - 6/30/03	7/1/03 - 6/30/04	7/1/04 - 6/30/05	7/1/05 - 6/30/06	7/1/06 - 6/30/07	7/1/07 - 6/30/08	7/1/08 - 6/30/09	7/1/09 - 6/30/10
Series1									
Series2	47.62%	51.00%	44.22%	45.93%	44.76%	45.82%	41.23%	42.87%	32.78%
Series3									



Meet Amber – a young lady from Bismarck who has cerebral palsy and requires a team of caregivers to support her daily activities. In 1988 Amber's family began using In-home Supports to assist her. In 2002 Amber graduated from school and moved into an apartment with support from the ISLA program. This is Amber's home today. Caring staff help Amber with her shopping, laundry, chores and all the simple daily things we take for granted.

Without the qualified and dedicated staff, Amber would not be the happy, social and healthy young lady that she is. She loves living independently and her family credits the outstanding direct support professionals

NORTH DAKOTA ASSOCIATION OF COMMUNITY PROVIDERS

Value our most vulnerable

Support increases of 3% and a 7.65% to cover health insurance for Employees working with people with developmental disabilities.

Support a $1.46 per hour equity increase to become competitive with the labor market in North Dakota.

We are more than 4,800 employees in North Dakota living in 90+ communities who provide support services for thousands of people with developmental disabilities. Our average employee is 36 years old and has a family to support.

Our goal is to continue giving quality and consistent support for people with developmental disabilities. Providing competitive wages will enable us to decrease employee turnover leading to better outcomes for the people we serve. With your support, turnover over has decreased from nearly 50% to 33%. However, that continues to be unacceptably high.

- March 8, 2011
- Attachment TWELVE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations Committee, Human Resources Division
Representative Chet Pollert, Chair

Chairman Pollert, members of the Human Resources Division, I am Sandi Marshall, President of the North Dakota Association of Community Providers (NDACP), and Chief Executive Officer of Development Homes, a large non-profit DD provider agency in Grand Forks. Thank you for the opportunity afforded to NDACP to provide information today relative to the needs of our industry, particularly on behalf of both the people we serve and the many citizens of North Dakota that we employ to provide those services.

First, I would like to recognize the significant increases in support of this industry resulting from the 2009 legislative session. In addition to increases in provider reimbursement and hourly staff wages, the final appropriation included $4.2 million in additional new funds to address critical needs of people we serve who present the most severe medical and behavioral challenges. These funds have gone a long ways towards addressing the costs associated with the staffing and program needs of our most vulnerable citizens, and represent a real commitment to quality and humane supports.

NDACP supports the continuation of the critical needs funding for severe medical and behavioral needs that is included in the Governor's budget for the Department of Human Services. These funds are distributed to providers based on individual consumer scores obtained using a standard assessment

tool, and supplement the regular provider rate-setting mechanism. The funds, called "bucket funds", allow for critical client needs to be met in a much more responsive manner than before. These funds reduce the need for providers to augment state funds with other charitable donations in order to adequately serve people in the community.

The critical needs funding helps to address increased needs as the people we serve age and lose skills, or as medical conditions deteriorate. For example, many people with Down Syndrome become afflicted with Alzheimer's disease as they age, and require a greater level of care over time. It is important that the critical needs funding is available in the 2011-2013 biennium, while the state continues to explore replacement of the current client assessment and rate-setting processes, as proposed in SB 2043.

NDACP supports enhancing the Department's budget as it relates to transitioning individuals from the Developmental Center to the community in the next biennium. It is anticipated that 95 individuals will reside at the center as of July 1, 2011, with plans to further reduce the population to 67 by July 1, 2013. Regrettably, the funds to support this movement are not included in the proposed budget, but are noted in un-funded OAR 407.

The 2005 legislature required the Department of Human Services to work with the DD provider community to develop a plan for further deinstitutionalization. A Transition to the Community Task Force was assembled and has supported the movement of many individuals into community life. It is recognized that now our system is at a cross-roads. The mechanisms for planning and implementing deinstitutionalization that were

developed in the 1980's are no longer adequate to create the community capacity needed to get to the next level. Consequently, the task force created a Centralized Project Development Team to encourage the development of this capacity.

Utilizing this team, the provider community has the ability to propose special projects in their communities designed around the specialized needs of small groupings of people with similar needs who now live in the institution. This is a much more focused effort than the old strategy of fitting people into existing living options. It allows for and facilitates state-of-the-art thinking in our field to be implemented that transcends the old models of 8-bed group homes, and provides for more specialized environments than typical apartments in the community.

For example, my agency, Development Homes, Inc. just opened a newly constructed apartment building designed to house 5 young adults with autism spectrum disorders. This project is extremely unique in North Dakota; no other program exists that is specially designed to serve adults with autism. The building is designed to take into consideration the significant sensory needs of people with autism, and the staff have specialized training in autism.

DHI was fortunate to have the construction of this project, called "Columbia Place" funded almost entirely by HUD, which includes a tenant rental assistance contract. This was a very competitive grant process that was very cumbersome and time-consuming, taking over 3 years from start to finish.

In order to more quickly develop new housing, such as new or remodeled duplexes, small group homes, or specialized apartment buildings, we need creative funding sources. NDACP has been in contact with officials from the Bank of North Dakota to review options for low-interest loans to augment those available from local lenders. We are hopeful that with existing programs like Flex Pace, which helped providers build our original group homes in the 1980's, we will be able to build the community capacity needed to serve the more specialized needs demonstrated by the next wave of deinstitutionalization. However, accessing housing options is only one piece, and it is imperative that funds are available to provide ongoing services for people who move into our communities throughout the next biennium.

Governor Dalrymple stated in his budget address that a society is best measured by the way it treats its most vulnerable. We are appreciative of the recognition of the citizens we serve and the thousands of people who work in this industry in North Dakota. Our collective quality of life is well-served by supporting all our citizens to contribute to community life. Thank you.

Testimony on SB 2012
Human Resources Section
House Appropriations Committee
March 08, 2011

-Attachment THIRTEEN

Chairman Pollert and members of the committee, my name is Jon Larson. I am the executive Director of Enable, Inc, a licensed service provider for people with intellectual disabilities in Bismarck and Mandan. I am also here today to testify on behalf of the North Dakota Association of Community Providers (NDACP).

I have been in my present position at Enable for nearly 27 years and I have seen many changes during that time, most of them positive. I want to express my appreciation for all the support the North Dakota Legislature has given to developmental disability service providers, especially in recent years. I also want you to know that your support makes a difference. North Dakota has reason to celebrate when it comes to services to people with intellectual disabilities. I want to mention just a few of those reasons.

The population at the Developmental Center in Grafton is projected to meet our goal of 95 people by July 01, 2011. Plans are in place to continue to place people in community settings, further reducing the number of people served in institutional settings.

Employee Turnover in provider agencies has been reduced to an average of 32.78%, down from an average of nearly 43% just two years ago. This has and will continue to improve the quality of service our consumers expect from us. Consistency in staff and the relationship building this provides, in my opinion, is the single most important thing we can to for the people we support. We still have a ways to go in this area.

Providers continue to meet national accreditation standards and are recognized for the quality of services they provide. All ND DD Service providers are accredited by the Council on Quality and Leadership, a national accreditation entity.

Utilization of new technology has created a more efficient method of sharing information enabling provider and state staff to share information and allow for more time for direct

service delivery and quality improvement strategies. DD provider staff and regional and state staff will soon have access to the same information about the people we support through a web-based software package called THERAP.

A review is underway of our reimbursement system that promises to change one of the most complicated provider payment systems in the country. A new payment system, when properly implemented should enhance creativity and reduce the administrative burden of operating our programs. This bill, SB2043 passed the Senate without the appropriation to make the necessary changes to our payment system.

A strong provider association where information, education and best practices are shared among member agencies. Our association, NDACP, provides a venue for peer support and education within our state and with the states surrounding us.

A positive, constructive relationship with the Department of Human Services. This has created a problem resolution process that benefits the entire service delivery system.

While there are many reasons to be optimistic about our service delivery system, there continue to be challenges. One of particular concern is the rapidly rising cost of employee health insurance. DD providers are given an allowance of 33% of approved salary dollars to provide benefits for our employees. From this 33% DD providers must pay several mandatory benefits such as FICA taxes (7.65%), Workforce Safety Insurance, and Unemployment Compensation. This leaves approximately 20% of approved salary dollars to pay for "optional" benefits such as health insurance and pension plans. The rapidly rising cost of health insurance, often increasing over 10% a year, over the past several years has dramatically affected the health insurance coverage our employees receive. DD providers have been forced to increase deductibles, co-insurance amounts and to shift ever larger portions of the premium to their employees. This problem, of course is not unique to DD providers, but our reimbursement system limits the amount available to pay for these increasing costs.

We are asking that you consider adding 7.65% to our fringe benefit allowance to stem the steady erosion of health insurance benefits to our employees, support the $.50/hour salary increase passed by the Senate and add the appropriation to fund the implementation of the new payment system.

Again, thank-you for your continued support and for this opportunity to talk to you today. I would be glad to answer any questions you may have.

Jon Larson, Executive Director Enable, Inc.
North Dakota Association of Community Providers (NDACP)

North Dakota Association of Community Providers - NDACP

Organizational Members	Location
4th Corporation	New Rockford, Carrington, Fessenden
Able, Inc.	Dickinson, Bowman, Hettinger
Agassiz Enterprises	Grand Forks
Alpha Opportunities	Jamestown
Anne Carlsen Center for Children	Jamestown, Grand Forks, Cooperstown
Catholic Charities North Dakota	Fargo, Statewide
Community Living Services, Inc.	Fargo
Community Options	Bismarck, Statewide
Developmental Center Community Services	Grafton
Development Homes	Grand Forks
Easter Seal Goodwill ND	Mandan, Statewide
ENABLE, Inc.	Bismarck, Mandan
ETC	Fargo
Fraser, LTD	Fargo
Friendship, Inc.	Fargo, Grafton, Park River
HAV-IT	Harvey
HIT	Mandan, Bismarck, Dickinson
Knife River Group Homes, Inc.	Hazen, ND
L.I.S.T.E.N., Inc.	Grand Forks
Lake Region Corporation	Devils Lake
Northern Plains Special Education KIDS	Crosby, Fargo, Grand Forks, Jamestown
Open Door Center	Valley City
Opportunity Foundation	Williston
Pride, Inc.	Bismarck, Hazen, Mandan, Wilton
Red River Human Services	Fargo, Wahpeton
Rehab Services, Inc.	Minot
REM North Dakota, Inc.	Bismarck, Dickinson, Grand Forks, Grafton
Support Systems, Inc.	Bismarck, Statewide
Tri-City Cares	Stanley, Newtown, Tioga

TESTIMONY – PROTECTION AND ADVOCACY PROJECT

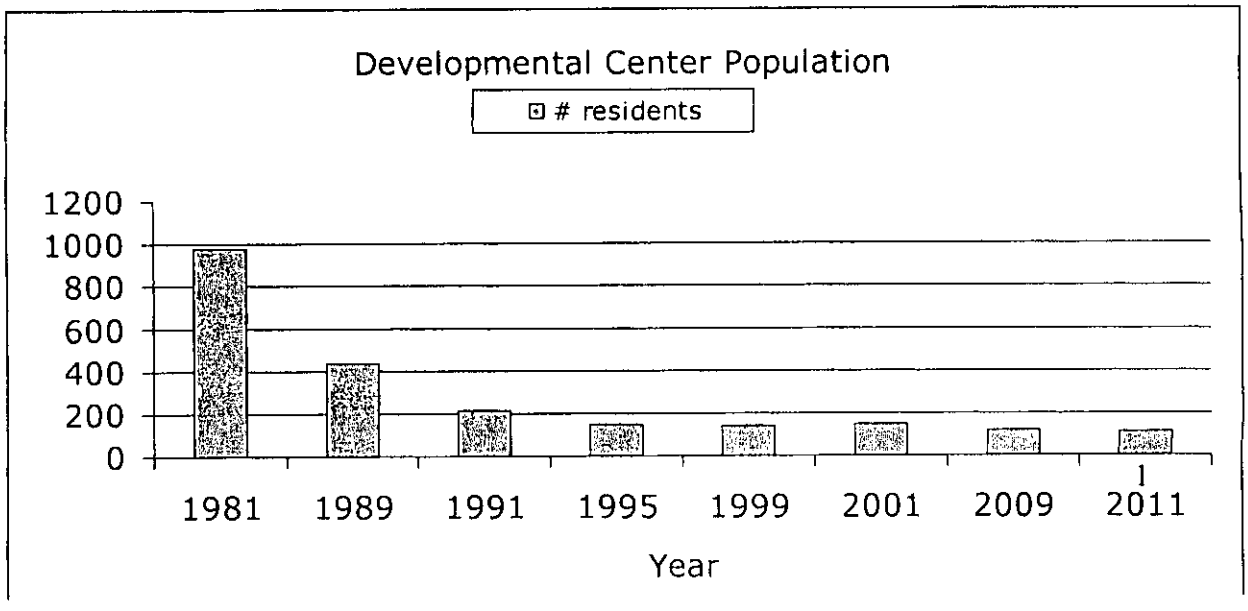
SB 2012 (2011)
HOUSE Appropriations-Human Resources Division
Honorable Chet Pollert, Chair
March 8, 2011

- Attachment FOURTEEN

Chair Pollert, and members of the House Appropriations Human Resources Division, I am Christine Hogan, a lawyer with the North Dakota Protection and Advocacy Project (P&A). The Protection & Advocacy Project is an independent state agency that acts to protect persons with disabilities from abuse, neglect, and exploitation, and advocates for the disability-related rights of persons with disabilities. Although we do support the merits of the SB 2012, my testimony solely addresses the bill's effects on persons with disabilities. My testimony today focuses on three primary areas in the DHS budget that have particular relevance to P&A priorities. P&A's first priority in the DHS budget is actually P&A's first priority as an agency—community integration.

Developmental Center

The Arc's law suit with the State of North Dakota ended in 1995. The population at the Developmental Center at that time had been reduced from just under than one thousand residents to just 144 residents. The state agreed to continue reducing this number.



The 12th anniversary of the U.S. Supreme Court's *Olmstead* decision will arrive in June. The *Olmstead* case stands for the proposition that it is unlawful discrimination for a state to place a person with a disability in an institution unnecessarily.

Now, twelve years after *Olmstead* and sixteen years after the *Arc* case, 107 individuals with developmental disabilities still remain at the institution. Despite the mandate of the *Olmstead* decision, the financial assistance of *Money Follows the Person*, and the target goals set by the Transition to the Community Task Force, we have discharged a net of fewer than three individuals per year for the last sixteen years. Sadly, most of this net decrease is due, not to community integration, but to deaths of the people residing at the Center.

The law

In the *Olmstead* case, the Supreme Court defined the least restrictive setting for an individual with a disability as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

In the context of the Developmental Center, this means a resident must have placement in a less restrictive setting when:

1) The State's treatment professionals determine a community placement is appropriate;
2) The individual resident does not oppose community placement; and
3) The State can reasonably accommodate that placement, taking into account the resources available to the State and the needs of others.

The federal trial court that initially decided the *Olmstead* case found that the State of Georgia could provide services to the plaintiffs in the community at considerably *less* cost than was required to maintain them in the institution. This is also true in North Dakota. The average cost per patient at the Developmental Center is well over $500/day, over $200,000/year.

The history

Since the economies favor community integration in North Dakota, why has de-institutionalization been so slow?

Here are the facts. The Developmental Center Transition to the Community Task Force has been in place since 2005. The Task Force's mission was to establish target populations—beginning in 2006—for the Developmental Center. The first target was to reach a population of **127** residents by July 1, 2007. This target was achieved.

The Task Force's next goal was to reach a patient population of **97** by July 1, 2009. This goal was not achieved. The goal was then revised to 115. The actual population of the Developmental Center on July 1, 2009, however, was **123**.

The long-term goal of the Task Force was to be at **67** residents by July 1, 2011. This goal cannot be achieved, and has also been revised. It is now a target of **95**. However, since the current population at the Developmental Center is at **107**, barring some form of divine intervention, that goal of **95** is also not likely to be achieved by July.

The Task Force has now reset its long-term population goal of **67** residents for July 1, 2013. Realistically, without legislative intervention in the form of funds for transition to group homes, how likely is it that goal will be achieved?

The problem

Here is the problem—there is a barrier to de-institutionalization. The patients must have a place to live in the community, with appropriate services and supports. The developmental disabilities service providers, along with other Task Force members, have been working together to address this issue. A Centralized Project Development Team has been assembled to encourage creative ways to address community capacity issues.

Transition funds, for the purpose of moving residents to the community, while down-sizing the institution, have been made available in the DHS budget: in the 05-07 biennium - $50,000; in 07-09 biennium - $2.5 million ($1.6 million Federal and $900,000 General); in 09-11 biennium - $0.

The solution

Here is the solution—DHS submitted an OAR (# 407) to the Governor for transition funds for the 11-13 biennium in the amount of $6,095,817 ($3,382,849 Federal and $2,712,968 General). This will reportedly provide for 28 ICF/MR beds, phasing in 4 beds each quarter. DHS has indicated that it cannot approach the goal of 67 by July 1, 2013 without these monies.

There are currently at least twenty-five individuals on a list, compiled by Developmental Center staff, who have already been determined by state professionals to be appropriate for community placement, and who want to move. This means these folks meet all the elements of an *Olmstead* action if they are not moved. The State of North Dakota has the resources to make community integration happen for these citizens.

As of June 2009, at least eight states and the District of Columbia have closed all state-operated residential facilities with sixteen or more residents who have intellectual or developmental disabilities. Those states are Alaska, Hawaii, Maine, New Hampshire, New Mexico, Rhode Island, Vermont, and West Virginia. The first of these states, New Hampshire, closed its facilities in 1991. Recently, federal court judgments and out-of-court settlements have required several more states to close their residential institutions. No court decisions have held in favor of keeping persons with developmental disabilities isolated in institutions. The law is clear. *Olmstead* is being enforced everywhere the issue is pressed. It is the right time for North Dakota to step up and act proactively.

There is no good reason why individuals with developmental disabilities should still be moving into the Developmental Center. There is every reason why they should be moving out. It is the law. Many residents are desperate to move out. North Dakota has the

resources and support systems in the community for individuals with disabilities to remain near their families and friends in small home settings. This is their right. This is the law.

OAR (# 407) ought to be included in the DHS budget to provide for local group homes for Developmental Center residents. Now is the right time to honor plans made and promises made back in 1995 to bring our citizens back to their own communities.

Increased Compensation for Provider Staff

North Dakota's use of the Medicaid Waiver has expanded greatly over the years. This has been a good thing for people with developmental disabilities and the State, allowing for the use of federal dollars to help provide more residential services in non-institutional settings.

Providers for individuals with developmental disabilities in our state deliver quality services. But in order to continue to so, adequate staff salaries and benefits are essential. Without adequate compensation, we have seen turnover rates from 41% to 51% in the last ten years.

For the year ending June 30, 2010, salary increases were authorized at $1.00/hour, along with a 6% inflationary increase for providers. This brought the turnover rate down to under 33%, and it was a much-needed gain for providers and the individuals they serve. It is imperative for people with developmental disabilities and the people who support them to stay on this path. P&A strongly supports providing another hourly increase as well as a benefit multiplier to cover increased health insurance premiums.

Without these compensation enhancements, our state's services for inidividuals with disabilities will will go backwards. We will surely lose some quality staff to other businesses that are currently offering significantly higher pay.

P&A supports the $1.46/hour market adjustment for provider staff along with the 7.65% benefit multiplier.

Aging Services

Ombudsman Program

P&A supports additional staff for the long-term-care ombudsman program. The purpose of the program is to provide services to protect the health, safety, welfare, and rights of residents, and to advocate on behalf of all individuals living in nursing facilities, assisted living, swing beds, transitional care units, and basic care facilities.

Currently, the program has one full-time State Ombudsman to administer the program. 2.45 FTE's are spread among the eight regions to implement the services. For example, with current staffing, the Bismarck/Mandan region has only 8 hours/week of ombudsman services to cover more than forty facilities and approximately 1,500 residents. This is not adequate to meet the outlined responsibilities.

OAR 409, as submitted to the Governor by DHS, is for one additional FTE at a cost of $135,665 for the biennium. This will help in addressing the service gap but not close it.

Guardianship Services

P&A supports OAR 408, as prepared by DHS, for guardianship services. This would provide for necessary guardianships for those who do not have a developmental disability but who have a mental illness, traumatic brain injury, or other serious disability. Only $40,000 per biennium has been available for these services, which is not addressing the need. No monies have been available for the costs of providing actual guardianship services. This OAR would provide funds of $80,000 for the establishment of

guardianships, plus an additional $24,000 to pay for professional guardianship services. These services are needed when there is no appropriate relative or other responsible person available to be the guardian.

Thank you very much for your consideration. I would be happy to answer any questions.

P&A is an independent state agency established in 1977 to advance the human and legal rights of people with disabilities. P&A strives to create an inclusive society that values each individual.

Under Title II of the federal Americans with Disabilities Act, "states are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. " Olmstead v. L.C and E.W.



North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: SB 2012
House Appropriations Committee
Human Resources Division
Appropriations for the Department of Human Services
March 8, 2011

- Attachment ONE

Chairman Pollert and Members of the House Appropriations Committee; I am Jerry Jurena, President of the North Dakota Hospital Association (NDHA). I am before you today presenting Testimony in support of SB 2012.

I believe the Governor's recommendation of a 3% inflator each year of the biennium for Medicaid reimbursement for Hospitals is appropriate and fair based on the current increases for supplies, utilities, insurance, equipment upgrades and wages.

I believe the recommendations made by the Governor regarding additional funding for Mental Health Services is long overdue. The additional funding in the proposed budget for the Department of Human Services will enhance reimbursement which will increase access and maintain quality Mental Health Services across the State. Access to Mental Health Services is an ongoing issue for rural Hospitals creating difficultly in placing patients for qualified services. Urban Hospitals do not have the necessary staff to meet the demand in urban areas let alone provide assistance to rural hospitals. The result of not funding Mental Health Services is; patients are being seen repeatedly in Hospital emergency rooms costing more than receiving appropriate treatment.

I believe the Interim Studies completed on Mental Health Services this last year by the Department of Health is right on in addressing the need to increase providers and services. Again I believe the Governor's recommendations to add additional funding is appropriate.

I am In support of SB: 2012. I am here to address any questions.

Jerry E. Jurena, President
North Dakota Hospital Association.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

Attachment A

North Dakota Total Reserves
2001-2011

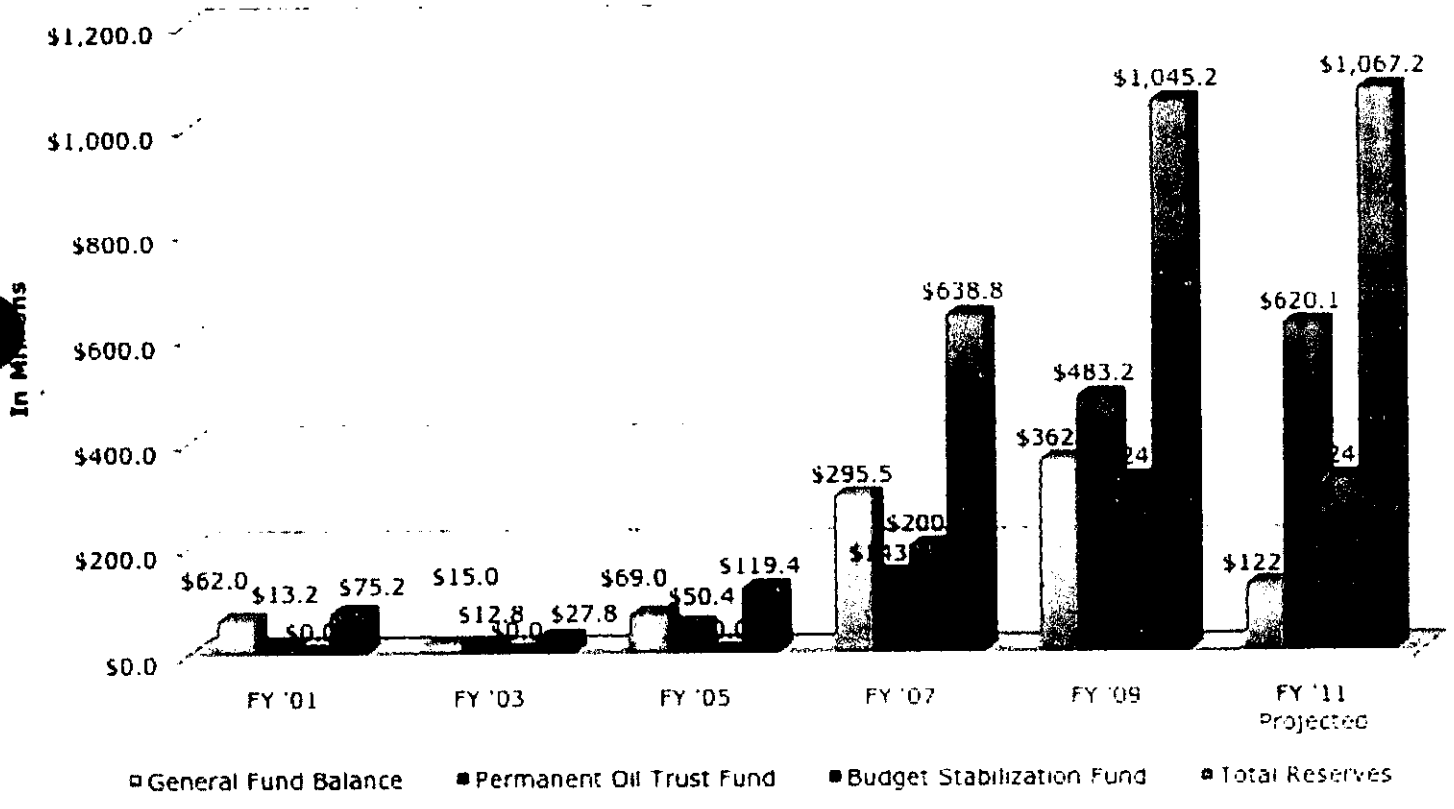


Chart Courtesy North Dakota Economic Policy Project

St. Alexius Medical Center
PrimeCare

-March 8, 2011
-Jackie Bugbee
- Attachment THREE

Chairman Pollart and Members of the House Human Services Appropriations Committee.

RE: SB 2012

I would like to submit this letter regarding the three percent inflationary increase for medical services proposed in SB 2012 for each year of the biennium. As I understand, this increase was included in the Governor's budget.

In the last biennium, the Legislature provided a rebasing for all PPS healthcare facilities in the state of North Dakota. Although the process used the "Medicare step-down method for cost finding" to determine cost for Medicaid patients, it failed to recognize that Medicare was being under-funded by approximately 10 percent at that time and the Medicare process does not pay operational costs. The "step-down" process eliminates many costs providers feel are necessary to operate effectively. The rebasing was an excellent start towards improving Medicaid reimbursement to North Dakota providers, but it left providers with a 12-18 percent shortfall in Medicaid payments to actual operational cost.

I hope you will take into consideration the fact that it will require an inflationary increase of six to eight percent per year to bring Medicaid reimbursement for services closer to actual cost. The total amount needed to bring Critical Access and Tertiary facilities to actual cost is estimated to be $30 million per year. An increase of this amount would cover our actual cost for services provided to Medicaid patients and restore fairness to the payment system.

St. Alexius Medical Center greatly appreciates the Governor's budget including a 3%/3% increase. I hope you will support SB 2012 and those percentage increases per year and recognize that an additional increase would positively impact the services provided to North Dakota Medicaid patients. Medicaid reimbursement is a very important and a very complex issue. Thank you for the time you devote not only to this issue but also to all the issues we face as members of the North Dakota community.

Sincerely,

Gary P. Miller

Gary P Miller
Interim President / CEO
St. Alexius Medical Center

CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

David Braddock, Ph.D.
Professor in Psychiatry, University of Colorado

March 7, 2006

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CLOSING THE NORTH DAKOTA DEVELOPMENTAL CENTER: ISSUES, IMPLICATIONS, GUIDELINES

PURPOSE AND FOCUS OF THE PAPER

This paper has been prepared at the request of the Arc-Upper Valley Board of Directors. It is intended to stimulate discussion and further study by the Arc and other interested parties in North Dakota on the possible closure of the North Dakota Developmental Center at Grafton (hereafter "Grafton").

The primary focus of the paper is to identify and discuss 10 key issues, expressed as questions, associated with the potential closure of Grafton, North Dakota's remaining mental retardation and developmental disabilities (MR/DD) institution. The implications of closing Grafton are considered in light of other states' experiences in closing state-operated MR/DD institutions and in light of relevant research. The paper addresses the following ten questions:

1. How did state-operated institutions for persons with mental retardation and developmental disabilities evolve nationally?
2. What are residential and community services trends in North Dakota today and in two groups of "comparison states"?
3. How many states have closed state MR/DD institutions and how many are planning to do so in the near future?
4. What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?
5. How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?
6. How do parents of individuals relocated from state institutions to community settings respond to this process of change?
7. How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

8. Should the State of North Dakota anticipate a need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?

9. What are some of the alternate uses to which a closed Grafton facility might be put?

10. What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

Question #1: How did state-operated institutions for persons with mental retardation and developmental disabilities (MR/DD) evolve nationally?

The first state-operated MR/DD institutions were opened in the Northeastern U.S. in the 1850s. They were developed to provide a temporary residential placement for individuals who, after a relatively brief period of education and training in these facilities, returned to community life. Early success at several schools led to the opening of additional state-operated MR/DD institutions across the U.S. (Braddock & Parish, 2003). The first state MR/DD institution in North Dakota was opened as the State Institute for Feeble-Minded in Grafton in 1904. In addition, the San Haven facility, opened originally as a tuberculosis hospital in 1922, was converted to MR/DD use in 1973, and closed in 1987 (Braddock & Hemp, 2004).

As the country industrialized and urbanized, state institution populations expanded much faster than facilities' capacities to provide appropriate training and educational services. By 1930, more than 100,000 persons with mental retardation were institutionalized across the U.S., and most residents received minimal custodial care. This trend toward custodial care and "warehousing" of persons with mental retardation increased after the Second World War and throughout the 1950s. Media exposés about deficient conditions were commonplace (Blatt & Kaplan, 1974).

In 1967, the nation's institutional census peaked at 195,000 residents in 240 state mental retardation facilities. Since 1968, the number of individuals with mental retardation served in state institutions has declined every year and, on average, four percent annually for 37 consecutive years. In 2004, the residential census of the nation's state institutions was 41,214 persons. If present trends continue, there will be fewer than 20,000 residents in state institutions in 10 years (2016). Costs for residential care, however, are climbing rapidly. Based on previous trends, in 10 years they are projected to reach an average of approximately $193,000 for each resident per annum ($530/day), in constant 2004 dollars. The per diem cost in the Grafton facility in 2004 was $392/day and $143,000 annually (Braddock, Hemp, Rizzolo, Coulter, Haffer, & Thompson, 2005).

Current trends promoting community services in the mental retardation field evolved out of the parent movement in the 1950s and 1960s. At that time, parents began insisting upon both a higher quality of institutional care and greater opportunities for community living. Federal legislation was enacted in 1963 (Pub. L. 88-156 and Pub. L. 88-164) that authorized the establishment of an initial, but incomplete, network of community centers and services across the country (Braddock, 1987). Segregating individuals with MR/DD in large, often remote institutions and providing substandard care became prominent civil rights issues in the 1970s and 1980s. Class action lawsuits (e.g., *Wyatt v. Stickney* in Alabama, *Ricci v. Okin* in Massachusetts, *New York State Arc v. Carey, Association for Retarded Citizens of North Dakota v. Olson*) were filed and such litigation continues in Federal District Courts throughout the U.S. (Braddock, 1998). By 1980, however, many states had begun implementing community services initiatives involving the development and funding of

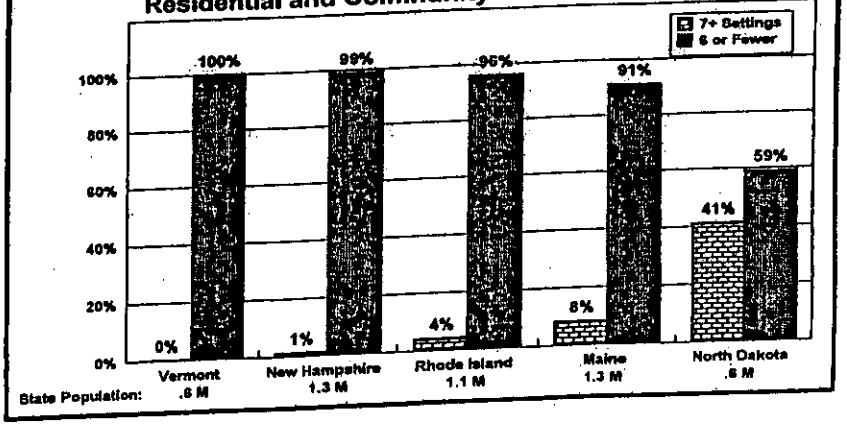
small group homes, supervised apartments, in-home family support programs, and supported employment.

Question #2: What are residential and community services trends in North Dakota today and in two groups of "comparison states"?

Today, institutional settings are being replaced by smaller, more individualized community placements and family support services. There are now more than 140,000 supervised living settings in the U.S. for six or fewer residents with MR/DD (Prouty, Smith, & Lakin, 2005). The total residential population of these small living environments was approximately 335,000 and this figure represented 68% of all out-of-home residential placements in 2004. In contrast, 86% of all persons with mental retardation in out-of-home residential placements nationally were living in large, 16 beds or more, publicly and privately-operated institutions in 1977 (Braddock et al., 2005).

North Dakota, however, significantly lags the dominant national trend in this regard. The State ranked 39th in 2004 in the percentage of persons with MR/DD living in smaller (six person or fewer), family-scale out-of-home environments, and 44th in the proportion of its total spending allocated to six-person or fewer settings. ***Figure 1*** compares North Dakota to four New England states with roughly the same state general population as North Dakota (Braddock et al., 2005).

Figure 1
Percentage of Total State Spending for 6-Person or Fewer Residential and Community Services: FY 2004



Another analytically useful comparison group of states includes South Dakota (.8 million population), Wyoming (.5 million), Montana (.9 million), and Idaho (1.4 million). Each of these "mountain west/plains states," like North Dakota, has one remaining institution. The 2004 MR/DD institutional censuses were 90 (MT), 92 (WY), 94 (ID) and 176 (SD), compared to 146 in North Dakota. Although South Dakota's census in 2004 was larger than North Dakota's, all four of these states had lower institutional utilization per capita rates (per 100,000 of the state general population).

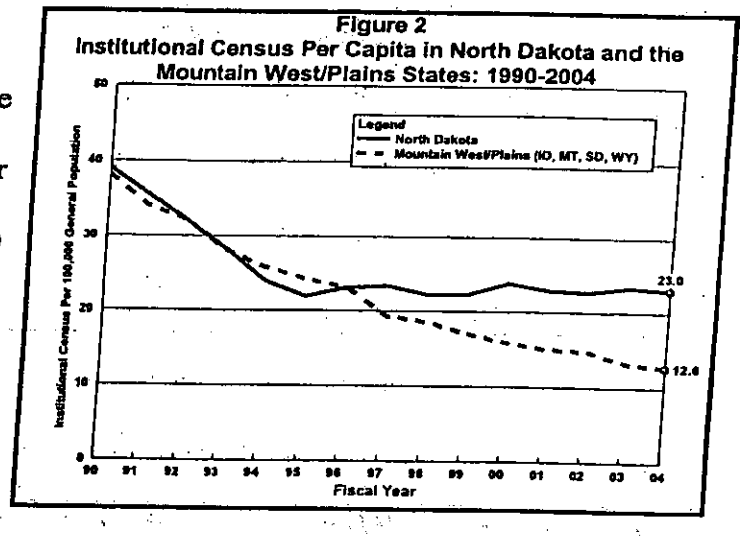


Figure 2 illustrates how the MR/DD institutional utilization per capita (of the state general population) for the four mountain west/plains comparison states began diverging from North Dakota in 1996. In 2004, North Dakota's institutional utilization exceeded the aggregate of the four comparison states by 83% (23.0 vs. 12.6). Moreover, South Dakota, Wyoming, Montana, and Idaho each committed a considerably larger share of total MR/DD spending to six-person or fewer residential and community services (70-77%) compared to only 59% in North Dakota. North Dakota's utilization rate for state-operated institutional care has been stable for the past 12 years, through 2006.

Question #3: How many states have closed state MR/DD institutions and how many are planning to do so in the near future?

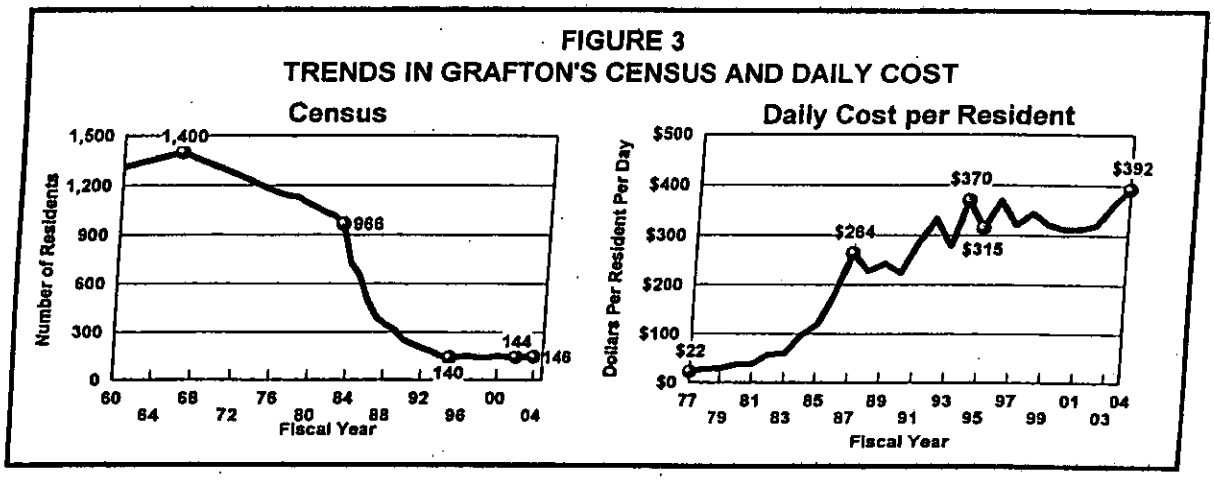
Since 1970, on a national basis, 39 states have closed, or are planning to close, 139 state-operated MR/DD institutions (***Appendix I***). This is more than one-half the 240

institutions that existed in 1970. (The average institutional census in 1970 was about 800 persons, compared to an average of 206 residents for the 200 facilities open in 2004.)

Sixty of the 139 completed and in-progress closures have occurred in the past 10 years. In January 1991, New Hampshire closed the Laconia State School and became the first contemporary American state to operate an institution-free service delivery system. The District of Columbia, Vermont, Rhode Island, New Mexico, West Virginia, Hawaii, and Maine became institution-free from 1991 to 1999. Michigan has closed 12 state institutions and in 2004, its only remaining facility, Mt. Pleasant, had a census of 162 persons. Minnesota has only one "institutional" program for persons with MR/DD. This is an intensive behavioral treatment program for seven consumers, located in a state psychiatric hospital.

Providing community-based services for persons with MR/DD and their families has gained considerable public support in recent years. Between 1977 and 2004, the annual growth of total community spending in the United States averaged 10% per year, after adjusting for inflation. Total state institution spending, however, actually declined 1% annually during 1977-04, and the average annual census of residents in institutions dropped by five percent per year.

The census of Grafton and San Haven in North Dakota (***Figure 3***) declined by an average of two percent per year from 1966 to 1983, one-half of the U.S. institutional rate over that period. Following the implementation of the consent decree in *Association for Retarded Citizens of North Dakota v. Olson* (1982), the North Dakota institutional census dropped by 15% per year from 1983 to 1995, from 966 to 140 persons. San Haven closed in 1987. In the past 12 years, through early 2006, there has been essentially no further decline in Grafton's institutional population. In fact, it has increased slightly since 1995.



Question #4: What are today's institutional costs per resident in North Dakota and, based on previous trends, what can these costs be estimated to be in future years?

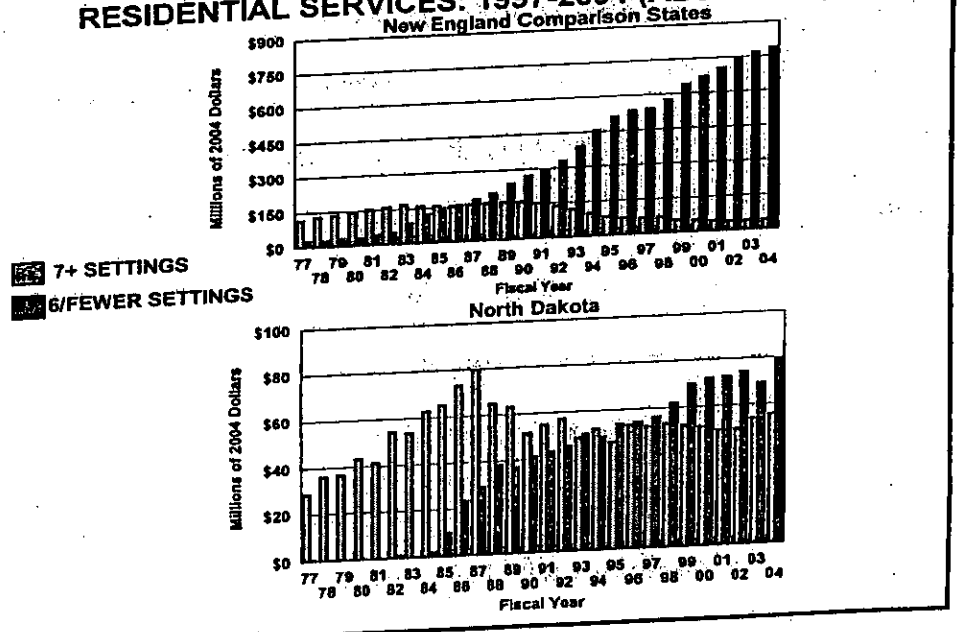
If present trends continue, an average of $193,000 per year, or $530 per day in constant 2004 dollars, is expected to be spent in the year 2016 for each institutional resident in the United States. From 1977 to 2004, average per diems grew nearly nine-fold, from $45/day to $400/day, and in 2004 per diems exceeded $500/day in 15 states, $400/day in 21 states, and $300/day in 35 states (Braddock et al., 2005).

Since 1995, the cost for each Grafton resident has advanced from $315 to $392 per day (***Figure 3***). The average cost of care in North Dakota's institution is now over $143,000 per year for each resident. Absent a decision to close Grafton, and given the stability of the Grafton census, the Grafton per diem for fiscal year 2016 in constant 2004 dollars may well surpass $600/day for approximately 146 residents. This amounts to $219,000 per year per resident, or $32.0 million per annum for the Grafton facility in 10 years.

An equally significant fiscal consequence of continuing to commit increasingly larger sums of money to institutional operations lies in the fact that, given current spending trends for Grafton, fewer "new" funds would be available to initiate additional or higher quality community services for consumers and families in the State. However, the New England

states of Maine, New Hampshire, Rhode Island and Vermont have all closed their remaining state MR/DD institutions, reallocated institutional funding, and greatly expanded their community services for thousands more individuals with MR/DD and their families (***Figure 4***). In contrast, North Dakota has continued to dedicate funding to persons in Grafton and to larger group living arrangements for seven or more persons. The New England states' decisions to close their MR/DD institutions lead to the development of a range of community housing and supported work options that subsequently received widespread political support (e.g., Covert, Macintosh & Shumway, 1994).

FIGURE 4
SPENDING FOR SIX PERSON OR FEWER RESIDENTIAL SERVICES: 1997-2004 (ADJUSTED)



Question #5: How well do persons with MR/DD typically adjust to relocation from institutions to community living environments?

Larson and Lakin (1989) of the University of Minnesota published a comprehensive review of research on changes in adaptive behavior associated with residents moving from state mental retardation institutions to smaller community living arrangements. Over 50

studies published between 1976 and 1988 were initially identified. After screening them according to six quality standards, 18 studies were subsequently analyzed. Results of the analysis indicated that institutions were "consistently less effective than community-based settings in promoting growth, particularly among individuals diagnosed as severely or profoundly retarded" (p. 330). The 18 studies reviewed involved 1,358 participants. The studies were conducted in 13 different states from all regions of the country. The authors concluded:

> ...it must be recognized that based on a substantial and remarkably consistent body of research, placing people from institutions into small, community-based facilities is a predictable way of increasing their capacity to adapt to the community and culture (p. 331).

In California, Brown, Fullerton, Conroy, & Hayden (2001) evaluated the well-being of more than 2,000 individuals with developmental disabilities who left state-operated California developmental centers from 1993 to 2001. The researchers assessed each individual at the state institution prior to the move, and, during 1994-2001, visited all 2,170 relocated individuals in their new homes in the community.

Data collected included measures of independence, behavioral challenges, choice-making, friendships, integration, person-centered planning, health, service intensity, earnings, and both consumer and family satisfaction. Brown et al. (2001) found that those relocated, compared to their lives in an institution in 1994, experienced improvement in "integrative activities," individualized treatment," "progress toward individual goals," "opportunities for choice-making," "reduced challenging behavior," and "perceived quality of life." Families were reported to be "unexpectedly and overwhelmingly happy with community living, even those who formerly opposed the change" (p. 3).

Brown et al. (2001) acknowledged that individuals relocated lost some of those gains between 2000 and 2001, stating that a plausible explanation was that "low salaries and high turnover rates translate into poorly motivated and poorly trained staff" in the community, an issue confirmed by family members who stressed the "poor quality and the short tenure of direct care staff" (p. 50). The State of California spent only 55% of the previous institutional cost per person, compared to community spending levels in New Hampshire, Pennsylvania, and Connecticut ranging from 80% to 86% of their states' institutional costs (Brown et al., 2001; Conroy, 1996).

Many people with levels of impairment once believed to be manageable only in institutional settings now live satisfactorily in community settings. This includes individuals with health problems (Gaylord, Abery, Cady, Simunds, & Palsbo, 2005; Hayden, Kim, & DePaepe, 2005; Larson, Anderson, & Doljanac, in press) and with challenging behaviors (Hanson, Wiesler, & Lakin, 2002; Kim, Larson, & Lakin, 2001; Stancliffe, Hayden, Larson, & Lakin, 2002). Undeniably, anecdotal reports of instances in which community placements did not work out are occasionally cited by proponents of continuing institutionalization of persons with MR/DD. However, the institutionalization of persons who have committed no wrong against society can only be justified by demonstrating clear benefits accruing to these persons from living in an institution. *Research literature noted above clearly indicates that state institutions do not provide a superior level of care for people with mental retardation.*

Question #6: How do parents of individuals relocated from state institutions to community settings respond to this process of change?

Families often initially oppose the transfer of their relatives from institutions to community settings, but after transfer occurs, the great majority of parents become strong

supporters of community placement (Heller, Bond, & Braddock, 1988). Since the late 1970s several studies have addressed the reactions of parents of institutionalized persons to the community placement of their relative with mental retardation. The studies demonstrated that, after community placement, parents consistently reported lower levels of satisfaction with the earlier institutional placement and higher levels of satisfaction with community placement (Brown et al., 2001; Larson & Lakin, 1991).

Initial family dissatisfaction with closure often bears little relationship to family attitudes toward closure a year later. The relative's medical status and the family's worry over "transfer trauma" have often both played significant roles initially upon the announcement of the closure, but not in determining longer-term parent reactions. The primary variables affecting both parent satisfaction with closure and parent stress levels is the family's current appraisal of the quality of the new community placement. Frequent staff consultation with the family members during the closure process was related to higher parent satisfaction with closure one year later (Heller et al., 1988).

Given that some families might resist institutional closure and the relocation of their relative, it is important to assure families that increased consumer health and adjustment problems are now uncommon during and following institutional closures. This is due to implementing the relocation process with sensitivity to the consumer's needs and preferences and involving families directly in the process. The literature on family reaction to institutional closure and relocation may be summed up as follows:

> ...the clearest message in these studies is that the overwhelming majority of parents become satisfied with community settings once their son or daughter has moved from the institution, despite general predisposition to the contrary (Larson & Lakin, 1991, p. 36).

Question #7: How might cost savings be achieved in North Dakota if Grafton were to be closed in the near future?

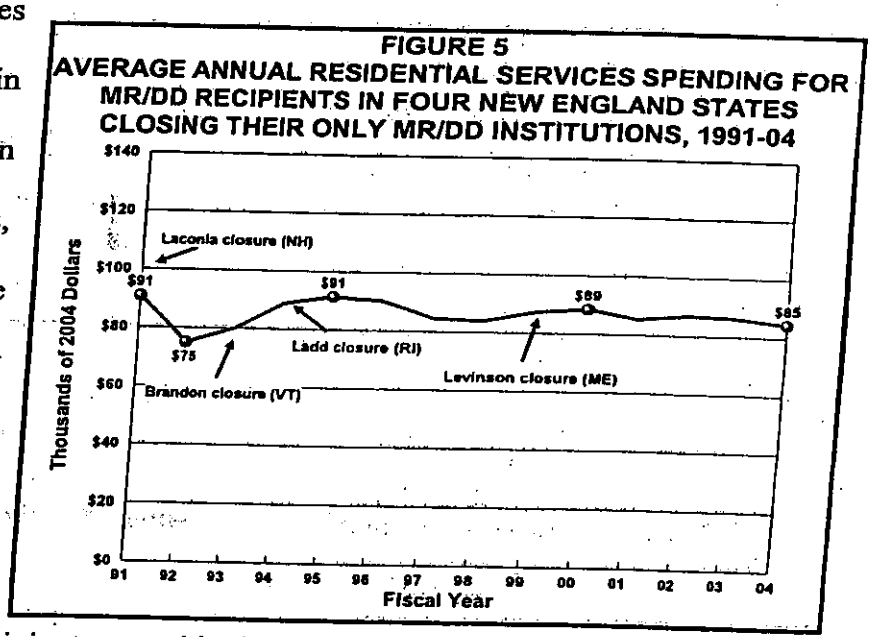
The closure of a state institution can generate savings for state government over time because it: 1) eliminates the high fixed cost of operating a state-owned facility, usually built for many more residents than live there at the time of closure; 2) shifts some fiscal responsibilities from state government tax revenues to federal Supplemental Security Income (SSI) and, in some cases, to local government sources; 3) increases the likelihood that individuals will engage in productive employment in a local community because they now live there; 4) utilizes less costly social, educational, religious, and recreational resources in the community rather than the relatively expensive, specialized services provided in the institution; and, 5) by renting/leasing residences it avoids the expensive institutional capital construction and remodeling costs necessary for most older institutions to remain open and certified for receipt of federal reimbursement (Braddock, 1991a, 1991b).

In a relevant study of closure costs and savings, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) retained the services of an independent consulting firm to study the cost implications of its decision to close multiple mental retardation institutions. The study, authored by the Grant-Thornton accounting firm, concluded that the average post-closure per diem operating costs for each client "were approximately 9% lower than the pre-closure costs" (New York OMRDD, 1990). The study found that closure had little effect on state employee levels. Conversion of a state school campus to an alternate use such as a prison or juvenile facility provided substantial new employment opportunities and absorbed much of the economic impact of the state institution closure.

Another perspective on pre- and post-closure costs is afforded by the four New England states (Maine, New Hampshire, Rhode Island, and Vermont). These states, upon the closures of their last remaining institutions during 1991-99, became "institution-free"--like North Dakota would with the closure of Grafton. New Hampshire closed Laconia in 1991, Vermont closed Brandon in 1993, Rhode Island closed Ladd in 1994, and Maine closed Levinson in 1999 (Braddock et al., 2005).

An analysis of pre- and post-closure costs per residential recipient across 1991-2004 was completed. From the dates of the first closure (Laconia in 1991) through 2004, in inflation-adjusted terms, annual spending per statewide residential recipient in the four New England states declined from $91,000 to $85,000 (***Figure 5***). In addition, the number of aggregate MR/DD recipients served in the four states increased by 44% from 1991 to 2004. The number of recipients post-closure increased by 76% in New Hampshire, 50% in Rhode Island, 41% in Vermont and 30% in Maine.

FIGURE 5
AVERAGE ANNUAL RESIDENTIAL SERVICES SPENDING FOR MR/DD RECIPIENTS IN FOUR NEW ENGLAND STATES CLOSING THEIR ONLY MR/DD INSTITUTIONS, 1991-04



Question #8: ***Should the State of North Dakota anticipate a short-term need for increased appropriations associated with Grafton's closure, to cover the temporary "dual costs"?***

Without specific knowledge as to how a closure process might be implemented in North Dakota, including the nature of the phase-down of the physical plant and the duration

of the closure's implementation, it is difficult to provide an accurate estimate of "dual" costs associated with the closure. However, the state should anticipate some temporary dual costs. Assuming closure takes three years to implement (i.e., 2007-09), and that approximately 50 residents move to the community each of the three years, "dual" costs were estimated to be $3.1 million in the first year, $5.7 million in the second year, and $1.9 million in the third year. These estimates, totaling $10.7 million for the three year implementation period are based on the following two additional assumptions:

- The annual cost per relocated consumer in the new community settings in FY 2007 was assumed to be equivalent to the projected per diem cost at Grafton in FY 2007. This assumption permitted community direct support staff wages in 2007, the first year of closure implementation, to be comparable with Grafton's wages. Community direct support staff wage costs for FYs 2008 and 2009 were projected to increase at the average annual rate of increase in Grafton's per diem rates during FYs 1977-04 (2.6% per year on an inflation-adjusted basis).[1]
- Consumer per diems for those residents remaining at Grafton during the closure process will increase significantly in the second and third years, due to fixed costs being spread over fewer residents. We estimated the increased Grafton per diem rates based on the average increases in per diems in the New England comparison states to be 17% in year one, 51% in year two and 57% in year three.

However, as noted in the previous discussion for ***Question 7***, average inflation-adjusted statewide costs per resident receiving services in the consolidated four New England comparison states actually declined from 1995 to 2004. This was due to the fact that additional community recipients with lower average support needs were able to be served as well. North Dakota may experience a similar trend in average overall community costs in the long-term as well.

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[1] Some studies, however, have indicated that community costs for individuals with MRDD who had comparable needs were only 55-86% of those in institutions (Brown et al., 2002; Conroy, 1996). These lower community cost estimates were not used to generate the community per diem estimates in favor of emphasizing the conservative assumption of equalizing FY 2007 direct support staff wages in community settings with Grafton's projected FY 2007 staffing costs.

Question #9: What are some of the alternate uses to which a closed Grafton facility might be put?

Alternate uses possible for the Grafton physical plant depend upon the facility's proximity to projected population growth areas, the adaptability of the facility to alternate public or private use (e.g., prison, factory, state or industrial warehouse, etc.), and other factors. ***Table 1*** presents a summary of the various alternate uses for 130 developmental disabilities institutional closures in the U.S. See ***Appendix I*** for additional detail on each of the facilities that closed.

TABLE 1: ALTERNATE USES FOR INSTITUTIONAL CLOSURES IN THE U.S.

Alternate Use	Number[1]	Alternate Use	Number[1]
Corrections (including federal corrections)	22	New MR facilities	2
DD or other state/local administrative offices	15	Unoccupied (asbestos)	2
Alternate use not yet known	9	Private institutions	2
Universities/junior colleges	9	Historic preservation	1
Property vacant	9	Housing	1
Various community uses	6	Public health infirmary	1
Community DD programs	5	Retirement program	1
To be sold (including realty, public auction)	5	Reverting to U.S. Department of Defense	1
Commercial uses	4	Veterans' medical center	1
MI facilities	4	Water survey office	1
Demolished	3	Women's prison	1
Juvenile facilities	3	Undetermined	29

[1]Total is 137--7 institutions had two alternate uses

The four New England closures demonstrate the range of possible alternate uses displayed in ***Table 1***. The Laconia State School in New Hampshire was quickly reopened in 1991 as the Lakes Region Adult Correctional Facility. The town of Laconia (population 16,411) is 30 miles from Concord (population, 40,687). Brandon Center in Vermont, closed in 1993, is near Rutland (population 17,292) which is 85 miles from Colonie, New York (population 79,258). The closed facility is currently under development as a manufacturing site, with both private and state ownership.

The Ladd Center in Rhode Island, closed in 1994, was located in Exeter (population

6,045), 13 miles from Warwick (population 85,808) and was also proximal to Providence, a large city. A $6.4 million state fire academy and new state police headquarters is being developed on the Ladd Center site. The Elizabeth Levinson Center in Maine closed as a state institution in 1999 and now operates as a state-run short-term residential and health program for medically fragile children. Levinson, in Bangor (population 31,473) is 129 miles from Portland (population 64,249). Like North Dakota, the institutions in New Hampshire and Vermont were located in small towns, somewhat distant from a larger city. Grafton, a town of 4,516, is located 38 miles from Grand Forks.

Question #10: What can North Dakota learn from the extensive experience of other states in planning and implementing institutional closures?

In 1983, Illinois successfully relocated the 820 residents of the Dixon State School within a single calendar year. More than 90% of the parents were satisfied with the closure process and outcomes. Resident friendship patterns were kept intact by moving small groups of individuals together and by closing down one residential unit at a time (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986).

Guidelines based on state experiences in MR/DD institutional closures are summarized in ***Appendix II.*** They are presented from five perspectives: 1) general guidelines; 2) the individuals with developmental disabilities who are being relocated; 3) their families; 4) the community programs receiving residents from the closing facility; and 5) the staff of the closing facility. The guidelines were revised from Braddock et al. (1983) and Heller, et al. (1986).

CONCLUSION

In three previous analyses of the structure, financing and quality assurance of residential and community services in North Dakota, Braddock & Hemp (2004, 2000) and Braddock, Hemp, & Rizzolo (2002) suggested service and funding priorities for the State. For example, it was noted that North Dakota had fared better than most states fiscally in the recent national economic downturn during 2003-2005, and North Dakota was one of 10 states with the strongest financial outlook for fiscal year 2005. Priority needs for MR/DD services identified in the most recent North Dakota study included: 1) continuing the expansion of the Medicaid Home and Community-Based Services (HCBS) Waiver; 2) reducing reliance on Intermediate Care Facility/Mental Retardation (ICF/MR) programs for 16+ person public and private institutional facilities; 3) increasing family support, supported employment and supported living; and, 4) enhancing direct support staff wages and benefits (Braddock & Hemp, 2004, p. 50).

Nationwide, there are over nine times more individuals with mental retardation and developmental disabilities living in supervised out-of-home community settings than in state-operated institutions. The number of families and persons with disabilities benefiting from community services and supports nationally is growing as well. State-operated institutions are being closed in many states across the country and few families prefer such programs. Thus, given the trends outlined in this paper, the long-term future of services to persons with mental retardation and developmental disabilities in North Dakota is in community settings.

It therefore seems appropriate for North Dakotans to seriously consider expanding community residential services and support programs for people with MR/DD and their families, and subsequently closing the North Dakota Developmental Center at Grafton.

However, if Grafton is slated for closure, the implementation of that closure needs to be planned and executed in a manner sensitive to the needs of Grafton's consumers and their families and considerate of the employees of the facility as well. As previously noted, suggested guidelines specifically addressing closure implementation issues are presented in ***Appendix II.***

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APPENDIX I
COMPLETED AND IN-PROGRESS CLOSURES OF STATE-OPERATED 16+ INSTITUTIONS IN THE U.S. (139 CLOSURES IN 39 STATES)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Alabama	Brewer-Bayside	1984	MR Facility	67	2003	Corrections
	Glenn Ireland	1988	MR Facility	20	1996	To be sold
	Tarwater	1976	MR Facility	74	2003	Corrections
	Wallace	1970	MR Facility	80	2003	Corrections
Alaska	Harborview	1964	MR Facility	45	1997	Community Programs
Arizona	Phoenix	1974	MR Facility	46	1988	Commercial
	Tucson	1972	MR Facility	13	1997	Outreach Offices
California	Agnews	1855/1966	MI Facility	411	2007	Undetermined
	Camarillo	1935	MR Facility	497	1998	University
	DeWitt	1942/1947	Army Hospital	819	1972	Placer County Recreation
	Modesto Unit	1943/1948	Army Hospital	1,394	1969	Modesto Co. Comm. College
	Napa	1875/1967	Asylum for MR/MI	30	2001	MI Use Only
	Stockton	1852	Asylum for MI	414	1996	University
Colorado	Pueblo	1935	MI/MR Facility	163	1989	Pueblo Regional Center
Connecticut	John Dempsey Center	1964	MR Facility		1998	Administrative Offices
	Mansfield	1908/1917	Epileptic Colony	148	1993	Corrections/U. of Connecticut
	New Haven	1964	MR Facility	56	1994	Job Corps
	Seaside	1961	MR Facility		1996	Administrative/Storage
	Waterbury	1963/1972	Convent	40	1989	Administrative Offices
DC	Forest Haven	1925	MR Facility	1,000	1991	Private Rehab/PH Infirmary
Florida	Community of Landmark	1965	MR Facility	256	2005	Revert to Dade County social programs
	Gulf Coast Center	1960	MR Facility	305	2010	Undetermined
	Orlando	1929/1959	TB Hospital	1,000	1984	Demolished, land to school, county
	Tallahassee	1926/1967	TB Hospital	350	1983	Unoccupied: asbestos
Georgia	Bainbridge	1967	WW II Air Force School	129	2001	Corrections
	Brook Run	1969	MR Facility	364	1997	Undetermined
	Georgia Regional-Augusta			438	2004	Undetermined
	Gracewood School/Hospital			93	2004	Undetermined
	Rivers' Crossing	1969	MR Facility	37	1994	Undetermined
Hawaii	Kula Hospital (privatized)	1984			1999	
	Waimano	1921	MR Facility	96	1999	Art Center for PWD
Illinois	Adler	1967	MI/MR Facility	18	1982	Water Survey Offices
	Bowen	1965	MR Facility	105	1982	Corrections
	Dixon	1918	MR Facility	820	1987	Corrections/New MR Facility
	Galesburg	1950/1969	Army Hospital	350	1985	Head Start/Community Programs
	Lincoln	1877	MR Facility	153	2004	Vacant*
	Meyer	1966/1970	MI Facility	53	1993	Women's Prison
	Singer	1966	MI Facility	45	2004	Undetermined
Indiana	Central State	1848	MI/MR Facility	83	1994	Undetermined
	Ft. Wayne	1879	MR Facility	120	2007	To be demolished
	Muscatatuck	1920	MR Facility	287	2005	Undetermined
	New Castle	1907	Epileptic Village	200	1998	Corrections
	Northern Indiana	1943	MR Facility	53	1998	Undetermined
Kansas	Norton	1926/1963	TB Hospital	60	1988	Corrections
	Winfield	1888	MR Facility	250	1998	Undetermined
Kentucky	Frankfort	1860	MR Facility	650	1972	Demolition
	Outwood	1922/1962	TB Hospital	80	1983	Demolition/New Campus
Maine	Aroostook	1972			1995	
	Levinson	1971			1999	
	Pineland	1908	MR Facility	265	1996	Undetermined
Maryland	Victor Cullen	1908/1974	TB Hospital	79	1991	Private Juvenile Facility
	Great Oaks	1970	MR Regional Center	273	1997	Private Senior Retire. Community
	Henryton	1928/1962	TB Hospital	312	1985	Undetermined
	Highland Health	1870/1972	General Hospital	88	1989	Sold to Johns Hopkins University
Massachusetts	Belchertown	1922	MR Facility	297	1992	Vacant
	John T. Berry	1900/1963	TB Sanitarium	101	1995	Undetermined
	Paul A. Dever	1940/1946	P.O.W. Camp	294	2001	Undetermined
	Fernald	1848	MR Facility	274	2007	Undetermined
Michigan	Alpine	1937/1959	TB Hospital	200	1981	Notsego County Offices
	Caro	1914			1998	
	Coldwater	1874/1939	Orphanage	113	1987	Corrections
	Fort Custer	1942/1958	Army Hospital	1,000	1972	Back to U.S. Dept. of Defense
	Hillcrest	1905/1961	TB Hospital	350	1982	Demolition
	Macomb-Oakland	1967/1970	CDA	100	1989	Reverted to Community Dev.
	Muskegon	1969	MR Facility	157	1992	Vacant
	Newberry	1896/1941	MI Facility	39	1992	Vacant
	Northville	1952/1972	MI/MR Facility	180	1983	Revert to MI Use
	Oakdale	1895	MR Facility	100	1991	Vacant/County Negotiating
	Plymouth	1960	MR Facility	837	1984	County/State Offices
	Southgate	1977	MR Facility	55	2002	Undetermined

APPENDIX I (CONTINUED)

State	Institution	Year Built/ Became MR	Original Use	# Residents, Closure Announcement	Year of Closure	Alternate Use
Minnesota	Brainerd	1958			1999	
	Faribault	1879	MR Facility	501	1998	Portion used by Corrections
	Fergus Falls	1888/1969	Asylum for MI	38	2000	Regional MH Center
	Moose Lake	1938/1970	Psychiatric Hosp	34	1993	Corrections
	Owatonna	1895/1947	Orphanage	250	1970	Abuse
	Rochester	1879/1972	MI Facility	150	1982	Federal Corrections
	St Peter	1968			1996	
	Willmar	1973			1996	
Missouri	Bellefontaine	1924	MR Facility	341	2005	Undetermined
Montana	Eastmont	1969/1979	Residential School	29	2003	Nursing Facility
New Hampshire	Laconia	1903	MR Facility	4	1991	Corrections
New Jersey	Edison	1975/1961	Corrections	70	1988	Sold at public auction
	Johnstone	1955	MR Facility	239	1992	Corrections
	North Princeton	1898/1975	Epileptic Colony	512	1998	Undetermined
New Mexico	Fort Stanton	1964	Army Apache Outpost/TB H	145	1995	Skilled Nursing/Respite
	Los Lunas	1929	MR Facility	252	1997	Community Based Program MR/DD
	Villa Solano	1964/1987	Missile Base	82	1982	Housing
New York	J.N. Adam	1912/1967	TB Hospital	180	1993	Undetermined
	Bronx	1977	MR Facility	217	1992	Plans Not Final
	Craig	1896/1935	Epilepsy Hospital	120	1988	Corrections
	Gouverneur	1962	MR Facility	N/A	1978	Leased site
	O.D. Heck	1972	MR Facility	274	1999	Administrative Offices; non-profit use
	Letchworth	1911	MR Facility	704	1996	Undetermined
	Long Island	1965	MR Facility	682	1993	Undetermined
	Manhattan	1918/1972	Warehouse	197	1991	OMRDD Office
	Newark	1878	Custodial Asylum	325	1991	Community College
	Rome	1825/1894	County Poorhouse	638	1989	Corrections
	Sampson	1860/1961	Naval Base	695	1971	Office of Mental Health
	Staten Island	1942/1952	Army Hospital	692	1987	OMRDD & Community College
	Sunmount	1922/1965	TB Hospital	503	2004	OMRDD Specialty Units
	Syracuse	1851/1972	MR Facility	409	1997	Undetermined
	Valatie	1971	MR Facility	N/A	1974	Private Holdings and ICFs/MR
	Westchester	1932/1979	MI Facility	195	1988	Office of MH
	Wilton	1960	MR Facility	370	1995	Sold to private industry
North Dakota	San Haven	1922/1973	TB Hospital	86	1987	Vacant
Ohio	Apple Creek	1931	MR Facility	176	2006	Undetermined
	Broadview	1930/1967	TB Hospital	176	1992	City Administration Building/Retirement
	Cleveland	1855/1963	MI Facility	149	1988	Vacant/Negot. with City of Cleveland
	Orient	1898	MR Facility	800	1984	Corrections
	Springview	1910/1975	TB Hospital	66	2005	Undetermined
Oklahoma	Hissom	1967	MR Facility	451	1994	Corrections/Educational
Oregon	Columbia Park	1929/1963	TB Hospital	304	1977	College
	Eastern Oregon	1929/1963	TB Hospital	240	1984	Corrections/Opened New MR Facility
	Fairview	1907	MR Facility	327	2000	Light commercial/housing
Pennsylvania	Altoona	1975	MR Facility	90	2005	Undetermined
	Cresson	1912/1964	TB Hospital	155	1982	Corrections
	Embreeville	1880/1972	County Poorhouse	152	1998	Undetermined
	Hollidaysburg	1974	MR Facility	60	1976	Revert to MI Use
	Laurelton	1920	MR Facility	192	1998	Undetermined
	Marcy Center	1915/1974	TB Hospital	152	1982	Vacant
	Pennhurst Center	1908	MR Facility	179	1988	Veterans' Medical Center
	Philadelphia	1983	MI/MR Facility	60	1989	Vacant
	Western	1982		133	1999	
	Woodhaven	1974	MR Facility	N/A	1985	Became private institution
Rhode Island	Dix Building	1945/1982	WPA	80	1989	Corrections
	Ladd Center	1907	MR Facility	292	1994	Undetermined
South Carolina	Clyde Street	1973	Home for unwed mothers	20	1995	Administrative Offices
	Live Oak	1987	Nursing home	50	1999	To be sold
South Dakota	Custer	1984	TB Hospital	76	1996	Boot camp for delinquent boys
Tennessee	Winston	1979			1998	
Texas	Forth Worth	1976	MR Facility	339	1995	Undetermined
	Travis	1934	MR Facility	585	1997	Undetermined
Vermont	Brandon	1915	MR Facility	28	1993	For Sale, Local Realty
Washington	Interlake School	1946/1967	Geriatric MI	123	1995	Other State Agency
West Virginia	Colin Anderson	1920s	MR Facility	85	1998	Possible Juvenile Corrections
	Greenbrier	1801/1974	Women's College	58	1994	Community College
	Spencer	1893	MI/MR Facility	150	1989	Vacant/Possible Corrections
	Weston	1864/1985	MI/MR Facility	99	1988	Revert to MI Use
Wisconsin	Northern Wisconsin Ctr.	1897	MR Facility	173	2005	Intensive Treatment/Dental

*Four 10-bed "grouphomes" to be built on the Lincoln, Illinois site, to be named "Lincoln Estates."

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

APPENDIX II
SUGGESTED PRELIMINARY GUIDELINES FOR INSTITUTIONAL CLOSURES

Institutional closure affects "sending" facility staff (staff at the institution that is closing), the "receiving" community staff and their agencies, and, of course, the individuals with disabilities and their families who are most affected. These guidelines were primarily adapted from closures at the Dixon and Galesburg Centers in Illinois (Braddock, Heller, & Zashin, 1983; Heller, Factor, & Braddock, 1986)

There are five sections in the Guidelines:

I. General Guidelines
II. Individuals Moving from the Institution
III. Families and Guardians
IV. Community Programs
V. Personnel of the Closing Facility

I. GENERAL GUIDELINES

1. Evaluate the Closure Systematically and Longitudinally

Develop a plan to evaluate (study) the closure of Grafton, first from the standpoints of the residents and their families but also from the standpoint of the impacted staff and the local community in which Grafton is situated. Use this evaluative information to help increase the likelihood of positive long-term impacts on consumers, employees, and communities. Announce the study at the same time the closure is announced. It should continue for at least two years after the last resident is moved to the community.

2. Seek Out Knowledge From Other States' Experiences with Institutional Closure

Many states have a great deal of experience with closing institutions for people with MR/DD. Seek out that experience if you choose to close Grafton.

II. GUIDELINES FOR INDIVIDUALS MOVING FROM THE INSTITUTION

1. Minimize Resident Transfer Trauma by Implementing an "Anticipatory Coping Strategy"

- Close Down Institutional Cottages or Units One at a Time;
- Keep Resident Groups and Friends Intact;
- Minimize Internal Transfer of Residents and Staff in the Closing Facility;

- Conduct Preparatory Programs for Consumers. This should include site visits to the new residential settings, as desired by the individuals, and in respect to any support needed based on their level of functioning; and,
- Involve Consumers Personally in Choosing Their Roommate(s) and Their New Community Home and Support Network.

2. Transfer Staff with Those Moving From the Institution

Determine whether institutional staff can be employed at community programs with individuals with developmental disabilities who know them and who are relocating to those programs.

3. Adopt a Relocation Assessment Process with an Appeal Mechanism

- Level One: Identification of an Alternative Plan

  The sending facility and state agency staff recommend a receiving program in the community for each resident based on service and support needs, preferences of the individual and/or the legally responsible persons, and availability of community resources.

- Level Two: Development of an Individual Services Plan

  A service plan is developed by the receiving program staff in collaboration with the sending facility staff. Minimizing internal transfers at the sending facility will improve the quality of information transmitted, as staff most familiar with the individuals moving would be available to provide the necessary input into the plans. The community agency staff has the final discretion in writing the plan.

- Level Three: Conference with Legally Responsible Person

  Prior to relocation, a meeting is offered at the community program with the legally responsible family member or guardian, if desired, to review with the community program staff the individual service plan. Closing facility staff may also participate in the meeting.

- Level Four: Appeal Process Available to Legally Responsible Person

  The legally responsible parent or guardian can object to the transfer plan if he or she believes it does not meet the individual's habilitation, support or medical needs. An appeal process is a necessary "relief mechanism."

III. FAMILY AND GUARDIAN GUIDELINES

1. Consultation with Closing Facility's Parents' Association

If a closure is decided upon, the state agency should promptly request permission to address the facility's parents' association. Meetings should be held, as necessary, to explain the closure process and to deal with problems that might arise during the relocation process. It is wise to acknowledge upfront to parents at both the sending facility, and to the community programs, that the relocations may temporarily disrupt routines at the institution and the community programs and in the lives of the individuals being relocated and their families. Every attempt to minimize this disruption should be made.

The state agency representative should convey to parents her or his willingness to work out solutions. It is also important for community program parents to be engaged to help provide a receptive environment for the relocated individuals and their families.

2. Involve Parents Who Have Been Through the Process

Parents involved in a successful institutional closure from a nearby state with such experience may be invited to the initial closure discussions with state agency representatives and with the closing facility parents' association. This can help reduce family anxiety and build support for the positive opportunities that a well-planned relocation can bring to their relatives.

3. Family/Guardian Notification

Individualized notification of families and guardians can serve to reduce anxiety and build support for individuals' planned relocations. Immediately upon the announcement of closure or phase-down, notification letters are sent to family members or guardians providing the following information:

- A rationale for the closure;
- The approximate time-frame;
- Anticipated positive aspects of the change;
- Types of community programs that will be available;
- Family and guardian options for alternative community programs;
- Reaffirmation of the state's commitment to serve the individual throughout relocation;
- Description of the four-level relocation assessment process--what will happen next; and,

- Name and phone number of a contact person designated by the state agency.

  Follow-up is continued through telephone contact reiterating essential information that was in the letter of notification and soliciting family or guardian participation in the individual's relocation to the community program.

4. Encourage Family Involvement

The following six steps can be employed to involve the families meaningfully in the process:

- Hold Informational Sessions at the Sending Facility

  Invite families to informational sessions at the sending (closing) facility. Representatives of the receiving community programs should also make presentations about their programs for the families.

- Open House at Community Programs

  Most community agencies operate a range of residential, day, work, and other support services. Invite families to an open-house at each receiving agency so that they have access to the appropriate information about the programs their family member is likely to be involved in.

- Parents at the Receiving Community Agencies. Contact families at the sending institution to offer assistance, inviting them for individualized or small group visits.

- Set Up a Family Buddy System at the Community Agency

  This system connects community agency families with the new families before, during and after the relocation.

- Family and Guardians Should be Present During the Actual Relocation if Desired

- The Community Agency Should Contact Families and Guardians to Inform Them When the Relocation is Scheduled and Invite Them to be Present. (The community agency parent buddy should also be present if possible.)

IV. COMMUNITY PROGRAMS RECEIVING RESIDENTS FROM THE CLOSING FACILITY

1. Develop Consistent Entry Criteria

Develop systematic criteria for accepting residents at each receiving program and communicate these clearly with sending facilities and family/guardians. Encourage pre-placement visits to the receiving programs by staff, consumers with disabilities, and families to enable them to evaluate the program's appropriateness.

2. Provide Staff Training

Prepare incumbent staff and personally orient new staff to the consumers who will be moving in. Often the persons coming from closing facilities are lower functioning, medically fragile, or have challenging behaviors. Without sufficient training, staff may lack the specific knowledge and skills to properly support some of the individuals moving.

3. Involve Receiving Programs in Planning

Once closure has been scheduled, involve receiving program representatives early in the planning process and keep them involved and well-informed.

4. Establish Mental Health Back-Up Supports

Mental health back-up supports to community residences should take the form of a troubleshooting group of trained and experienced professionals drawn from the state facility and community agencies. A "behavioral unit" at one of the community programs or at a state mental health center could function as a temporary placement until appropriate, permanent back-up programs are established in the community and/or state mental health center.

5. Develop Public Relations and Education Programs for Communities

Community providers and state agency personnel can enlist community support by attending meetings with persons and groups in the receiving communities. These meetings could be held at churches, schools, or informally with immediate neighbors, to educate and reassure.

6. Establish Relationships with Local Resources

Some new community residences may need to establish relationships with such local resources as the fire department, health providers, and public safety offices. Specific recommendations for local resources include the following topics:

- Testing, counseling and behavioral support for community mental health providers;
- Updated treatment and medication training for physicians and hospitals on topics such as challenging behavior, seizures, and motor problems;

- Dental monitoring and treatment techniques for neighborhood dentists; and,
- General orientation to developmental disabilities for firemen, police, recreation facilities.

7. Provide Financial Incentives for Community Residential Development

Community placements will be greatly facilitated by financial incentives for community programs. The Medicaid Home and Community-Based Services (HCBS) Waiver has been used successfully in most states.

8. Facilitate Development of Needed Support Services in the Community

Closure affords the opportunity for the development of necessary community services "infrastructure." For example, expanded supported living and supported employment programs for individuals moving from the institution will be needed.

V. PERSONNEL GUIDELINES

1. Plan Ahead Beginning Early in the Process

Develop a plan for future staffing patterns as individuals are relocated, conduct surveys of employee desires for transfer, and determine clear personnel policies early in the closure process. Do not promise employees what cannot be delivered.

2. Terminate One Unit at a Time and Minimize Internal Transfers

Close down one unit, wing, ward, or cottage at a time when possible and determine the schedule ahead of time, not during implementation. Closing down one component at a time keeps groups of individuals with developmental disabilities and familiar staff together, and can also result in increased administrative efficiency and cost savings.

3. Minimize Employee "Bumping"

"Bumping" (whereby staff working elsewhere in a state agency have more seniority and can replace less senior employees) should be avoided or at least minimized during the closure process. Bumping destroys program continuity in the closing facility at precisely the moment individuals being relocated need it most, with a deleterious effect on individuals who have developed interdependent relationships with staff over a long period of time.

4. Establish Employee Counseling Service

Establish an employee counseling and job placement service at the closing facility as soon as the closure is announced and becomes evident to staff. This service

would include individual counseling, workshop training, job relocation and transfer planning, job fairs, resume writing, and retirement planning.

5. Conduct Early and Continuing Briefings for Staff

Have a representative of the state agency or the state's personnel department present comprehensive briefings to facility staff when closure is announced. The briefings should announce the initiation of the employee counseling service, and fully discuss employee rights, benefits, and realistic expectations concerning layoffs, employee transfers, and retirement.

6. Develop an Open Door Policy

Develop clear lines of communication between management and all levels of staff at the closing facility.

7. Establish Liaison with Other Departments and Facilities

Establish positive working relationships with the other major employers in the closing facility's community, and in neighboring municipalities.

8. Adopt as Many Staff Incentives as Possible

Consider using one or more of the following incentives for staff in the closing facility:

- Early Retirement Inducements
- Staff Retraining

  In particular, develop staff retraining programs for community-based services employment.

- Extended Health Coverage

  Temporarily extend health insurance benefits for laid-off workers and their families throughout the first year if the workers remain unemployed.

- Adopt a Priority Interviewing Policy at Community Agencies

  Implement a priority for community agencies to interview staff from the closing facility, but give the community agency complete latitude to judge an employee's potential for working at the agency.

- Payment of Moving Expenses

Consider paying a pre-designated sum of money for moving expenses for employees transferring to MR/DD community agencies or to other MR/DD-related employment in North Dakota that is beyond 30 miles from Grafton.

9. Develop/Distribute Newsletter

Develop a periodic newsletter, perhaps monthly, and distribute it to staff at the closing facility and at the community agencies receiving individuals from the closing institution. A newsletter is useful in dispelling rumors and improving communication between the supervisory staff at the closing facility and employees affected by the closure. Rumors breed anxiety in staff and this can be transmitted to individuals who are undergoing the relocation to community agencies. The newsletters should include time tables, administrative policies including changes in policy, information about employees receiving new positions, job search information, and where to obtain counseling or other services.

10. Use a Participatory Management Approach

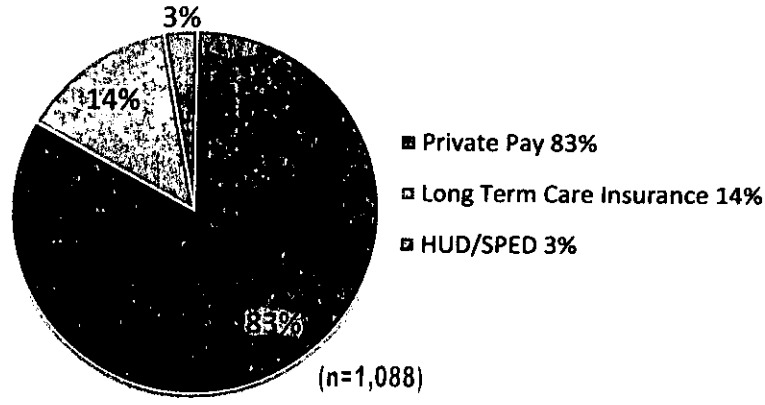
Involve top management and employee unions (if applicable) in the initial and ongoing planning for the closure. Make it clear to them that they cannot change the fact that closure is going to happen, but that they can and should influence and help make the decisions about the best way to carry out the closure and implement the relocation process.

Assisted Living Facilities

Assisted Living Facilities at a Glance:

- 71 licensed assisted living facilities
- 2,595 licensed units
- 2010 average daily rate is $97
- 2010 average occupancy is 94%

Who Pays the Bill in Assisted Living Facilities



Assisted Living Facts:

- A congregate residential setting with individual private apartments where you contract for specific services.
- Services are contracted for al-carte based upon an agreed upon service plan.
- A basic rental package generally includes three daily meals, housekeeping, activities, transportation, cable TV, laundry and snacks.
- Generally all facilities provide a full range of services from bathing to medication management to hospice care.
- Physical decline is the top issue precipitating the desire to move into an assisted living facility.
- Current tenants range in age from 55 to 106 years old, with the average age being 86.

Care Needs of Assisted Living Tenants:

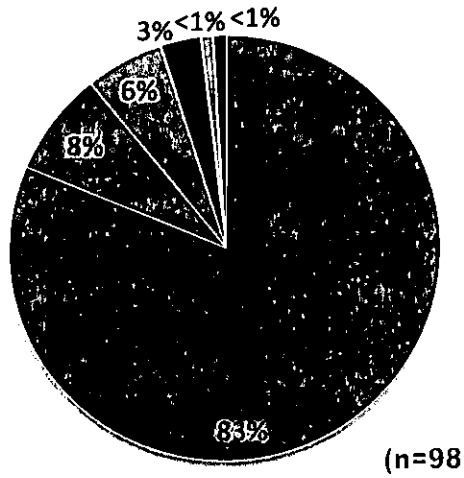
- 30% of tenants have impaired mental status, ranging from confusion/forgetful to a mental health diagnosis.
- 45% of tenants need full assistance with medication administration.
- Most tenants are fully independent in eating (91%), transferring (90%), toilet use (88%) and dressing (70%).
- About one-third of tenants periodically use the assistance of a walker.

Assisted Living Facilities (continued)

When Individuals Move Into an Assisted Living Facility, Where Did They Come From?

Most individuals were living in their own home prior to moving into an assisted living facility.

Living Arrangements Prior to Move-In

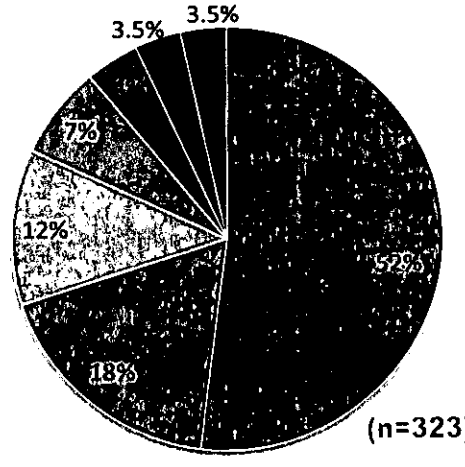


(n=986)

When Tenants Move-Out, Where Do They Go?

Over half of tenants moving out of assisted living facilities are admitted to a skilled nursing facility. Generally, advancing medical needs and growing cognition issues necessitate the move to a higher level of care.

Move-out Destination

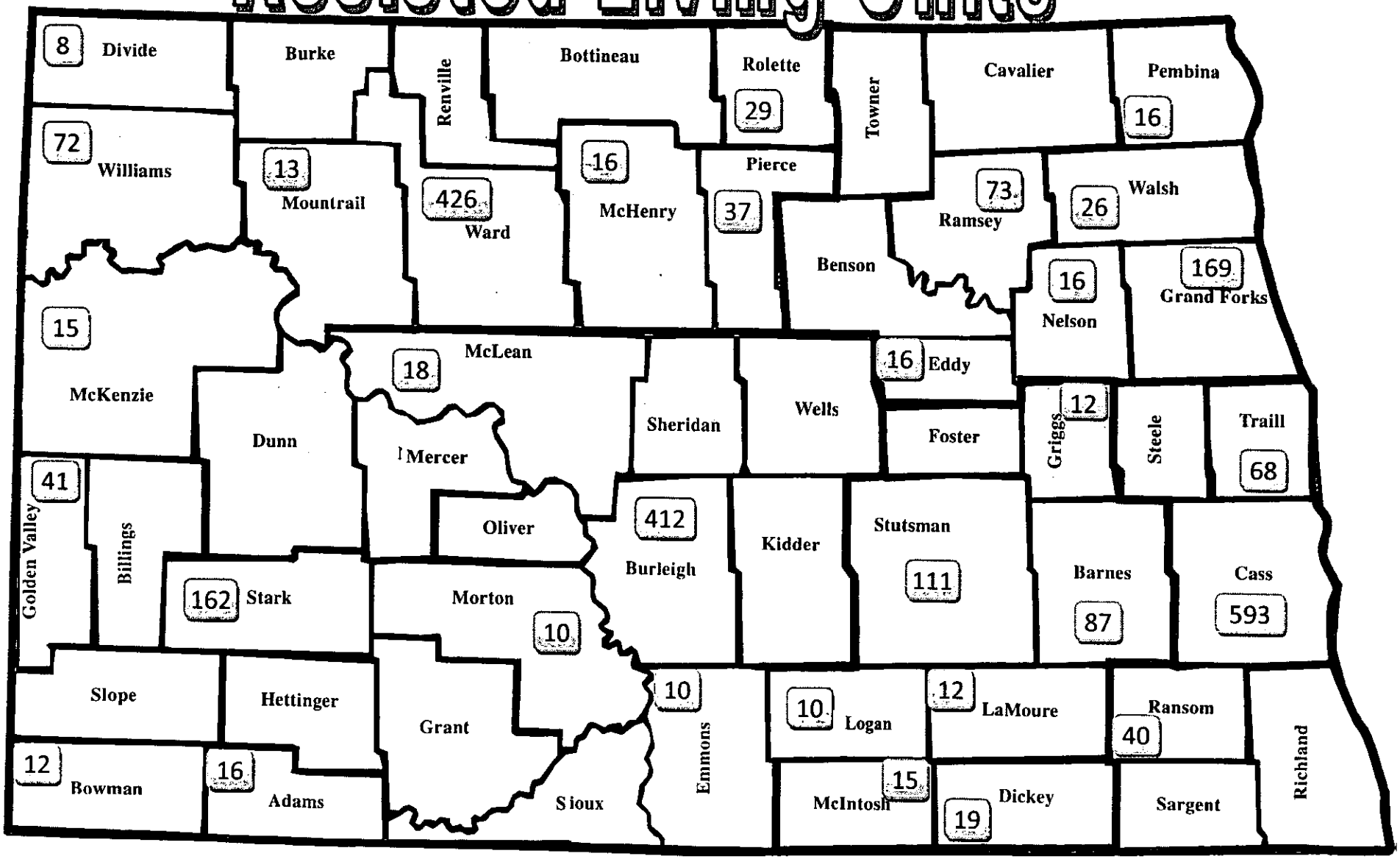


(n=323)

Assisted Living Cost:

- In 2010, the average charge for rent in a one bedroom assisted living facility was $1,776 per month ($21,312/year), with a range of $530-$2,858.
- The average cost for services in an assisted living facility ranged from $300 to $2,350 per month, with an average of $1,162 per month ($13,944/year).
- The cost of a assisted living is highly dependent on the size of the living space, location in North Dakota and the amenities in the rental package.
- Almost 60% of facilities responding to the survey felt rent assistance for low and moderate income individuals should be made available to assisted living tenants.

Assisted Living Units



Seventy-one licensed assisted living facilities as of January 18, 2011

Purple Box – Number of licensed assisted living units as of January 18, 2011 (total licensed units = 2,580).

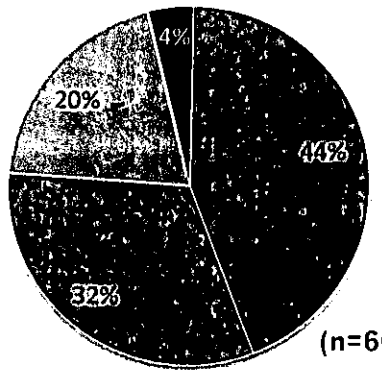
North Dakota Long Term Care Association

Basic Care Facilities

Basic Care at a Glance:

- 65 licensed basic care facilities
- 1,777 licensed beds
- 2010 average daily rate is $97
- 2010 average occupancy is 83%

Payment Source for Basic Care Bills



(n=669)

Basic Care Facts:

- A congregate residential setting with private and semi-private rooms where you receive 24-hour supervision with a comprehensive service plan to meet your needs.
- Basic care provides an all inclusive rate providing room, meals, personal care services, supervision, activities, transportation, medication administration, nursing assessment and care planning.
- Seventy percent of residents are female and the majority were living in their own home prior to admission.
- Cognitive decline is the top issue precipitating the need for placement.
- Current residents range in age from 23 to 104 years old, with the average age being 78.

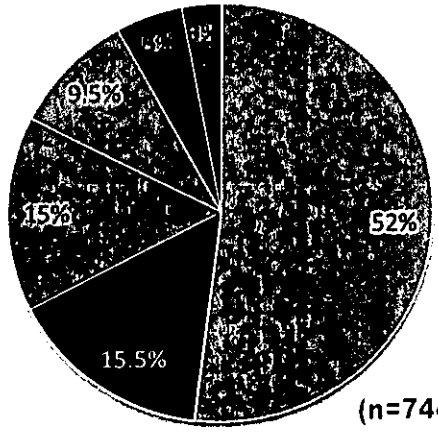
Care Needs of Basic Care Residents:

- 72% of residents have impaired mental status, ranging from early state dementia to significant mental health issues.
- 85% of residents need full assistance with medication administration.
- Over one-third of residents (35%) are receiving psychoactive drugs.
- Most residents are independent in dressing (60%), with less than 10% requiring extensive assistance (8.6%).
- 81% of residents need assistance in bathing.
- Most residents are fully independent in eating (88%), toileting (80%) and transferring (92%).
- 60% are ambulatory and do not need any staff assistance, 48% use a walker and very few use a wheelchair (7%).

Basic Care Facilities (continued)

When Individuals Move Into a Basic Care Facility, Where Did They Come From?

Living Arrangements Prior to Admission



(n=744)

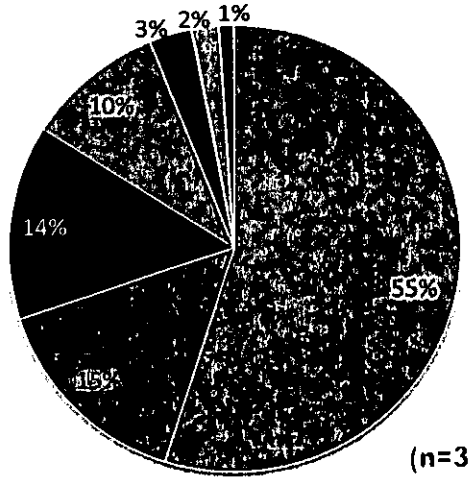
- Home 52%
- Hospital/Swing Bed 15.5%
- Nursing Facility 15%
- Assisted Living Facility 9.5%
- Other Basic Care Facility 5%
- Other 3%

Top three reasons for basic care admission:

1. Cognitive decline
2. Progressive physical decline
3. Social isolation

When Residents Move-Out, Where Do They Go?

Discharge Destination

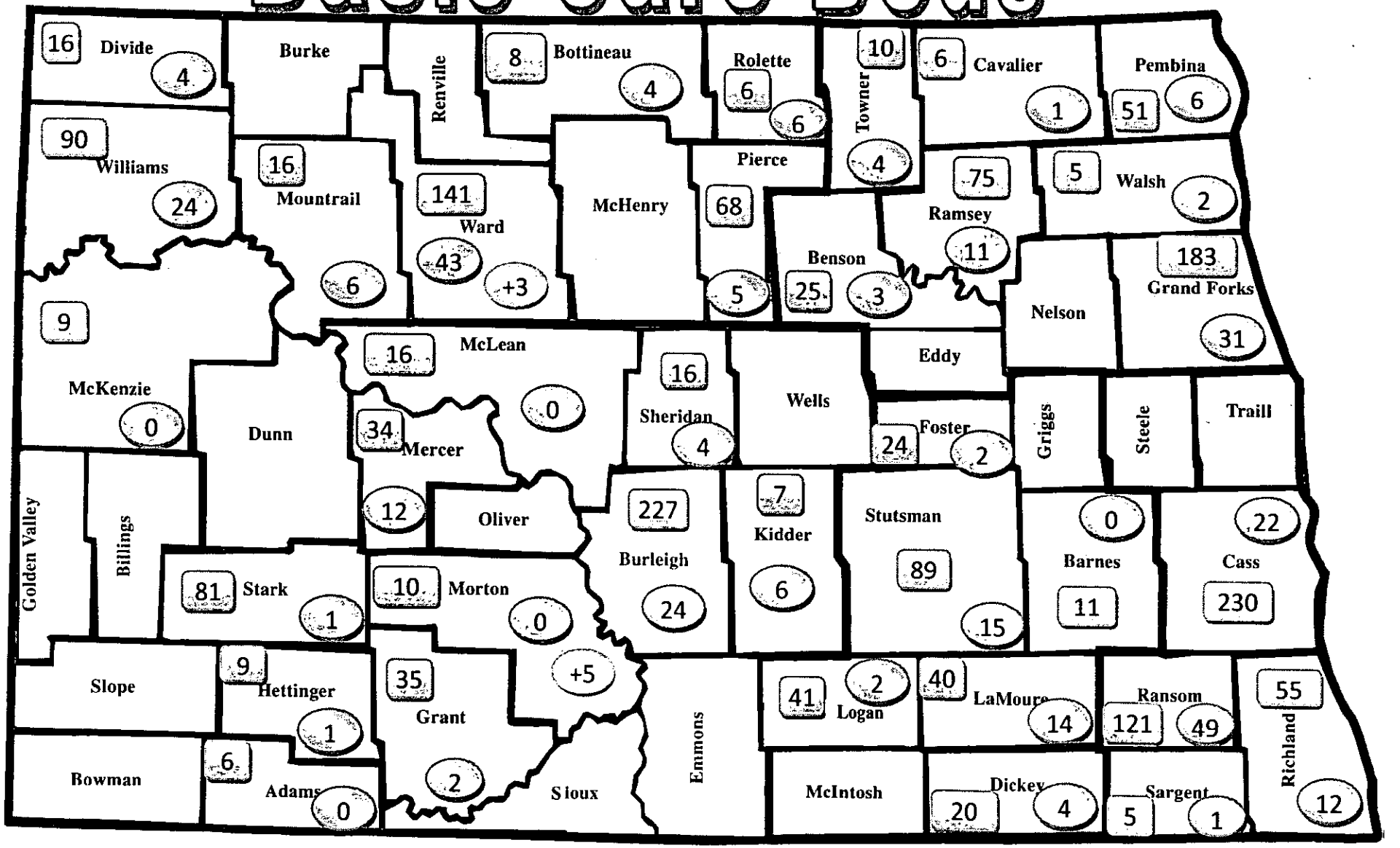


(n=357)

- Nursing Facility 55%
- Home 15%
- Hospital/Swing Bed 14%
- Death 10%
- Assisted Living Facility 3%
- Other Basic Care Facility 2%
- Other 1%

Over half of residents discharged from a basic care facility are admitted to a skilled nursing facility. Generally medical needs, physical limitations and growing cognition issues necessitate the admission.

Basic Care Beds



Sixty–five licensed basic care facilities as of March 1, 2011

Purple Box – Number of licensed basic care beds as of March 1, 2011 (total licensed beds = 1,786).

Red Box – Number of vacant licensed basic care beds available on March 1, 2011 (total vacancies = 317).

Green Box – Number of licensed basic care beds expected to increase in the county (purchased or transferred).

North Dakota Long Term Care ASSOCIATION

Licensed Basic Care Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Arthur	Cass	Prairie Villa	25	4	25	2
Bismarck	Burleigh	Baptist Home, Inc.	10	0	10	0
Bismarck	Burleigh	Edgewood Bismarck Senior Living	73	10	91	16
Bismarck	Burleigh	Good Samaritan Society—Bismarck			18	0
Bismarck	Burleigh	Maple View – East & North	48	4	48	7
Bismarck	Burleigh	The Terrace	40	1	40	0
Bismarck	Burleigh	Waterford on West Century	20	2	20	1
Bottineau	Bottineau	Good Samaritan Society – Bottineau	8	0	8	4
Cando	Towner	St. Francis Residence	10	0	10	4
Carrington	Foster	Holy Family Villa	24	0	24	2
Crosby	Divide	Good Samaritan Society – Crosby	16	5	16	4
Devils Lake	Ramsey	Good Samaritan Society – Devils Lake	10	3	12	3
Devils Lake	Ramsey	Odd Fellows Home	43	0	43	0
Dickinson	Stark	Dickinson Country House LLC	30	3	30	1
Dickinson	Stark	Evergreen	51	0	51	0
Edgeley	LaMoure	Manor St. Joseph	40	1	40	14
Edmore	Ramsey	Edmore Memorial Rest Home	25	14	20	8
Elgin	Grant	Dakota Hill Housing	35	1	35	2
Ellendale	Dickey	Evergreen Place	20	4	20	4
Fargo	Cass	Bethany Towers I and II	33	6	33	1
Fargo	Cass	Edgewood Vista at Edgewood Village	33	1	33	0
Fargo	Cass	Evergreens of Fargo	72	7	54	13
Fargo	Cass	Good Samaritan Society – Fargo	30	0	36	4
Fargo	Cass	Waterford at Harwood Groves	20	0	25	0
Forman	Sargent	Four Seasons Healthcare Ctr Inc.	5	0	5	1
Gackle	Logan	Gackle Care Center	41	1	41	2
Grand Forks	Grand Forks	Maple View Memory Care Community	26	5	36	6
Grand Forks	Grand Forks	Parkwood Place	40	4	40	12
Grand Forks	Grand Forks	St. Anne's Guest Home	54	8	54	10
Grand Forks	Grand Forks	Tufte Manor	40	0	53	3
Hazen	Mercer	Senior Suites at Sakakawea	34	1	34	12
Hettinger	Adams	Western Horizons Care Center	6	4	6	0
Jamestown	Stutsman	Bethel 4 Acres Ltd	16	0	16	1
Jamestown	Stutsman	Rock of Ages, Inc.	53	8	53	13
Jamestown	Stutsman	Roseadele	20	1	20	1
Kenmare	Ward	Baptist Home of Kenmare	60	23	60	41
Lisbon	Ransom	North Dakota Veterans Home	111	43	111	48
Lisbon	Ransom	Parkside Lutheran Home	10	1	10	1
Maddock	Benson	Maddock Memorial Home	25	0	25	3
Mandan	Morton	Dakota Pointe	10	0	10	0
McClusky	Sheridan	Sheridan Memorial Home	16	2	16	4
Minot	Ward	Edgewood Vista Memory Care	22	0	22	0
Minot	Ward	Edgewood Vista Minot Senior Living	31	0	31	0
Minot	Ward	Emerald Court	28	0	28	2

Licensed Basic Care Facility Beds, Locations and Vacancies

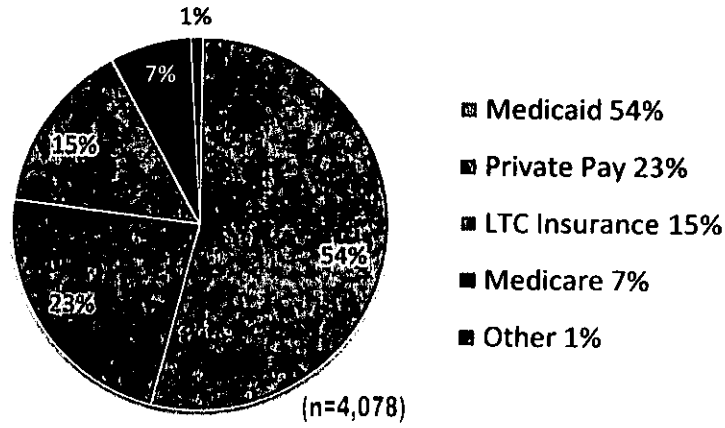
City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Mott	Hettinger	Good Samaritan Society – Mott	9	1	9	1
Mountain	Pembina	Borg Pioneer Memorial Home	43	0	43	3
New Town	Mountrail	Good Sam. Society – New Town	16	7	16	6
Osnabrock	Cavalier	Good Samaritan Society – Osnabrock	6	1	6	1
Park River	Walsh	Good Samaritan Society—Park River			5	2
Parshall	Mountrail	GSS – Rock View at Parshall	6	6	CLOSED	
Rolette	Rolette	Rolette Community Care Center			6	6
Rugby	Pierce	Haaland Estates – Basic Care	68	16	68	5
Steele	Kidder	Golden Manor Inc.			7	6
Valley City	Barnes	HI Soaring Eagle Ranch	11	0	11	0
Wahpeton	Richland	St. Catherine's Living Center	16	11	16	10
Wahpeton	Richland	The Leach Home	39	1	39	2
Walhalla	Pembina	Pembilier Nursing Center	10	8	8	3
Watford City	McKenzie	McKenzie Cty HC Systems	9	2	9	0
West Fargo	Cass	Eventide at Sheyenne Crossings	24	2	24	2
Williston	Williams	Bethel Lutheran Nrsng & Rehab Ctr	19	0	19	0
Williston	Williams	Kensington Williston LLC	71	5	71	24
Wilton	McLean	Redwood Village	16	0	16	0
TOTAL			**1727**	**227**	**1786**	**321**

Nursing Facilities

Nursing Facilities at a Glance:

- 85 licensed nursing facilities
- 6,397 licensed beds
- 2010 average daily rate is $196
- 2010 average occupancy is 93%

Payment Source for Nursing Facility Bills



Nursing Facility Facts:

- Resident needs are complex and they are in need of 24-hour nursing care and supervision.
- Most residents are admitted from their own homes, with over half coming directly from a hospital stay.
- The most significant need necessitating the need for admission to a nursing facility is the need for care throughout the day. Residents are unable to meet their own needs for dressing, toileting, eating and remaining safe.
- Current residents range in age from 18 to 106 years old, with the average age being 84.

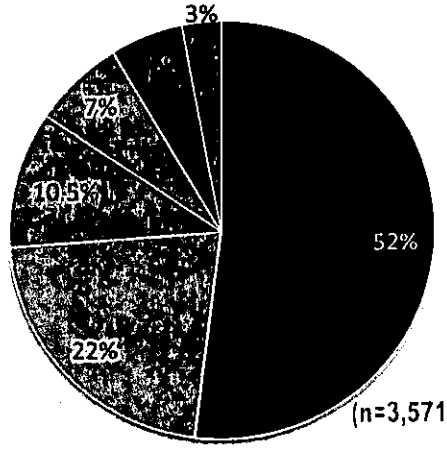
Care Needs of Nursing Facility Residents:

- 75% of residents need help in three or more activities of daily living, such as bathing, dressing, toileting, ambulation, transferring and eating.
- The average resident is on eleven different medications a day.
- Many have cognitive limitations and cannot live safely at home.

Nursing Facilities (continued)

When Individuals Move Into a Nursing Facility, Where Did They Come From?

Living Arrangements Prior to Admission



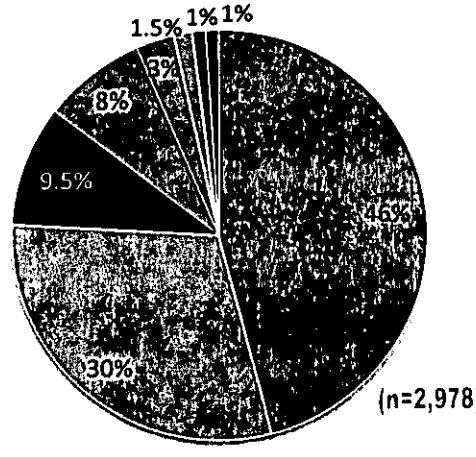
- Hospital/Swing Bed 52%
- Home 22%
- Other Nursing Facility 10.5%
- Assisted Living Facility 7%
- Basic Care Facility 5.5%
- Other 3%

Top five reasons for nursing care admission:

1. Needs assistance with daily care throughout the day
2. Complex medical needs
3. Needs continuous supervision
4. Dementia
5. Falls

When Residents are Discharged from a Skilled Nursing Facility, Where Do They Go?

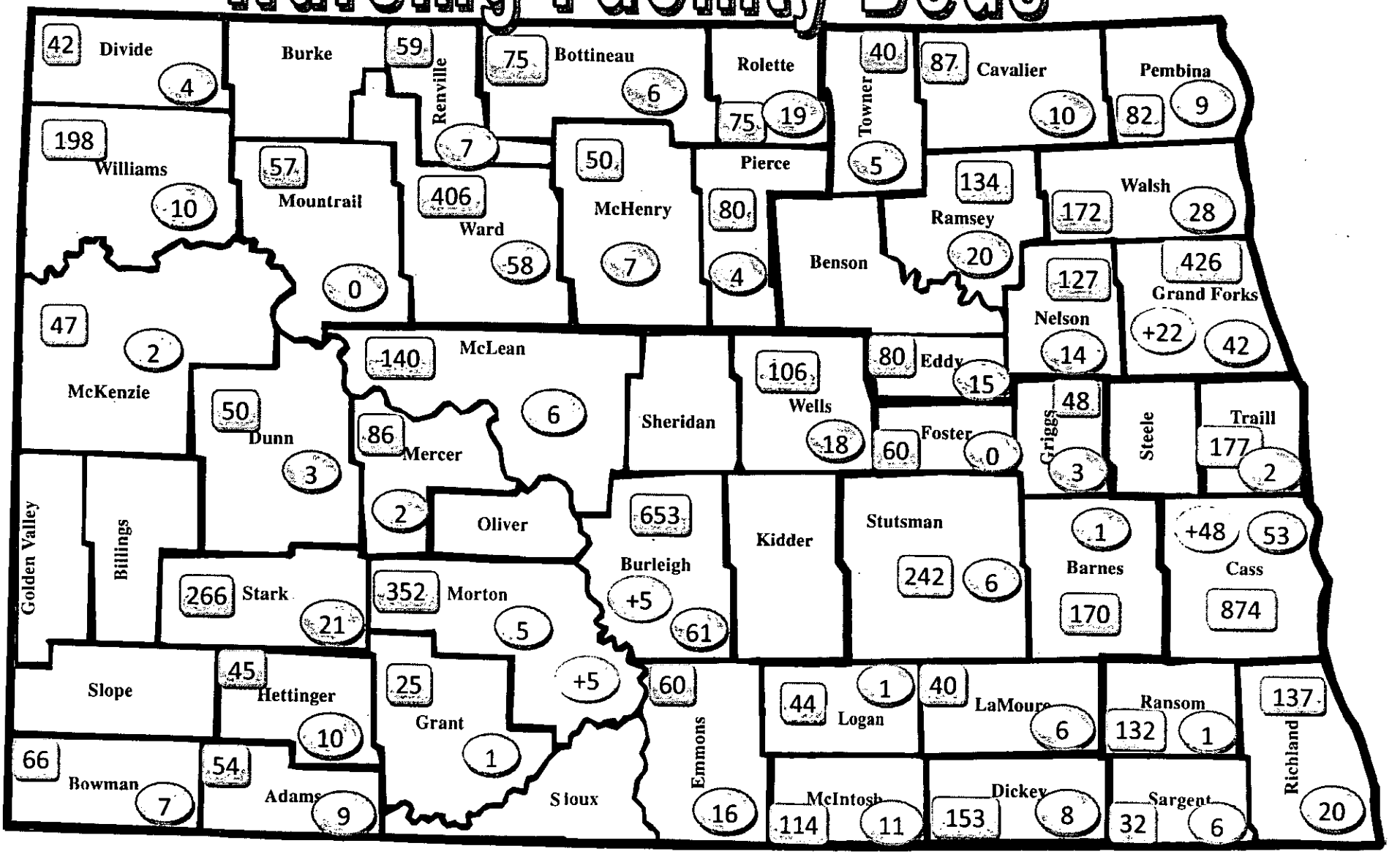
Discharge Destination



- Death 46%
- Home 30%
- Hospital/Swing Bed 9.5%
- Nursing Facility 8%
- Assisted Living Facility 3%
- Basic Care Facility 1.5%
- Family 1%
- Other 1%

- One-third of all residents admitted to a nursing facility are discharged to their own home or a lower level of care.
- Average length of stay in 2010 was 289 days (9.6 months), down 61 days from the 2009 average of 350 days.

Nursing Facility Beds



Eighty-five licensed nursing facilities as of March 1, 2011.

Purple Box – Number of licensed nursing facility beds as of March 1, 2011 (total licensed beds = 6,363).

Red Box – Number of vacant licensed nursing facility beds available on March 1, 2011 (total vacancies = 537).

Green Box – Number of licensed nursing facility beds expected to increase in the county (purchased or transferred).

North Dakota Long Term Care Association

Licensed Nursing Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Aneta	Nelson	Aneta Parkview Health Center	39	2	39	0
Arthur	Cass	Good Samaritan Society – Arthur	42	3	42	14
Ashley	McIntosh	Ashley Medical Center	44	1	44	0
Beulah	Mercer	Knife River Care Center	86	0	86	2
Bismarck	Burleigh	Baptist Home, Inc.	141	7	141	12
Bismarck	Burleigh	Good Samaritan Society—Bismarck			48	9
Bismarck	Burleigh	Medcenter One St. Vincent's	101	0	101	0
Bismarck	Burleigh	Medcenter One Subacute Unit	22	5	22	6
Bismarck	Burleigh	Missouri Slope Luth Care Center	250	0	250	2
Bismarck	Burleigh	St. Alexius Medical Center – TCU	19	1	19	8
Bismarck	Burleigh	St. Gabriel's Community			72	24
Bottineau	Bottineau	Good Samaritan Society – Bottineau	73	5	75	6
Bowman	Bowman	Southwest Healthcare Services	66	0	66	7
Cando	Towner	Towner County Living Center	45	0	40	5
Carrington	Foster	Golden Acres Manor	60	5	60	0
Cavalier	Pembina	Wedgewood Manor	50	6	50	4
Cooperstown	Griggs	Cooperstown Medical Center	48	1	48	3
Crosby	Divide	Good Samaritan Society – Crosby	42	0	42	4
Devils Lake	Ramsey	Good Samaritan Society – Devils Lake	62	13	60	16
Devils Lake	Ramsey	Heartland Care Center	74	4	74	4
Dickinson	Stark	St. Benedict's Health Center	164	7	164	12
Dickinson	Stark	St. Luke's Home	84	0	84	9
Dunseith	Rolette	Dunseith Comm. Nursing Home	35	7	35	9
Elgin	Grant	Jacobson Memorial Hosp Cr Ctr	25	0	25	1
Ellendale	Dickey	Prince of Peace Care Center	55	11	53	1
Enderlin	Ransom	Maryhill Manor	54	3	54	1
Fargo	Cass	Bethany on 42nd	50	6	78	0
Fargo	Cass	Bethany On University	192	12	172	1
Fargo	Cass	Elim – A Caring Community	136	16	136	15
Fargo	Cass	Manor Care of Fargo ND, LLC	131	34	131	11
Fargo	Cass	Rosewood On Broadway	111	0	111	1
Fargo	Cass	Villa Maria	140	6	140	5
Forman	Sargent	Four Seasons Healthcare Ctr Inc.	32	1	32	6
Garrison	McLean	Benedictine Living Ctr of Garrison	63	14	52	4
Garrison	McLean	Garrison Memorial Hosp & NF	28	4	28	0
Glen Ullin	Morton	Marian Manor HealthCare Center	86	3	86	2
Grafton	Walsh	Lutheran Sunset Home	104	9	104	6
Grand Forks	Grand Forks	Valley Eldercare Center	176	13	202	30
Grand Forks	Grand Forks	Woodside Village	118	2	118	2
Hankinson	Richland	St. Gerard's Com Nrsng Home	37	4	37	5
Harvey	Wells	St. Aloisius Medical Center	106	10	106	18
Hatton	Traill	Hatton Prairie Village	42	6	42	0
Hettinger	Adams	Western Horizons Care Center	54	8	54	9
Hillsboro	Traill	Hillsboro Medical Center	36	0	36	0
Jamestown	Stutsman	Ave Maria Village	100	0	100	1
Jamestown	Stutsman	Eventide at Hi-Acres Manor	142	5	142	5

Licensed Nursing Facility Beds, Locations and Vacancies

City	County	Facility Name	Licensed Capacity 3/5/2010	Number of Vacancies 3/5/2010	Licensed Capacity 3/1/2011	Number of Vacancies 3/1/2011
Killdeer	Dunn	Hill Top Home of Comfort	50	2	50	3
Lakota	Nelson	Good Samaritan Society – Lakota	49	5	49	9
LaMoure	LaMoure	St. Rose Care Center	40	4	40	6
Langdon	Cavalier	Maple Manor Care Center	63	6	63	4
Larimore	Grand Forks	Good Samaritan Society – Larimore	45	8	45	5
Lisbon	Ransom	North Dakota Veterans Home	38	0	38	0
Lisbon	Ransom	Parkside Lutheran Home	40	1	40	0
Mandan	Morton	Dakota Alpha	20	2	20	2
Mandan	Morton	Medcenter One Mandan Care Center	128	1	128	1
Mandan	Morton	Medcenter One Mandan CC Off Collins	50	0	50	0
Mayville	Traill	Luther Memorial Home	99	6	99	2
McVille	Nelson	Nelson Cty Hlth System Care Ctr	39	1	39	5
Minot	Ward	Manor Care of Minot ND, LLC	114	8	114	12
Minot	Ward	Trinity Homes	292	37	292	46
Mohall	Renville	Good Samaritan Society – Mohall	59	4	59	7
Mott	Hettinger	Good Samaritan Society – Mott	45	1	45	10
Napoleon	Logan	Napoleon Care Center	44	4	44	1
New Rockford	Eddy	Luth Home of the Good Shep NH	80	12	80	15
New Salem	Morton	Elm Crest Manor	68	3	68	0
Northwood	Grand Forks	Northwood Deaconess Hlth Ctr	61	4	61	5
Oakes	Dickey	Good Samaritan Society – Oakes	102	12	100	7
Osnabrock	Cavalier	Good Samaritan Society – Osnabrock	24	5	24	6
Park River	Walsh	Good Samaritan Society – Park River	73	7	68	22
Parshall	Mountrail	GSS – Rock View at Parshall	30	9	CLOSED	
Richardton	Stark	Richardton Health Center	18	0	18	0
Rolette	Rolette	Rolette Community Care Center	46	10	40	10
Rugby	Pierce	Heart Of America Medical Center	80	5	80	4
Stanley	Mountrail	Mountrail Bethel Home	57	3	57	0
Strasburg	Emmons	Strasburg Nursing Home	60	4	60	16
Tioga	Williams	Tioga Medical Center LTC	30	0	30	0
Underwood	McLean	Medcenter One Prairieview	60	5	60	2
Valley City	Barnes	Sheyenne Care Center	170	0	170	1
Velva	McHenry	Souris Valley Care Center	50	0	50	7
Wahpeton	Richland	St. Catherine's Living Center	112	11	100	15
Walhalla	Pembina	Pembilier Nursing Center	37	12	32	5
Watford City	McKenzie	McKenzie Cty HC Systems	47	1	47	2
West Fargo	Cass	Sheyenne Crossings Care Center/TCU			64	6
Westhope	Bottineau	Westhope Home	25	7	CLOSED	
Williston	Williams	Bethel Lutheran Nrsng & Rehab Ctr	168	5	168	10
Wishek	McIntosh	Wishek Home for the Aged	70	11	70	11
TOTAL			**6248**	**450**	**6363**	**537**

NURSING FACILITY PAYMENT SYSTEM

MINIMUM DATA SET FOR PAYMENT

The state adopted the Minimum Data Set (MDS) for its payment system on January 1, 1999. The MDS provides a wide array of information regarding the health status of each resident. The payment system has thirty-four facility specific rates. Each resident is evaluated at least quarterly and the intensity of their needs determines their rate classification.

EQUALIZATION OF RATES

The legislature implemented equalization of rates between Medicaid residents and self pay residents for nursing facilities in 1990. Equalization of rates requires all residents be charged the same rate for comparable services. Minnesota and North Dakota are the only states in the nation with equalization of rates. Nursing facilities are the only providers/private business subjected to an equalized rate system in the State of North Dakota.

RATE CALCULATIONS

The determination of rates is the sum of **four components**: direct care, other direct care, indirect care and property. Today's limits are calculated based on the **June 30, 2006 cost report** inflated forward to 2011. The 2009 legislature allowed rates and limits to be increased by 6% in 2010 and 2011.

Limits (the maximum that will be paid) are set for the direct care, other direct care and indirect care components by utilizing the **2006** cost report of all Medicaid nursing facilities, arraying the facilities from least expensive to most expensive, selecting the facility at mid-point (median facility) and then adding either 10% or 20% to the cost of that median facility. The **direct care** and **other direct care** limit is established by adding **20%** to the cost of that median facility. The **indirect care** limit is established by adding **10%** to the cost of that median facility. The limits are then inflated annually by the legislative approved inflation factor. In addition, an adjustment was made to the limits in 2011 to recognize the increases for the salary enhancements approved in the 2009 session.

Direct Care Rate. Costs in the Direct Care Category include: nursing and therapy salaries and benefits, OTC drugs, minor medical equipment and medical supplies. On January 1, 2011 the direct care limit was set at $127.76 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities over the limit are spending at least $1,056,229 in nursing that will never be recouped.

North Dakota Long Term Care ASSOCIATION
1900 N 11th St
Bismarck, ND 58501
701.222.0660
www.ndltca.org

Other Direct Care. Costs in the Other Direct Care Category include: food, laundry, social service salaries, activity salaries and supplies. On January 1, 2011 the other direct care limit was set at $23.95 per day. Seven nursing facilities currently exceed this limit. The seven nursing facilities exceeding the limit are spending at least $206,937 in costs that will never be recouped.

Indirect Care. Costs in the Indirect Care Category include: Administration, pharmacy, chaplin, housekeeping salaries, dietary salaries, housekeeping and dietary supplies, medical records, insurance, and plant operations. On January 1, 2011 the indirect limit was set at $60.60 per day. Nineteen nursing facilities currently exceed this limit. The nineteen nursing facilities exceeding the limit are spending at least $1,799,029 in indirect care expenses. These costs will never be recouped.

Property rate includes depreciation, interest expense, property taxes, lease and rental costs, start-up costs and reasonable and allowable legal expenses. The average property rate is $14.34 per resident per day, with a range of $3.39 to $52.40.

Occupancy Limitation – In the June 30, 2010 cost reporting period, twenty-two nursing facilities reported twelve month occupancy averages at less than 90%. Together they incur $1,726,047 in penalty costs because they operate under 90% occupancy.

Incentives - A reward is provided to nursing facilities that are under the limit in indirect care. The incentive is calculated for each facility based upon their indirect costs compared to the indirect limit. Facilities are able to receive 70 cents for every dollar they are below the limit up to a maximum of $2.60 per resident day. In 2011, fifty-five nursing facilities received an incentive, with the average per day incentive at $2.10. Of the fifty-five nursing facilities receiving an incentive, they ranged from $0.07 to $2.60 per resident per day.

Operating Margin - All nursing facilities receive an operating margin of three percent based on their historical direct care costs and other direct care costs (up to limits). The operating margin provides needed cash flow to cover up-front salary adjustments, replacement of needed equipment, unforeseen expenses, and dollars to implement ever increasing regulations. The operating margin covers the gap between the cost report and the effective date of rates (this can be up to 18 months). In 2011, the average operating margin is $3.59 per resident per day.

Inflation - Rates are adjusted for inflation annually. Inflation is a rise in price levels that are generally beyond the control of long term care facilities. Examples of price level increases include the 9.7% increase in health insurance and significant increases in fuel. To attract and retain adequate staff, nursing facilities need to offer salary and benefit packages that reward people. Approximately 75% of a nursing facility's budget is dedicated to personnel costs. Adequate inflation adjustments are critical for salary and benefits so nursing facilities can compete in the market place. Turnover of certified nurse assistants, the largest pool of employees was 62% in 2010.

Annual inflationary adjustments are set every legislative session.

Rebasing – A limit is establish on the maximum that will be paid in each cost category. The 2011 limits are based upon the June 30, 2006 cost report inflated forward to 2011. The next time limits will be rebased is January 1, 2013 using the June 30, 2010 cost report.

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Updated Jan [redacted] 011

CR #	Facility	Provider	Total Days	Total Operating Costs	Property Costs	Total Costs	2011 Medicaid Rate	Total MA Paid Days Including Bedhold	Cost PPD	Medicaid Allowable Cost	Medicaid Payments
0110	Ashley Medical Center	30188	15,884	2,985,424	81,188	3,066,612	197.83	8,968	193.06	1,731,389	1,774,139
0210	Missouri Slope Lutheran Care Center, Inc.	30004	90,685	20,448,132	1,027,794	21,475,926	224.36	40,395	236.82	9,566,301	9,063,022
0310	Medcenter One St. Vincent's Care Center	30005	36,670	7,974,179	504,286	8,478,465	210.72	21,276	231.21	4,919,221	4,483,279
0410	Towner County Medical Center	30379	13,925	2,388,137	328,543	2,716,680	188.87	6,632	195.09	1,293,862	1,252,586
0610	Golden Acres Manor Nursing Home	30008	21,356	3,562,213	260,168	3,822,381	184.67	10,441	178.98	1,868,772	1,928,139
0710	Cooperstown Medical Center	30095	17,272	3,126,984	140,802	3,267,786	193.40	9,333	189.20	1,765,762	1,805,002
0810	Heartland Care Center	30010	25,840	5,259,108	456,104	5,715,212	216.28	13,654	221.18	3,019,950	2,953,087
0910	Jacobson Memorial Hospital Care Center	30077	9,006	1,676,921	95,406	1,772,327	183.82	4,313	196.79	848,772	792,816
1010	Garrison Memorial Hospital	30134	9,490	1,968,327	123,637	2,091,964	218.87	5,082	220.44	1,120,270	1,112,297
1110	Marian Manor Healthcare Center	30067	30,792	6,004,895	160,024	6,164,919	198.78	17,692	200.21	3,542,146	3,516,816
1310	St. Gerard's Community Nursing Home	30163	11,822	2,199,123	41,235	2,240,358	184.51	5,136	189.51	973,311	947,643
1410	Tri County Health Center	30018	14,116	3,042,958	202,125	3,245,083	221.87	5,082	229.89	1,168,285	1,127,543
1810	Dakota Alpha - HIT, Inc.	30225	5,941	1,971,991	253,742	2,225,733	363.61	3,417	374.64	1,280,143	1,242,455
2010	Trinity Nursing Home	30028	93,799	20,033,120	1,265,853	21,298,973	215.91	47,890	227.07	10,874,400	10,339,930
2210	MCO Mandan Care Center Off Collins	30106	18,007	3,868,682	218,418	4,087,100	216.05	7,979	226.97	1,811,016	1,723,863
2310	Strasburg Care Center	30033	19,253	3,378,007	99,773	3,477,780	189.69	9,867	180.64	1,782,333	1,871,671
2410	Tioga Medical Center	30176	10,806	2,048,783	83,207	2,131,990	201.94	2,217	197.30	437,407	447,701
2510	Prairieview Health Center	30053	20,573	3,950,194	97,056	4,047,250	193.33	10,205	196.73	2,007,592	1,972,933
2610	Wishek Home for the Aged	30039	21,616	4,286,028	100,985	4,387,013	201.13	12,091	202.95	2,453,894	2,431,863
2710	Aneta Parkview Health Center	30322	13,634	2,432,088	103,324	2,535,412	181.31	5,845	185.96	1,086,950	1,059,757
2810	Good Samaritan Society - Arthur	30058	11,413	2,295,775	161,212	2,456,987	191.56	4,071	215.28	876,403	779,841
2910	Baptist Home	30003	49,694	10,645,392	176,237	10,821,629	209.03	23,914	217.77	5,207,640	4,998,743
3010	Good Samaritan Society - Bottineau	30118	25,344	5,075,408	288,188	5,363,596	204.32	12,111	211.63	2,563,073	2,474,520
3110	Southwest Healthcare Services	30403	22,939	4,810,365	333,240	5,143,605	214.79	7,584	224.23	1,700,558	1,628,967
3210	Wedgewood Manor	30424	16,296	3,570,513	172,737	3,743,250	208.38	5,161	229.70	1,185,500	1,075,449
3310	Good Samaritan Society - Crosby	30122	14,336	2,470,473	121,753	2,592,226	175.73	5,742	180.82	1,038,264	1,009,042
3410	Good Samaritan Society - Devils Lake	30115	19,026	3,684,477	158,305	3,842,782	187.35	9,980	201.98	2,015,713	1,869,753
3510	St. Benedict's Health Center	30237	56,314	10,872,126	538,813	11,410,939	189.97	29,824	202.63	6,043,255	5,665,665
3610	St. Luke's Home	30011	30,100	5,878,267	155,584	6,033,851	190.73	14,579	200.46	2,922,509	2,780,653
3810	Prince of Peace Care Center	30012	16,949	2,893,519	232,896	3,126,415	173.01	7,892	184.46	1,455,759	1,365,395
3910	Maryhill Manor	30421	19,057	3,389,788	160,294	3,550,082	191.49	9,232	186.29	1,719,807	1,767,836
4010	Bethany on University	30060	65,796	14,408,426	754,960	15,163,386	217.81	20,492	230.46	4,722,599	4,463,363
4210	Elim Home	30051	45,258	9,541,205	273,791	9,814,996	199.26	15,975	216.87	3,464,461	3,183,179
4310	Rosewood on Broadway	30420	40,040	8,453,532	861,995	9,315,527	216.23	16,080	232.66	3,741,101	3,476,978
4410	Villa Maria Healthcare	30419	47,906	10,068,063	1,173,380	11,241,443	218.11	18,783	234.66	4,407,549	4,096,760
4510	Four Seasons Health Care Center, Inc.	30406	11,180	1,590,404	107,755	1,698,159	149.28	4,762	151.89	723,313	710,871
4610	Benedictine Living Center of Garrison	30247	18,117	3,277,780	167,851	3,445,631	181.30	8,750	190.19	1,664,143	1,586,375
4710	Lutheran Sunset Home	30016	34,579	7,040,976	212,856	7,253,832	212.86	14,760	209.78	3,096,289	3,141,814
4810	Ave Maria Village	30422	36,222	7,118,236	788,172	7,906,408	217.13	15,924	218.28	3,475,833	3,457,578

UPL Calculation

CR #	Facility	Provider	Total Days	Total Operating Costs	Property Costs	Total Costs	2011 Medicaid Rate	Total MA Paid Days Including Bedhold	Cost PPD	Medicaid Allowable Cost	Medicaid Payments
5010	Good Samaritan Society - Lakota	30097	16,953	2,746,732	216,993	2,963,725	176.89	7,964	174.82	1,392,267	1,408,752
5110	St. Rose Care Center	30119	12,627	2,350,304	146,427	2,496,731	189.21	5,161	197.73	1,020,482	976,513
5210	Maple Manor Care Center	30083	21,567	3,343,889	1,144,646	4,488,535	209.81	5,431	208.12	1,130,303	1,139,478
5310	Good Samaritan Society - Larimore	30113	46,506	2,743,848	192,323	2,936,171	187.78	4,869	63.14	307,406	914,301
5510	Medcenter One Mandan Living Center	30288	46,516	10,058,372	1,592,316	11,650,688	235.83	28,107	250.47	7,039,855	6,628,474
5610	Luther Memorial Home	30024	33,088	6,191,993	252,064	6,444,057	201.65	12,334	194.76	2,402,110	2,487,151
5810	Good Samaritan Society - Mohall	30173	20,038	3,523,999	229,690	3,753,689	185.31	8,917	187.33	1,670,409	1,652,409
5910	Good Samaritan Society - Mott	30142	16,201	2,584,773	88,917	2,673,690	164.38	7,715	165.03	1,273,225	1,268,192
6010	Napoleon Care Center	30114	15,261	2,664,468	124,239	2,788,707	185.30	7,660	182.73	1,399,744	1,419,398
6110	Lutheran Home of the Good Shepherd	30029	26,289	5,139,605	591,563	5,731,168	215.91	13,184	218.01	2,874,195	2,846,557
6210	Elm Crest Manor	30116	22,851	4,301,029	809,666	5,110,695	222.26	11,518	223.65	2,576,035	2,559,991
6410	Northwood Deaconess Health Center	30031	19,670	4,392,478	512,624	4,905,102	241.89	9,208	249.37	2,296,196	2,227,323
6510	Good Samaritan Society - Oakes	30124	33,294	4,984,315	285,660	5,269,975	156.69	14,370	158.29	2,274,570	2,251,635
6610	Good Samaritan Society - Osnabrock	30117	6,892	1,188,382	54,976	1,243,358	171.74	2,123	180.41	383,002	364,604
6710	Good Samaritan Society - Park River	30154	21,582	3,757,075	215,897	3,972,972	181.58	8,328	184.09	1,533,079	1,512,198
6810	Good Samaritan Society - Rock View	30155	8,785	1,807,830	132,887	1,940,717	201.43	3,529	220.91	779,600	710,846
6910	Mountrail Bethel Home	30032	19,776	4,186,642	126,460	4,313,102	207.49	9,747	218.10	2,125,799	2,022,405
7010	Sheyenne Care Center	30418	50,129	11,313,841	810,869	12,124,710	198.60	23,830	241.87	5,763,766	4,732,638
7110	Souris Valley Care Center	30216	17,167	2,873,541	163,777	3,037,318	172.50	6,572	176.93	1,162,769	1,133,670
7210	St. Catherine's Living Center	30034	32,692	5,318,679	476,824	5,795,503	168.52	14,241	177.28	2,524,586	2,399,893
7310	Pembilier Nursing Center	30035	9,245	1,476,954	44,712	1,521,666	164.32	2,709	164.59	445,883	445,143
7410	McKenzie County Healthcare System	30449	16,174	3,432,204	119,368	3,551,572	216.88	6,490	219.59	1,425,108	1,407,551
7610	Bethel Lutheran Home	30038	58,945	11,095,402	527,143	11,622,545	202.34	25,916	197.18	5,110,016	5,243,843
7910	Knife River Care Center	30002	30,651	6,495,605	1,177,838	7,673,443	232.99	16,827	250.35	4,212,620	3,920,523
8010	Heart of America Medical Center	30135	27,039	6,064,914	278,844	6,343,758	213.92	17,422	234.62	4,087,464	3,726,914
8210	Parkside Lutheran Home	30109	14,348	2,899,033	334,381	3,233,414	222.14	4,962	225.36	1,118,219	1,102,259
8310	Rolette Community Care Center	30466	11,843	2,296,549	646,533	2,943,082	225.60	7,989	248.51	1,985,332	1,802,318
8410	St. Aloisius Medical Center	30129	35,833	6,432,234	243,139	6,675,373	188.10	18,952	186.29	3,530,591	3,564,871
8610	Hillsboro Medical Center	30019	12,873	2,755,247	654,877	3,410,124	260.32	4,450	264.91	1,178,828	1,158,424
8710	Valley Eldercare Center	30017	60,049	12,690,290	1,504,441	14,194,731	218.65	20,098	236.39	4,750,882	4,394,428
8810	Woodside Village	30201	42,558	8,636,530	1,229,640	9,866,170	221.54	16,550	231.83	3,836,767	3,666,487
8910	Hill Top Home of Comfort, Inc.	30271	17,561	3,710,483	164,280	3,874,763	210.35	8,994	220.65	1,984,490	1,891,888
9110	Manor Care of Fargo ND, LLC	30478	34,348	7,166,032	505,616	7,671,648	176.79	11,676	223.35	2,607,842	2,064,200
9210	Manor Care of Minot ND, LLC	30479	36,514	6,692,759	328,842	7,021,601	168.36	8,924	192.30	1,716,075	1,502,445
9310	Western Horizons Living Center	30477	17,331	4,012,075	270,458	4,282,533	229.07	5,537	247.10	1,368,206	1,268,361
9410	Richardton Health Center	30487	5,901	1,480,331	91,690	1,572,021	231.92	4,149	266.40	1,105,290	962,236
9510	Bethany on 42nd	30492	8,419	2,768,063	1,316,696	4,084,759	266.22	1,773	485.18	860,230	472,008
			2,008,569		30,091,005	425,357,523		881,357		188,828,783	180,629,652

UPL Above/(Below) of Medicaid Payments for Private Facilities 8,199,131

Fargo Police Department

"Dedicated to Serving the Community"

Scott Stenerson
Homeless Population Liaison

222 4th St. N.
Fargo, ND 58102
Phone: 701-298-6907 ext. 7051
Email: sstenerson@cityoffargo.com

The Fargo Police Department strives to provide the citizens of Fargo with quality service and a safe community.

Case #: _____

Police Dispatch: 235-4493
Crime Tip Line: 241-5777
Web Address: www.fargopolice.com

NDacp NORTH DAKOTA ASSOCIATION OF COMMUNITY PROVIDERS

North Dakota Association of Community Providers

PUBLIC POLICY PLATFORM 2011 – 2013 BIENNIUM

Priority	Items:	Fiscal Impact
1	We support the Governor's request for 3% annual inflator for each year of the biennium.	Total: 397 Million General Funds: 63.5 Million
2	7.65% increase in the benefit multiplier to cover the increasing costs of health insurance.	Total: $19.1 Million General Funds: 8.3 Million
3	$1.46 an hour market adjustment for all staff	Total: $33 Million General Funds: $14.5 Million
4	Continuation of funding for the critical needs of individuals who are medically fragile and / or behaviorally challenged	Contained within priority #1 dollar amount
5	Transition from Developmental Center to the community, including increased community capacity development through use of flexible funding mechanisms (BND collaboration)	Partially managed through DHS (DC & DD Community Services) budget authority
6	State set-aside for employment of people with disabilities	No fiscal note
7	Increased Corporate Guardianship Capacity	Partially Funded within the DHS Budget

For more information, contact: Barb Murry 220.4778
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Recruitment and Retention of Direct Support Professionals in North Dakota: Analysis of 2010 NDACP Data

In 2008, North Dakota provided services to 4, 242 persons with Intellectual and Developmental Disabilities living in the community in either Home and Community Based Waiver (HCBS) services or Intermediate Care Facilities (ICF-MRs) (Lakin, Larson, Salmi & Scott, 2009).

Direct support professionals (DSPs) receive monetary compensation to provide supports to people with disabilities so they can live and work in our communities. Finding and keeping qualified DSPs has been a long standing problem in types of long-term supports and service settings (Larson & Hewitt, 2005). These low wage low status careers are often occupied by women, with recent immigrants and racial minority groups disproportionately represented. During the last 30 years services for people with intellectual and developmental disabilities have moved nationally and in North Dakota from institutional to small community settings.

Research on the DSP workforce has reported turnover rates averaging 42% for organizations providing multiple types of services (e.g., residential and vocational; Hewitt & Larson, 2007). High turnover rates disrupt services and create hardships for both the people being supported and their families. Just as concerning are the demographic changes expected in the next decade as Baby-Boomers retire and the number of people living with disabilities increase dramatically. The number of working-age females (aged 25 to 54) is expected to remain constant between 2006 and 2016 (Toosi, November 2007), while the number personal and home care aides are expected to increase 46% and the number of home health aides are expected to increase 50% between 2008 and 2018 (Lacy & Wright, 2009). These national statistics are mirrored by North Dakota's estimates. The U.S. Census estimates that by 2030 North Dakota's elder population will increase by 61.3% while the workforce 25 to 44 years old will decrease by over 27%.

In 2009, the Centers for Medicaid and Medicare Services, Direct Support Worker Resource Center issued a paper recommending that state Medicaid Agencies collect annual data on the direct support workforce. The North Dakota Association of Community Providers (NDACP) has worked with its member organizations that provide supports to people with intellectual or developmental disabilities (IDD) to collect turnover and other workforce data since 2002. This report highlights some of the results from the FY 2010 data collection along with selected historical trends.

2010 Turnover, wage and benefits for North Dakota organizations supporting people with IDD.

In fiscal year 2010, 2,870 direct support professionals were employed by 25 provider agencies of the NDACP. The NDACP collects workforce outcome data for three position types: DSP, Professional, and Administrative. The DSP category consists of all staff whose primary responsibility is the care of a person with IDD. Professional staff includes the titles of Behavioral Analyst, Qualified Mental Retardation Professional (QMRP) and Nurse. The administration category includes all other job titles.

In Fiscal Year 2010, ND turnover rates (calculated here as crude separation rate) were 32.8% for DSPs, 9.8% for professional staff, and 5.4% for administrative staff (See Table 1). Vacancy rates (the proportion of the total positions vacant) at the end of the fiscal year was 2.6% for DSPs, 0.6% for professional staff, and 0.6% for administrative staff. DSPs earned an average of $12.51 per hour while professional staff earned an average $19.82 per hour, and administrative staff earned an average of $22.50 hour.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Table 1 Turnover, Wages and Benefits by Position Type for FY 2010

	DSP	Professional	Administrative
Turnover Stats			
Number of Staff	2,870	208	160
# Separations	964	15	9
# Vacancies	78	1	1
Crude Separation Rate	32.8%	9.8%	5.4%
Vacancy Rate	2.6%	0.6%	0.6%
Wages and Benefits			
Average Hourly Wage	$12.51	$19.82	$22.50
% Full-time	54%	92%	93%
% Earns paid Sick Leave or Vacation	50.2%	84.6%	82.8%
% Provider Paid Health Insurance	33.5%	50.1%	50.3%

In NDACP organizations, 54% of DSPs, 92% of professional staff, and 93% of administrative staff were considered full-time employees. Overall, 50% of DSPs, 85% of professional staff, and 83% of administrative staff were eligible to earn paid time off including sick leave or vacation. Overall, 34% of DSPs, and 50% of professional or administrative staff received health insurance paid for in full or in part by the provider organization.

Characteristics of DSPs who left their job in FY 2010.

The first part of this report summarized workforce outcome data for all employee groups for FY 2010. For the rest of the report, we will focus on workers in the Direct Support Professional job classification. While it is helpful to know the overall turnover and vacancy rates, designing interventions to improve those rates requires additional assessment. The NDACP collected detailed information for 941 DSPs who left their position in FY 2010 ("leavers"; See Table 2) to help with this task. DSP leavers in FY 2010 had worked in their positions an average of 1.8 years before separating. They earned an average of $11.21; were 31 years old; and 33% were considered full-time employees. Overall, 64% of all staff who left were 30 years old or younger. Compared to the current DSP staff contingent, those who left their positions earned $1.30 per hour less, and were less likely to be considered full-time (33% versus 54%). Of all the DSPs who left their position in FY 2010, 39% left within 6 months of hire, and an additional 20% left between 6 and 12 months after hire.

Table 2 Characteristics of ND Staff who left their positions in FY 2010

	Direct Support Professionals	
	Number	Mean
Number of Leavers	941	100%
Years Tenure		1.82
Hourly Wage		$11.21
Mean Age		31.4

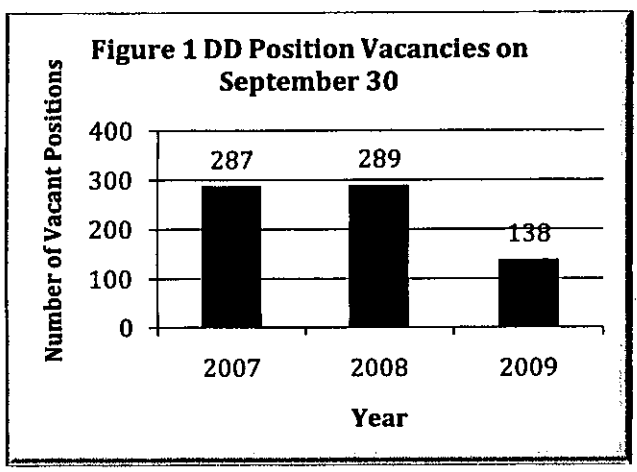
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% Full-Time	311	33%
Tenure Category		
0 to 6 months	364	39%
7-12 months	184	20%
13 - 24 months	173	18%
25 months or more	220	23%
Age Group		
18 to 30	600	64%
31 to 40	116	12%
41 to 50	108	11%
51 to 60	68	7%
61 +	49	5%

Together these data show that in ND those who left were younger, newer, more likely to be employed part time, and lower paid than those who remained. This picture, which is very similar to that in other states, suggests that interventions to retain DSPs for a longer period should focus, at least in part, on new employees. Several evidence based interventions are available for this purpose including improving hiring practices by using structured behavioral interviews, reducing unmet expectations by implementing realistic job previews, and better supporting new staff with training and effective supervision (Hewitt & Larson, 2007). The CMS DSW Resource Center technical assistance team has been working with NDACP and the North Dakota Medicaid office to develop a workforce development plan, and to craft specific interventions. One intervention that will be rolled out in 2010 is a North Dakota specific Realistic Job Preview. Additional interventions are also being considered.

DSP Workforce trends over time.

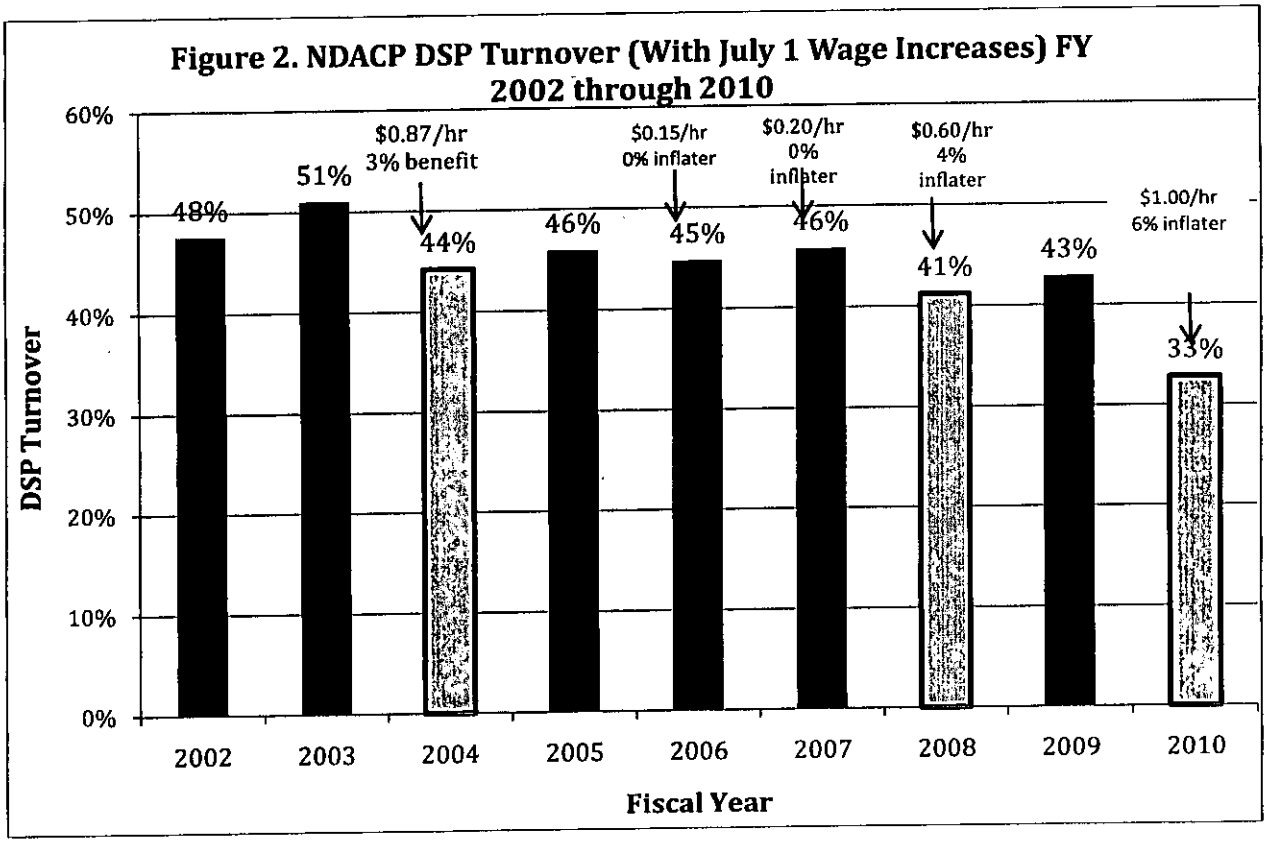
Data have been collected about vacancy rates and turnover for DSPs for several years. Three years of data are available on vacancy rates (See Table 3). While the total number of people with IDD served in ND increased between FY 2006 and FY 2008, the total number of vacant DSP positions at the end of the Fiscal Year declined from 287 on Sept 30, 2007 to 138 on Sept 30, 2009 (See Figure 1). On June 30, 2010, 78 DSP positions were vacant.



Data about DSP turnover in ND are available for 2002 through 2010 (See Figure 2). Figure two shows two separate trends. The bars reflect the crude separation rate in June 30 of the listed years. The text and arrows above the bars are legislatively authorized wage and benefit changes for DSPs. Overall, the turnover rate for DSPs in ND has declined from 48% in 2002 to 33% in 2010. During this period there were five wage and benefit changes. Three of those wage and benefit changes were for $0.60 per hour or greater (2004, 2008 and 2010). In each of the three years that included a large wage increase, turnover was notably lower than the previous year (44% in 2004 versus 51% in 2003; 41% in 2008 versus 46% in 2007; and 33% in 2010 versus 43% in 2009). The two small wage increases ($0.15 per hour in 2006 and $0.20 per hour in 2007) did not result in notable declines in turnover, and turnover increased in each of the years in which no wage/benefit increases were provided. This pattern of changes in turnover rates during years with large wage increases suggests that those wage increments had a measurable effect on turnover.

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Data collected in Wyoming has shown a similar pattern. A decrease in turnover occurred when large wage increase were provided to DSPs supporting individuals with IDD in 2002 (Average wages were increased from $7.38 per hour to $10.32 per hour; turnover declined from 62% to37%). These findings, together with large research studies showing a robust correlation between wage and turnover for DSPs (See Hewitt & Larson, 2007), support the assertion that wages matter. It is possible to reduce turnover by implementing wage increases.



Note: N of Agencies Reporting in 2010 = 25

Research reviews support the association between wage and turnover rates. However, wages aren't the only thing that matters. Turnover can also be reduced by improving hiring practices, implementing interventions to reduce unmet expectations for newly hired staff, improving socialization and orientation and practices, implementing a robust system of competency based training, improving the capacity of supervisors to know and use effective supervision practices, and improving the status and image of the DSP profession (Larson & Hewitt, 2005).

The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Conclusions and Recommendations

North Dakota like most states struggles to find, choose and keep qualified direct support professionals to support people with disabilities in community residential and vocational support settings.

The wage increments provided in FY 2004, FY 2008 and FY 2010 for DSPS supporting individuals with IDD resulted in notable reductions in turnover for this employee group, and the FY 2010 increase also was associated with a reduction in the number of vacant positions.

Continued efforts to measure workforce outcomes including turnover, vacancy rates and wages and benefits will support efforts to measure the impact of interventions chosen by the ND Medicaid authority and the provider organizations.

Efforts to measure workforce outcomes in North Dakota should be expanded include other sectors of the DSP workforce (such as services for people with mental health needs, physical disabilities, and for seniors).

Reducing turnover is one strategy to address the growing challenge of staff shortages in the direct support professional workforce in North Dakota.

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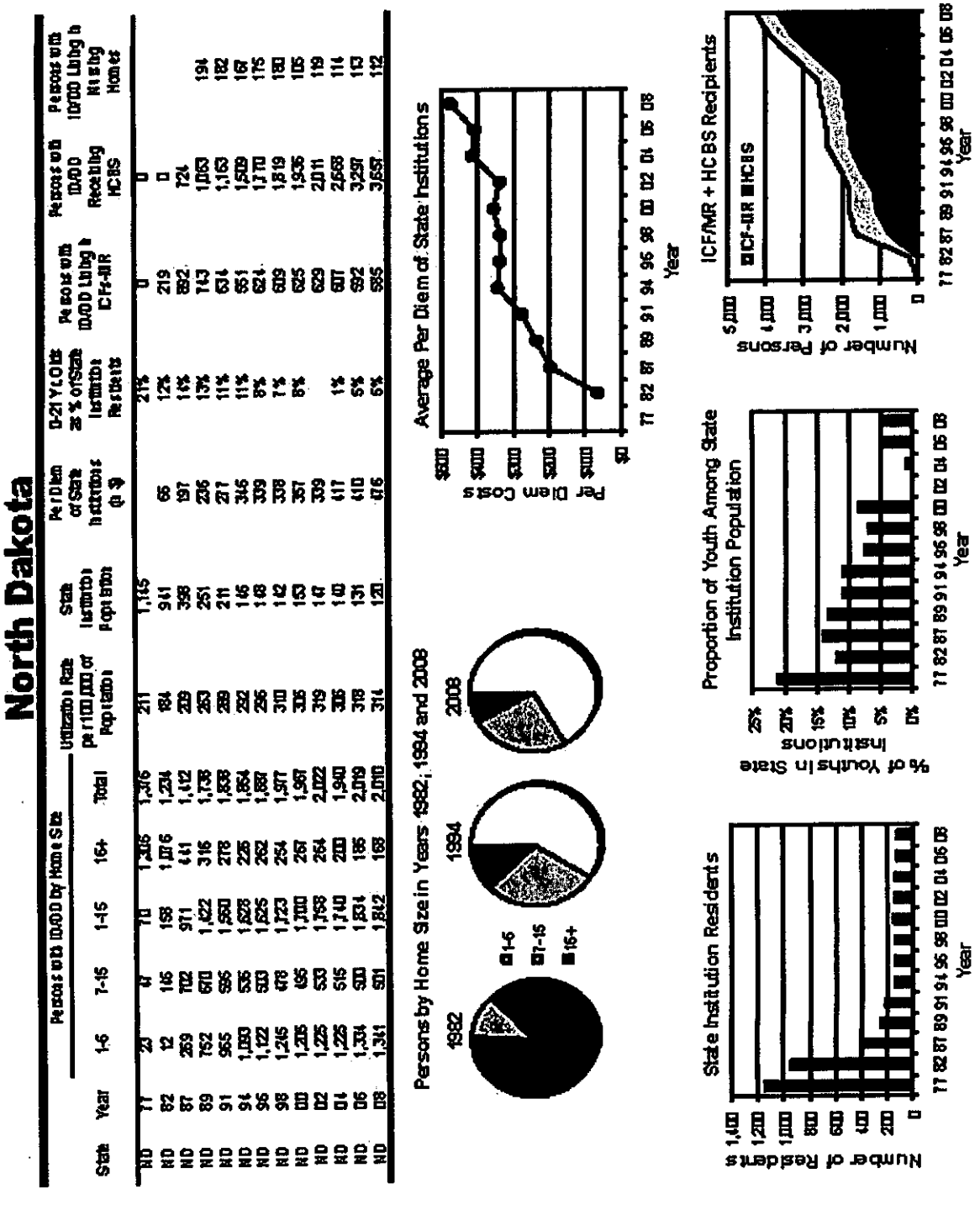
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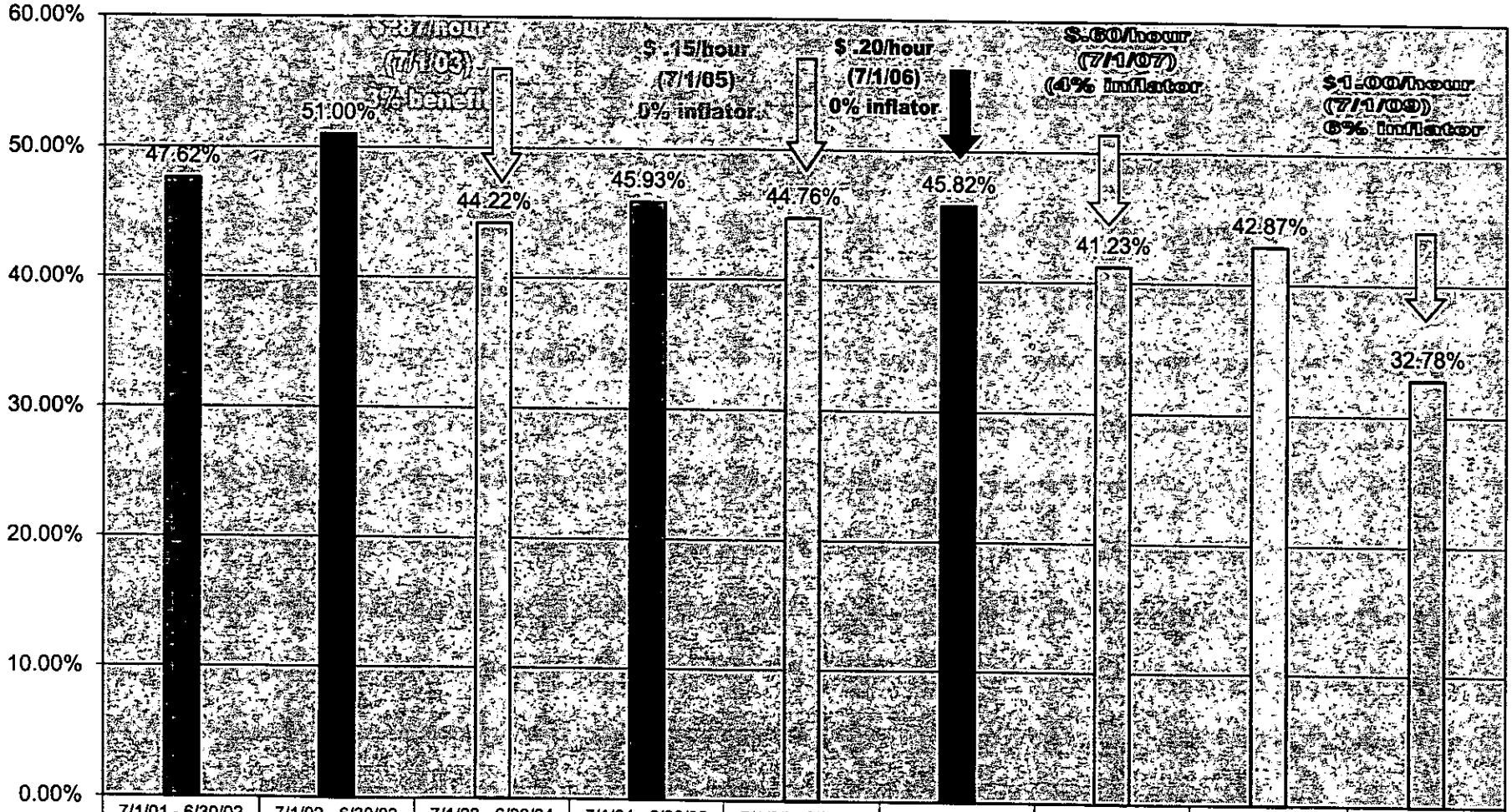
The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

Appendix A: North Dakota's Medicaid Funded Service System in FY 2009



The North Dakota Association of Community Providers (NDACP) provided all ND data for this report. This report was prepared by the CMS DSW Resource Center Technical Assistance Team, November 2010.

NDACP TURNOVER
FY 2001 - 2010



	7/1/01 - 6/30/02	7/1/02 - 6/30/03	7/1/03 - 6/30/04	7/1/04 - 6/30/05	7/1/05 - 6/30/06	7/1/06 - 6/30/07	7/1/07 - 6/30/08	7/1/08 - 6/30/09	7/1/09 - 6/30/10
Series1									
Series2	47.62%	51.00%	44.22%	45.93%	44.76%	45.82%	41.23%	42.87%	32.78%
Series3									

-SB2012
- March 8, 2011
- Attachment ONE

Budget Adjustment for PACE Senior Care Services Expansion
Testimony by Timothy C. Cox

Chairman Pollert and members of the House Appropriations Human Services Subcommittee, my name is Tim Cox and I am President of Northland Healthcare Alliance. Northland is a member driven provider based organization of 25 hospitals and long-term care facilities located throughout North Dakota. For more than 6 years Northland Healthcare Alliance has worked to bring a PACE program to North Dakota. PACE is a (P) program of (A) all-inclusive (C) care for the (E) elderly. This program is a relatively new Federal and State program that works to keep the frail elderly independent and healthy. In developing Northland PACE we have pursued funding opportunities and were fortunate enough to receive one of 14 Rural PACE grants from CMS. We have expended great resource to became a licensed PACE site and in August 2008 were awarded a PACE license to provide healthcare services to locations in Bismarck and Dickinson. The PACE program is growing nationally and is being implemented in many states. When we were approved as a PACE site there were 46 programs in operation. Today there are more than 75 approved. CMS loves PACE and feels that it is a good value for their investment and that it provides excellent care to recipients.

The Northland PACE program is already making a difference. Several of our current participants moved into our PACE Program right out of a Long-term Facility. In visiting with them and members of their family they indicate that they have seen remarkable improvement in the health and quality of life. This is amazing given the short time in which we have been in operations. The PACE model is in many ways the future of healthcare. We have a steadily growing graying population and we need to figure out how to take care of their healthcare needs. This model is one that is working. Statistics show that is reduces hospitalizations and makes them shorter when they occur. It will save the state

many dollars as it keeps individuals from moving into the Long-term Care Environment and even when the PACE participant do move to long-term care, the PACE program pays for the services. We need to remember that the population is aging and we will not have enough beds for the need in the very near future. This program is one that will prepare us for the Baby Boomer transition, but we must keep going on its implementation.

Two years ago when we presented information to the legislature many of the legislators asked when the program was going to be available in their community. It was our intention to insure that we developed a solid foundation and learned how to operate PACE effectively before venturing into other North Dakota communities. I believe that we have accomplished this and have developed a model that fits the urban and rural environment. With our experience in Dickinson and Bismarck, we are prepared to expand into Jamestown and Fargo, Jamestown this year and Fargo next year.

We see several key benefits that come to the state of North Dakota as the result of this PACE expansion. Let me spend just a few minutes to elaborate.

- PACE will save North Dakota money.
- PACE will bring additional healthcare dollars into the state.
- The PACE Model is the future of healthcare. It keeps individuals healthy using a proactive approach to care delivery with a fixed dollar attached to that care. It is proactive in that it focuses on a wellness model not illness. It is supported in Washington DC because of its innovative approach that delivers effective results.
- With a moratorium of Long-term Care beds in the state, PACE provides a mechanism to provide coverage without having to build additional

infrastructure and it does it for less money per participant. It will enable that moratorium on beds to be extended into the future.

- PACE takes care of individuals that are nursing home eligible and are mostly Medicaid eligible. The benefit to the State is PACE effectively keeps these frail elderly out of Long-term care and when they are admitted into the Nursing home or Acute Care Settings, the payment of the costs of that care is still the responsibility of PACE.

In the budget there are key dollars to pay for the current PACE operation in Bismarck and Dickinson. We believe that expansion of the PACE program into additional communities is a prudent economic decision for the legislature and will have a positive impact on the state by exchanging dollars that will be flowing into long-term skilled facilities into a program that provides documented efficient care and improves the quality of life for the frail elderly in our state at a fixed rate with substantial savings. The expansion is a prudent decision and we encourage the adjustments in the budget to allow for this expansion over the next two years.

Estimated State Expense - 2 year Site Expansion

Year 1: 1 Site

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 1 PPTs
James - # of PPTs	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	***12***
M/Caid-Jmst	$4,500	$9,000	$13,500	$18,000	$22,500	$27,000	$31,500	$36,000	$40,500	$45,000	$49,500	$54,000	**$351,000**
Medicare	$2,000	$4,000	$6,000	$8,000	$10,000	$12,000	$14,000	$16,000	$18,000	$20,000	$22,000	$24,000	**$156,000**
Total Expense	**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**	**$71,500**	**$78,000**	**$507,000**

Year 2: 2-Sites

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 2 PPTs
James - # of PPTs	*13*	*14*	*15*	*15*	*16*	*16*	*17*	*17*	*17*	*18*	*18*	*18*	***18***
Fargo - # of PPTs	*2*	*4*	*6*	*8*	*10*	*12*	*14*	*16*	*18*	*20*	*22*	*24*	***24***
M/Caid-Jmst	$58,500	$63,000	$67,500	$67,500	$72,000	$72,000	$76,500	$76,500	$76,500	$81,000	$81,000	$81,000	**$873,000**
M/Caid-Fargo	$9,550	$19,100	$28,650	$38,200	$47,750	$57,300	$66,850	$76,400	$85,950	$95,500	$105,050	$114,600	**$744,900**
Medicare	$30,000	$36,000	$42,000	$46,000	$52,000	$56,000	$62,000	$66,000	$70,000	$76,000	$80,000	$84,000	**$700,000**
Total Expense	**$98,050**	**$118,100**	**$138,150**	**$151,700**	**$171,750**	**$185,300**	**$205,350**	**$218,900**	**$232,450**	**$252,500**	**$266,050**	**$279,600**	**$2,317,900**

2-Year Totals

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL PPTs
# of PPTs	*15*	*18*	*21*	*23*	*26*	*28*	*31*	*33*	*35*	*38*	*40*	*42*	***42***
Medicaid	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Medicare	$32,000	$40,000	$48,000	$54,000	$62,000	$68,000	$76,000	$82,000	$88,000	$96,000	$102,000	$108,000	**$856,000**
Total Expense	**$104,550**	**$131,100**	**$157,650**	**$177,700**	**$204,250**	**$224,300**	**$250,850**	**$270,900**	**$290,950**	**$317,500**	**$337,550**	**$357,600**	**$2,824,900**

Estimated Savings: PACE vs. Nursing Home

2-Year Totals

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL
SNF	$101,680	$127,100	$152,520	$171,585	$197,005	$216,070	$241,490	$260,555	$279,620	$305,040	$324,105	$343,170	**$2,719,940**
PACE	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Total Savings	**$29,130**	**$36,000**	**$42,870**	**$47,885**	**$54,755**	**$59,770**	**$66,640**	**$71,655**	**$76,670**	**$83,540**	**$88,555**	**$93,570**	**$751,040**

Current Average Savings:

**** 15 % of 56 PPTS are in SNF**

SNF Avg Cost =	$53,340	($6355 average per month)
PACE Avg Cost =	$35,860	($4269 average per month)
	$17,480	**Current avg. savings per month**

north dakota department of human services

Fact Sheet

March 2009

Program of All-inclusive Care for the Elderly (PACE)

Background:

- The Balanced Budget Act of 1997 established the PACE model for both Medicaid and Medicare programs.
- PACE providers receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide patient-centered and coordinated care to frail elderly individuals living in the community.
- PACE has been approved by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced based model of care.

What is PACE?

PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Who Can Participate?

Participants must:

- Be a Medicare or Medicaid enrollee who is age 55 or older,
- Be eligible for nursing home level of care, and
- Live in a PACE service area.

PACE Services:

The emphasis of the PACE program is on enabling participants to remain in their community and enhancing their quality of life. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services if necessary). Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. The services are provided primarily in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs. PACE is a voluntary program.

Location:

The Northland Healthcare Alliance has developed two PACE organizations in North Dakota. They are located in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

Contact Information:

For information about PACE and how to enroll into the program, contact Northland PACE:

- Bismarck 701-751-3050
- Dickinson 701-456-7387
- Toll Free 1-888-883-8959



Northland PACE

Senior Care Services

(Program of All-inclusive Care for the Elderly)

HOME. It is where we want to be. Home is where the heart is. It is where people who love each other gather, and it is where older adults want to live out their days.

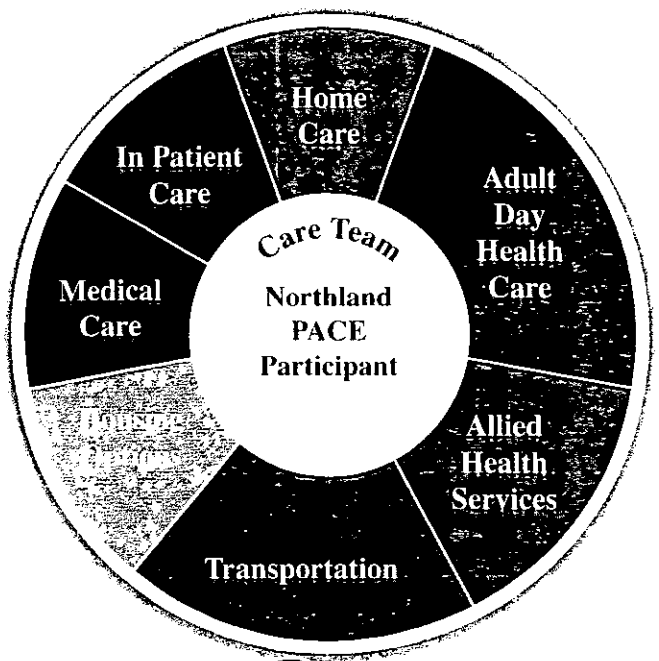
Northland PACE Senior Care Services is designed to keep seniors who are at risk for nursing home care, living independently at home by providing the highest level of healthcare. This includes health-care appointments to help participants remain as healthy and independent as possible.

The program includes medications, eye glasses, hearing aids and other assistance that **PACE** doctors may prescribe. Additional services may include In-home assistance ... personal care such as bathing, dressing, housecleaning, meals and nutritional counseling.

THE TEAM APPROACH

Northland PACE Senior Care Services employs a group of professionals called a Care Team that coordinates all aspects of healthcare and in-home services for **PACE** participants. This team of specialists includes a physician, nurse practitioner, registered nurse, social worker, health aides and several others who will assist in your healthcare. Families are encouraged to be actively involved in decision making.

As a participant's needs change, their care plan will change to meet any new situation. If hospitalization or nursing home placement is required, **Northland PACE Senior Care Services** covers the cost.



ELIGIBILITY REQUIREMENTS

- Be at least 55 years old
- Be in need of long-term care services
- Be able to live safely at home
- Live within an area served by **Northland PACE**

RANGE OF SERVICES

These services are based on the needs of each individual. Additional services may be necessary to maintain and improve the health of the individual. These are determined by the Care Team.

- Primary Care and Specialty Medical Care
- All Prescription drugs
- Adult Day Center with therapists
  - Physical • Occupational • Recreational
- Healthcare Specialists
  - Audiology • Dentistry • Optometry
- Dietary Services
  - Meals and Nutritional Counseling
- In-Home Support and Care
- Rehabilitation and Restorative Therapies
  - Speech Therapy • Physical Therapy
  - Recreation Therapy • Occupational Therapy
- Social Services
- Transportation
- Hospital Emergency Care and Nursing Home Care when necessary



ADVANTAGES OF PARTICIPATING IN NORTHLAND PACE SENIOR CARE SERVICES INCLUDE:

- Dedicated, qualified healthcare professionals
- Long-Term Care Services
- Coordinated care 24 hours a day, 365 days a year
- Support for family caregivers
- Personalized individual care

THE COST

The **Northland PACE Senior Care Services** program accepts Medicare and Medicaid.

There are no hidden costs, co-payments or deductibles for any **PACE** services. Your Care Team will determine what medications, services and supplies are necessary for your care. The cost for these services are paid for and provided by **Northland PACE Senior Care Services.**

PARTICIPATION AND DISENROLLMENT:

- Participants receive all of their health care from Northland PACE, except for emergency services.
- Because PACE provides and is responsible for all of your care, you may be held financially responsible for any care you receive outside the program that is not approved by the PACE program.
- Participants may disenroll from the program at any time.
- Northland PACE offers Medicare Part D prescription drug coverage. If you are in a PACE program, you don't need to join a separate Medicare drug plan. If you do, you will lose your PACE health and prescription drug benefits. If you enroll in another Part D program, it will result in your disenrollment from PACE.

Mission Statement

Northland PACE Senior Care Services promotes independence through the coordination of all health services, allowing participants to continue living safely and with dignity at home.

Northland PACE Bismarck
201 N. 24th Street • Bismarck, ND 58501
701-751-3050

In Bismarck, we serve the following zip codes:
58501-58502-58503-58504-58554-58558

Northland PACE Dickinson
830 2nd Ave. East, Suite 212
Dickinson, ND 58601 • 701-456-7387

In Dickinson, we serve the following zip codes:
58601-58602-58652-58655-58680

NORTHLAND/PACE

Senior Care Services

Program of All-inclusive Care for the Elderly



DEDICATED TO

PROVIDING

THE *highest level* OF **CARE**

TO **SENIORS** IN OUR COMMUNITY

- Attachment TWO

Testimony
SB 2012- Department of Human Services
House Appropriations Human Resource Committee
March 8, 2012

Chairman Pollert and members of the House Appropriations Human Resource Committee, my name is Shari Doe. I am the Director of Burleigh County Social Services here in Bismarck. I'm also the President of the ND Association of County Social Service Directors and I am here to speak in support of Senate Bill 2012.

Local county Social Service agencies are instrumental in carrying out the work of the Department of Human Services. In North Dakota's state supervised, county administered system, the Department depends on county social service agencies to provide services. Counties depend on the department for direction and resources to carry-out this work. I wish to speak to a few issues that are important to the counties and how those issues fit within SB 2012.

- The FMAP decrease has a significant increase on the Department's budget, $171.4 million, I believe. The FMAP decrease means that North Dakota has a growing economy and rising personal incomes. It seems counter intuitive then that at the same time the FMAP rates goes down, the number of Medicaid recipients are increasing. In Burleigh County, the number of Medicaid/SNAP recipients has increased over 25% in the past three years – the fastest growing Economic Assistance program we administer. Counties pay for the workers needed to determine Medicaid eligibility, and the non-federal share of our Medicaid reimbursed programs such as, Targeted Case Management for Child Welfare case management. Counties bill Medicaid for the full amount of the service. The state then turns around and bills the counties for the non-federal share. With the FMAP decrease, the amount counties are billed (the non-federal share) will increase proportionally to the Medicaid cost increases realized by the state.

- The federal Health Care Reform legislation as it currently stands calls for an expansion of the Medicaid Program to all individuals at 133% of poverty. And though this implementation is a couple of years away, we are beginning to look at how determining eligibility for all the newly eligible Medicaid recipients will affect counties. Currently, county Eligibility Workers

determine client eligibility for Medicaid. Counties are wondering how continued increases in Medicaid cases will impact staffing, technology and space needs. The "word on the street" has been that North Dakota could expect up to 30,000 individuals newly eligible for Medicaid. With such a significant increase in Medicaid recipients, counties would have to add additional workers to meet the increased demand and additional space to house the workers. That is, unless the health insurance exchange takes over the determination of Medicaid eligibility. In that case, counties may actually be able to reduce the number of workers responsible for determining Medicaid eligibility because the health insurance exchange will take over that function. What happens in Washington D.C. and here the North Dakota Legislature will ultimately determine how we move ahead with the implementation of the Patient Protection and Affordable Care Act. However, when North Dakota does adopt legislation to meet federal requirements, consideration must be given to the role counties play in the administration of Medicaid benefits.

- Computer technology in the administration of programs is a key area in which counties depend on the Department of Human Services. A continuing need for county social service agencies has been for a comprehensive Eligibility Computer System to determine eligibility for all programs including: the Medicaid Program, the Supplemental Nutritional Assistance Program (SNAP formerly known as Food Stamps), Temporary Assistance to Needy Families Program (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care Payment Program and Child Care Assistance Program. At this time, county eligibility workers must enter data in four different aged computer systems (NATL, TECS, VISION, and CCWIPS) to determine eligibility for a single combined case. And though EW's are quite adept at making these systems work, having to work within four different computer systems is inefficient, difficult to learn and prone to error. The Eligibility System re-write did not make it into the Governor's budget. I understand, however, that the Industry, Business and Labor Committee is considering legislation on behalf of the Insurance Commissioner's office (HB 1126) regarding establishment of a Health Insurance Exchange in accordance with the Patient Protection and Affordable Care Act. An amendment has been offered for the Eligibility System re-write so that Medicaid and Healthy Steps (Children's Health Insurance Program) are able to interact with the Health Care Exchange. Although this is a round-about-way to address the aging and cumbersome Eligibility System, we very much support the state's efforts to move ahead with an Eligibility System re-write. In this

day of continuous program changes, more complex policies and high quality performance standards, a computer system that allows workers to deliver timely and accurate benefits is essential. And just to clarify, the MMIS system will not address the eligibility issues I've just described. MMIS is a Medicaid payment and benefits management system and not intended for eligibility determination.

- Another important computer system needing attention is Frame. Frame is the North Dakota's child welfare data management system. Frame was created by Information Technology Division in collaboration with the Department of Human Services and counties for foster care and child abuse neglect case management purposes. It combined two functioning systems (CCWHIPs and the Child Abuse and Neglect data-base system) so child welfare workers would have a less complicated system for case documentation and the state would have a single source for data collection. Additionally, the system was designed to meet reporting and documentation requirements of the Children and Family Services Performance Improvement Plan. Frame is relatively new. It was rolled out as a pilot in Burleigh County in September 2009 and implemented state-wide shortly after that. We applaud the Department's efforts to improve the child welfare computer system, but enhancements to the system are necessary to make Frame the single source of documentation and data-collection as originally intended. The project was under-funded so critical programming had to be eliminated due to budget constraints. Enhancements to Frame will improve efficiency at the state, regional and county level. We strongly encourage additional resources be directed towards Frame enhancements.

- In the area of child welfare, counties are constantly in "putting out fires" mode. And though we all talk about the value of prevention services, the reality is that the "in your face" emergencies and the "deep end" families take up the majority of our resources. Services such as home visiting programs, parent resources centers, early intervention case management, intensive in-home services, family team/group decision making all significantly impact on a family's ability to provide safe, nurturing parenting. Family Preservation services such as safety and permanency funds, parent aides, and case management are often the critical difference between being able to keep a child at risk in the home, or taking custody away from a parent and placing the child in foster care. Early intervention with a family in stress is much more efficient and cost-effective

than working with a family already in the system. The problem is that the child welfare workers are so busy with the "really bad" cases; we do not have the time or resources to do the prevention work we'd like. The Department of Children and Family Services is very committed to prevention as an overall strategy but that does not address the fact that some secondary prevention services are not available throughout the state. Burleigh County and Cass County will be able to offer family team decision making services to every family at risk of losing custody of their child. This service is not available anywhere else. The Minot region has access to Family Group Decision-Making and the Bismarck Region does not. Grand Forks and Burleigh/Morton have access to Healthy Families, a home visiting program. Efforts to enhance funding for these child abuse and neglect prevention services were defeated on the Senate side. We understand the Department's limitations in making these resources available to more North Dakota families, but we must invest more in prevention and intervention services. These children are our future.

In conclusion, all aspects of the human service budget, impact the citizens of our counties. As I stand up here and speak about computer systems and health care reform and lack of resources it's easy to forget that what we do is about improving the lives of people.

Chairman Pollert and members of the Committee thank you for the opportunity to provide testimony on SB 2012 and I would be happy to address any questions you may have.

House Appropriations Committee
Human Resource Division
Testimony on Senate Bill 2012
Representative Chet Pollert – Chairman
March 8, 2011

-Attachment THREE

Chairman Pollert and members of the House Appropriations Sub-Committee, my name is Larry Bernhardt and I am the Executive Director of Catholic Charities North Dakota (CCND) and I am respectfully asking your committee to provide increased funding for Special Needs Adoption above the line item in the DHS Budget in SB2012.

The AASK Program (Adults Adopting Special Kids) is a collaborative effort between Catholic Charities North Dakota and PATH ND, Inc.. We have been providing this Program since 2005 and collectively with the Department of Human Services we are responsible to provide the adoption services for children in the foster care system in North Dakota. These children have generally been in the custody of County Social Services or a Tribe prior to the termination of parental rights. Many times they have had multiple placements outside of their birth home. They may be older children, children placed along with a sibling for adoption, children with a mental, physical, emotional disability, or children of minority race which make them difficult to place. Often, many of these children meet several of these criteria. Parents adopting these children can be family members, grandparents, foster parents, or other parents wishing to start, add to, or complete their family. All of these parents choose to open their hearts and their homes to adopt these challenging children.

In Fiscal Year 2010, the AASK Program accomplished:

117 children from ND were placed for adoption, including
- 19 children from other states placed into ND homes
- 15 children from ND to be placed with families outside ND
- 27 sibling groups, involving 69 children placed for adoption

87 adoption assessments were completed by the AASK Program

104 children had their adoptions finalized

The Special Needs Adoption line item within the DHS budget for next biennium is the same as was appropriated for the 2009-2011 biennium and this will be insufficient to meet the needs of those children with special needs for the 2011-2013 biennium. We are requesting additional funds in two (2) areas:

1) Funding for a 3% inflationary increase for each year of the biennium. This area of the budget did not receive the 3% inflationary increases as did other providers in other service areas.

2) Additional funding to allow for the increase of two additional staff for the Program. One of the positions would be of a caseworker, so that the caseload of the program could be spread out further to lower the current caseload among all of the workers. The second position would be of a supervisor, so that we could better support the increased complexity of the work and enhance the quality of the work.

In closing, I respectfully ask for your support of funding for Special Needs Adoption as outlined in SB 2012 and the following increases:

1. 3% inflation increase in each year of biennium	**$ 73,401**
2. Additional funding for two positions for biennium	**$ 314,453**
Total:	**$ 387,854**

With your help, the good and essential work of the Special Needs Adoption Program can continue to provide children and families in North Dakota a permanent home.

Thank you for the opportunity to stand before you today and I would be happy to try to answer any questions you may have.

- Mar 8, 2011
- Attachment Four

March 9, 2011

Testimony for SB 2012

Chairperson Delzer and Members of the House Appropriations Committee,

My name is Tim Hathaway, Executive Director of Prevent Child Abuse North Dakota.

Child abuse, much like smoking, has for most of North Dakota's existence been viewed as harmless and perhaps even beneficial for those engaging in the behavior. "Spare the rod and spoil the child" has too often licensed harmful punishment where thoughtful guidance was needed. It is only in the past thirty years that we have really begun to understand the far reaching impact of child maltreatment and the high cost it has for victims, communities and our culture at large.

The success achieved by smoking cessation advocates has been brought through effective efforts at cultural change. Their labor has focused on changing the image of "lighting up" from normal to harmful. The work of Prevent Child Abuse North Dakota is that of cultural change as well. We are working to change attitudes about children, their place in society, and violence perpetrated against them.

Our office does this work through partnership with individuals and organizations with in communities and across the state. One essential partner to our work is the Department of Human Services, Division of Children and Family Services. Through the funding support of CFS, our office is enabled to provide education to parents about how to better deal with the kind of overwhelming stress that causes them to lash out at their child in a moment of anger. It helps us provide information and assistance to families, extended families, and friends of victims as they struggle to understand how their sister, child or coworker could kill a child. This funding allows our office to work with communities as they develop capacity to respond to families in effective ways before there is a crisis with a child.

Included with my testimony, you have a brochure produced by our office detailing the various projects supported by DHS. These include the Wakanheza community capacity development project, Happiest Baby on the Block shaken baby syndrome prevention program, Authentic Voices survivor advocacy network, Alliance for Children's Justice prevention action network, and Child Abuse Prevention Month in April. We are supportive of and grateful to the Department for their work on behalf of children and families and look forward to continued partnership with them.

In the past two month's our communities have been shocked by the death and life altering injuries dealt to children at the hands of their parents and care givers. While we are making progress on this issue, there is much more work to be done. Next month, our office has a goal to reach every household in North Dakota with the message that there are alternatives to family violence and that we can have a culture here that does not tolerate emotional, physical, or sexual abuse of our children. I am confident that with this Legislature's ongoing support and the continued partnership of the Department we can realize this change in our culture.





All **Prevent Child Abuse** America Chapters share the Vision of a culture (and a *cultural attitude*) wherein the well-being of children is universally understood and valued; and where raising children in surroundings which ensure healthy, safe and nurturing experiences is supported by the actions of every individual and every community.

It is a Vision in which it becomes the norm for all parents and caregivers to seek and accept qualified support regarding the knowledge and skills required for effective parenting and child development; and for the general public to become educated and engaged in supporting the well-being of children.

And it is a Vision wherein "preventing child abuse" no longer describes the cause we each support; but rather, begins to define the effect of everything that we do to help children and families.

Contact us at:

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We work in partnership with the ND Department of Human Services, whose financial support helps us maintain our free to low-cost programs and services.

Prevent Child Abuse
North Dakota

www.PCAND.org

Prevent Child Abuse
North Dakota



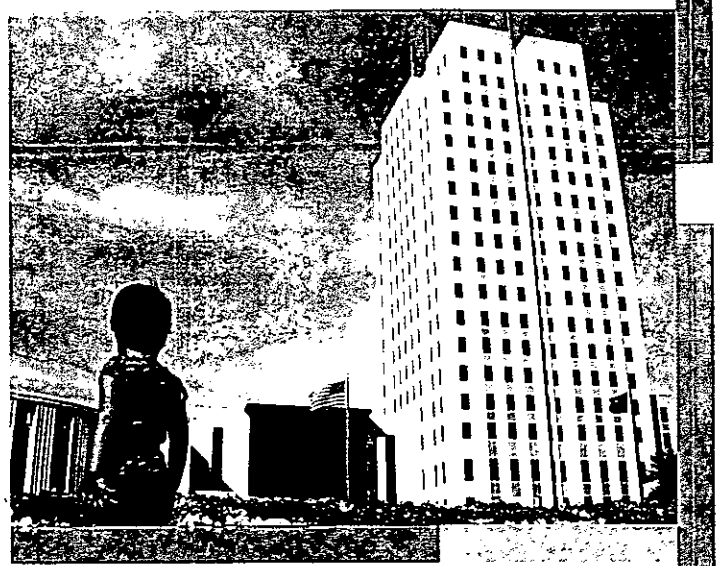
You can make a difference in the life of a child!

A Chapter of
Prevent Child Abuse America

Prevent Child Abuse

North Dakota

is committed to a safe and nurturing environment, free from abuse and neglect for all children.



About us:

Prevent Child Abuse North Dakota (PCAND) is an independent 501(c)3 nonprofit, that has been working to improve the lives of children and families since 1978.

We do this through:

- Public Awareness and Education
- Training and Technical Assistance
- Coordination of Services
- Strategic Partnerships
- Advocacy

Our Programs

The Wakanheza Project teaches community members to appreciate, assure and help parents particularly when they are trying to deal with a child's tantrum. Trainers also offer site-specific advice to turn areas of common child power struggles, like checkout lanes and waiting rooms, into kid-friendly environments.

The Happiest Baby on the Block works to prevent child abuse and neglect associated with excessive infant crying, colic and parental exhaustion, providing simple tools to help combat post partum depression, bonding failure, marital stress and shaken baby syndrome.

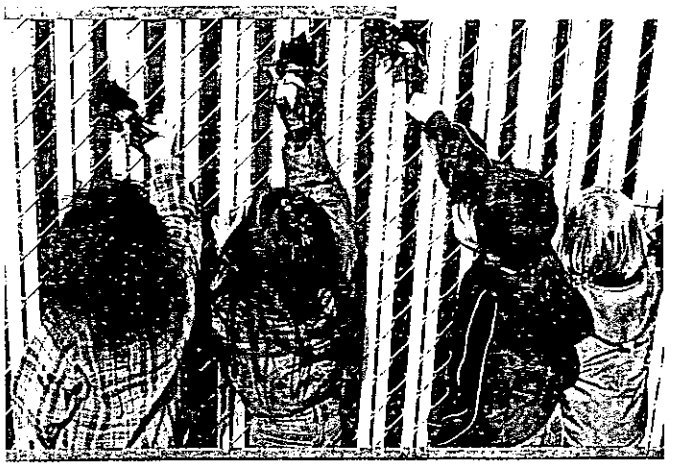
Authentic Voices provides opportunities for survivors of child maltreatment to educate adults and protect children by sharing their Voice. Members receive training and logistical support as they advocate for children and families at events across North Dakota.

Circle of Parents provides a friendly, supportive environment led by parents and other caregivers. It's a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. Where they can find and share support.

Community Outreach

Services:

- Educational booklets, posters and magnets
- Video and book lending library
- Newsletters
- Program assistance
- On-site consultations
- Presentations and training



CAP Month

April is Child Abuse Prevention (CAP) Month, a time which reminds us of our important individual and collective responsibilities to help raise North Dakota's children. This month's symbol, the pinwheel, stands for hope, health and happiness – bright futures all children deserve. PCAND provides materials, funding and support to coalitions of volunteers as they bring public awareness events to their communities.

- Attachment FIVE

Testimony
Senate Bill 2012 - Human Resource Division
House Appropriations Committee
Representative Chet Pollert – Chairman
March 8, 2011

Chairman Pollert and members of the Human Resources Division of the House Appropriations Committee, my name is Susan Rae Helgeland. I am Executive Director of Mental Health America of ND (MHAND). Our non-profit is 59 years old in ND and 102 years old nationally. Our Mission is to promote mental health through advocacy, education, understanding and access to quality care for all individuals.

An average of one individual dies by suicide every four days in ND. Suicide is the fourth leading cause of death in ND preceded only by cancer, heart disease and accidental deaths. (CDC Report). People are dying because help is not available due to the stigma that still surrounds mental illness and the barriers to access behavioral (mental illness and substance use) health services.

I recently received a letter from someone in a ND county jail who says he has a diagnosis of paranoid schizophrenia. He has been denied medication. If he had diabetes, would he be denied insulin? The question I have is, why is this happening in ND? Why are there so many people with behavioral health issues in prison in the first place?

I want to share a personal story with you of an individual that came to my attention a couple of weeks ago. He gave me his permission to use his name only to help others and to talk to legislators. He is a member of the Myrt Armstrong Center (MAC) in Fargo. It is a recovery center that the ND Legislature funds to help provide community support for people with mental illness who are participating in recovery.

Brian Speaker, Fargo, writes, "*I have tried everything on an honorable and honest level to convince the people who I trust with my care to pay attention when I tell them things are headed towards self Injury. I have a new case manager who is probably one of the hardest working people I know, who have even tried to get help and a new advocate who is a Social Worker. Great people who fully understand how important it is for me to avoid impulse and seek and get help with safety when I'm really in trouble.*

Today I was failed by 3 doctors/systems and could not get access:
1) the doctor didn't know me well enough to understand how imperative it was to get the support needed when faced with the last option;
2) a crowded system to the point where people occupy crisis beds for 3-4 weeks at a time (A serious lack of access);
3) dealing with an undereducated ER Doc who is communicating my situation to a doctor who knows me, but loses the message along the way resulting in No Admit.

I today also failed myself. 19 months erased. 11 cuts, none requiring stitches. Why am I still home? My case manager and advocate will have been made aware of this failure on my part by the time you see this. I'm almost certain of the severity of the consequences even though I was loud and clear with my needs that were not met.

I guess I am asking for a clue being the providers lately I have made decisions to put their blinders on until the act was done. Now it would be punishment for me to endure a hospitalization even though the event has passed. It wouldn't surprise me in the least that I would be sent inpatient even though it's way too late for that."

I bring you these two stories that recently have come to my attention to demonstrate the behavioral health crisis that exists in our state. MHAND, though grant support, has produced a documentary. We have presented it in several venues and it will be statewide on cable public access television. The documentary is called, *Resolana: Voice of the People. Resolana: Voice of the People*, a documentary recently produced by MHAND, is about personal testimonies by real rural ND behavioral health consumers and providers telling their stories. Every one of the eight who were interviewed for the documentary talked about the weeks and sometimes months of waiting to see a provider. After a diagnosis is made, the individuals interviewed said there are very little to no case management services to help support recovery in the community and to help the individual stay out of the hospital or jail.

I have been involved in advocacy since 1964 when, as a senior in Social Work at UND, I visited the ND State Hospital. I saw over 2000 people segregated in the state hospital and "zoned out" in what, at that time, were the drugs of choice, Haldol and Thorazine. I was shocked to see that individuals, through no fault of their own, were warehoused in this way. I was so shocked that it has motivated me to be an advocate for the last 47 years. I was hoping that by now I would have worked myself out of a job. But sadly, that is not the case.

Deinstitutionalization happened in the 70's. It happened without a comprehensive transition plan for individuals to be able to be successful and live independently in the community after leaving the various state hospitals. There were no community-based or support services in place. Now we have, in my words, reverse deinstitutionalization, prison. For example more that 65% of people in the ND Corrections System have, or are experiencing behavioral health symptoms. ND is critically short of behavioral health services including in-patient care. The State Hospital has a waiting list as well as many of our regional human service centers.

Community based out-patient and support services are under-funded when compared to people with intellectual disabilities, nursing home services and, of course, all other medical illness like diabetes, arthritis, heart disease, etc.

Governor Dalrymple has included funding to help meet the current needs of people with behavioral health issues in his budget. MHAND applauds and supports the Department of Human Services budget as it relates to specific line items for behavioral health issues.

However, MHAND is concerned about systemic change and therefore supports the OAR request, # 703, for the MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT. Psychiatric care delivered in general hospitals and freestanding psychiatric hospitals is an integral component of community-based care for people with mental illnesses. With a 30% decline in inpatient psychiatric beds over the past two decades, it is hard to find beds for individuals needing mental health care services. Individuals with mental health needs are diverted to emergency rooms or travel long distances to receive care.

In a June 1, 2009, Government Accountability Office report (GAO-09-347) on hospital emergency departments, it was reported that difficulties in transferring, admitting, or discharging psychiatric patients from the emergency department were a factor contributing to emergency department overcrowding.

Medicaid is vital for people with mental disorders, funding more than 50% of state and local spending on behavioral health services. Community-based psychiatric hospitals could help relieve this access problem; however, due to a Medicaid provision called the Institution for Mental Disease exclusion, patients receiving care in these hospitals are not covered for their care if the patients are between the ages of 22-64.

The Medicaid Emergency Psychiatric Demonstration Project will expand the number of options available in communities by establishing a three-year demonstration project. Among other things the demonstration will allow states to cover patients in non-governmental freestanding psychiatric hospitals and receive Federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms and improve the efficiency and cost-effectiveness of inpatient psychiatric care.

Key immediate issues are:

1. Three-year demonstration/Medicaid dollars became available 10/1/10.
2. States must contribute their $1.2 million match dollars to the $1.4 million Federal match.
3. States may apply to the HHS Secretary for approval on a competitive basis.
4. The Centers for Medicare and Medicaid Services is developing a Request for Proposal, which may be made available in the Federal Register by April 2011, demonstration projects chosen by summer, and money provided to demonstrations in October 2011.

The IMD Demonstration Project is part of the solution to the over-crowding of the ND State Hospital and it will increase access to crisis beds in the communities.

While MHAND supports the Governor's Budget, we ask you to make a long term decision by supporting an amendment attached for your consideration. Thank you for the opportunity to testify today.

I will be happy to answer any questions.

National organizations endorsing the IMD Demonstration Project:

American Academy of Child and Adolescent Psychiatry * American Association for Geriatric Psychiatry * American Association for Marriage and Family Therapy * American Association of Pastoral Counselors *American College of Emergency Physicians * American Counseling Association * American Group Psychotherapy Association * American Hospital Association * American Mental Health Counselors Association * American Psychiatric Association * American Psychiatric Nurses Association * Anxiety Disorders Association of America * Association for Ambulatory Behavioral Healthcare * Association for Behavioral Health and Wellness * Child Welfare League of America * Children and Adults with Attention-Deficit/Hyperactivity Disorder * Clinical Social Work Association * Eating Disorders Coalition * Emergency Nurses Association* Federation of American Hospitals * National Alliance on Mental Illness* National Association for Children's Behavioral Health * National Association of County Behavioral Health and Developmental Disability Directors * National Association of Psychiatric Health Systems *National Association of Rural Mental Health * National Association National Association of Rural Mental Health * National Association of Anorexia Nervosa and Associated Disorders * National Coalition of Mental Health Professionals and Consumers, Inc.* National Foundation for Mental Health* Therapeutic Communities of America.

Prepared by the Legislative Council staff for
Senator Mathern
March 4, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace lines 7 through 10 with:

"Grants - Medical assistance	1,300,642,323	328,874,163	1,629,516,486
Total all funds	$1,870,492,778	$387,226,319	$2,257,719,097
Less estimated income	1,381,801,240	137,729,602	1,519,530,842
Total general fund	$488,691,538	$249,496,717	$738,188,255"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$287,895,144	$934,244,660
Grand total special funds	1,549,066,932	143,644,024	1,692,710,956
Grand total all funds	$2,195,416,448	$431,539,168	$2,626,955,616"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	47,538,412	0	47,538,412
General fund	$31,521,462	$31,521,462	$0	$31,521,462
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,686	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	$0	$53,488,637
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	$0	$4,958,832
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	4,536,041	0	4,536,041

General fund	$6,882,190	$6,882,190	$0	$6,882,190
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	$0	$13,209,723
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	$0	$22,185,733
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	$0	$9,343,547
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	$0	$14,109,532
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	$0	$6,529,292
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	$2,580,462	$2,626,955,616
Less estimated income	1,683,661,250	1,691,270,800	1,440,156	1,692,710,956
General fund	$927,363,658	$933,104,354	$1,140,306	$934,244,660

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes	House Version
Salaries and wages	$50,346,211	$50,346,211		$50,346,211
Operating expenses	90,850,363	90,850,363		90,850,363
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	2,580,462	1,629,516,486
Total all funds	$2,241,950,229	$2,255,138,635	$2,580,462	$2,257,719,097
Less estimated income	1,510,481,136	1,518,090,686	1,440,156	1,519,530,842
General fund	$731,469,093	$737,047,949	$1,140,306	$738,188,255
FTE	374.50	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of House Changes

	Adds Funding for Demonstration Grant[1]	Total House Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	2,580,462	2,580,462
Total all funds	$2,580,462	$2,580,462
Less estimated income	1,440,156	1,440,156
General fund	$1,140,306	$1,140,306
FTE	0.00	0.00

[1] This amendment adds funding of $2,580,462, of which $1,140,306 is from the general fund and $1,440,156 is from federal funds, for a competitive institution for mental disease demonstration grant available through federal health care reform.

- Attachment 5/X
- Mar 8, 2011
- SB 2012

PRAIRIE ST. JOHN'S™

March 7, 2011

Dear Committee Members:

I am Dr. Emmet M. Kenney, Jr., a Child and Adolescent and General Psychiatrist. I am here today to speak on behalf of Prairie St. John's and the North Dakota Hospital Association, of which I am a member of the Governing Board. We are here to speak in strong support for Senate Bill 2012 and recommend your passage of this bill.

Switchboard
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www.prairie-stjohns.com

I wish to speak specifically to the mental health and substance abuse portions of this bill. Under the leadership of Executive Director Carol Olson, the Department of Human Services undertook Stakeholders' Meetings in both the eastern and western parts of the state beginning last winter. They carefully considered the input of providers and consumers of mental health and addictions treatment in making recommendations to Governor Dalrymple for his budget proposal. Governor Dalrymple's budget contains a realistic affirmation of where we are currently at in the State of North Dakota in the provision of psychiatric and addictions care and where we need to go. Highlights of this bill as it pertains to mental health and addictions:

1. Supports community-based treatment. Community-based treatment is less expensive and more accessible to North Dakota citizens than the alternative of simply funding treatment at the Jamestown State Hospital or various Human Service Centers. It is more respectful of patient choice, and leverages the available resources in communities beyond those currently provided by DHS HSCs.

2. It provides for services to be according to the patient's level of need. Therefore, expanded services such as residential treatment or crisis services could be offered as an alternative to the more expensive and more time constrictive hospital services that currently fill the gap when clinic level care alone is not appropriate for the patient populations.

3. Operates in fairness to providers already providing mandated care without payment, so they have an opportunity to partake in a contractual relationship for providing these services to North Dakota citizens.

In summary, we strongly urge you to issue a "do pass" recommendation on this important legislation of Senate Bill 2012. I am happy to address any questions that you may have.

Sincerely,

Emmet M. Kenney, Jr., M.D.

-Attachment SEVEN
- SB 2012

March 8, 2011

Hello Chairman Pollert and Members of the House Appropriations – Human Resources Division

My name is Carla Meyer and Dakota Center for Independent Living has helped me out in many ways. They helped in teaching me how to fill out job applications, how to cook, wash dishes, clean them and go grocery shopping. Dakota Center for Independent Living has helped me to live out on my own, has helped me to manage my money and to learn it.

Please continue financial support for Centers for Independent Living SB 2012, so that they can continue to help others like myself. Thank you for your time.

Carla Meyer
700 South 12th St. # 270
Bismarck, ND 58504
701-355-6397

-Attachment EIGHT

Testimony
Senate Bill 2012 – Department of Human Services
Aging Services Budget
Human Resources Division
House Appropriations Committee
March 8, 2011

Chairman Pollert and members of the committee, my name is Brian Arett. I am the Executive Director of Valley Senior Services and a representative of the 26 agencies that are members of the North Dakota Senior Service Providers (NDSSP) that provide Older American Act Services to the senior population of this state. I am here to testify in support of the budget for the Aging Services Division of the North Dakota Department of Human Services. In particular I am here to testify in support of the $300,000 increase in reimbursement to Older Americans Act Service Providers.

At the same time I am here to speak in support of this increase I am here to ask your committee to consider a request for an additional increase for Older Americans Act Service Providers. I make this request because of the significant challenges we face in providing for the growing numbers of seniors, particularly those ages 85 and older, throughout the state, and because of the significant number of services that we continue to provide with no reimbursement.

Older Americans Act services such as Home Delivered and Congregate Meals, Outreach, Health and Senior Companion services are an important part of the continuum of care that helps our seniors to remain in their homes as late in life as possible. They represent "a comprehensive and coordinated system of home and community-based services that allows older individuals to lead independent, meaningful, and dignified lives in their own homes and communities." (taken from Older American Act Services published by the North Dakota Department of Human Services – Aging Services Division; 2009.)

When we met with Governor Hoeven's office last fall to talk about our need for additional support for the services we provide for the elderly, our request once again, was to ask that the state fully fund the established reimbursement rate for the meals programs we operate. In addition we asked that the state fully fund the established reimbursement rate for Health Services provided to assist seniors to remain in their homes.

In FFY 2009 (the most recent year statistics are available) 1,198,725 Congregate and Home Delivered Meals and 139,688 units of Health Services were provided throughout the state. Of this number, 1,100,501 meals and 79,092 units of Health Services were reimbursed leaving 98,224 meals that were not reimbursed and 60,596 units of Health Services. The estimated combined cost to reimburse these units would have been $707,358 for one year or a total of $1,414,716 for a two year period of time.

The agency I work for, Valley Senior Services, provides services for seniors in the 6 counties in Region Five including meal sites in 33 communities. In 8 of these communities we contract with a local restaurant for meal services. Our agency has 24 full time and 60 part time employees with a total annual payroll of more than $1.5 million. We spend over $1 million annually on food purchased from wholesale vendors and restaurants.

In 2008 in our region, we provided 49,192 meals that we were not compensated for. In 2009 we provided 53,157 meals that were not compensated for. In 2010, following an increase in funding approved during the 2009 Legislative Assembly, that number dropped to 38,721 meals that were not compensated for. The additional local dollars we were required to generate to provide these uncompensated meals in 2010 were $135,524.

In the last several weeks I have been contacted by many of the rural restaurants that we contract with for meals asking about getting an increase in the per meal

reimbursement rate. They all have expressed concern about being able to continue to provide meals at the $5.25/meal rate we are able to afford. I explained to each of them that we are working with the Legislature to hopefully increase the number of meals we are compensated for so that we will be in a position to increase the reimbursement rate for all of the restaurants we contract with.

Our request of your committee is to increase funding for Older Americans Act Providers for meals and health services by an additional $1.1 million so that we can be reimbursed at the established state rate for every meal and every unit of health service we provide. Please note, these funds would not be spent unless the units of service are provided.

The member agencies of the NDSSP are the organizations providing services to older people in the most rural parts of our state. Meal services are provided in 190 communities of all sizes and in all corners of the state. Many of the older residents of small towns throughout the state rely on these meal services as one of the few alternatives to institutional care available in their community.

The increase being requested in the DHS budget will help us to keep up with the inflationary increases we are experiencing. In particular, it will help us to maintain an adequate reimbursement rate for the many rural restaurants we work with.

If we are going to keep up with the growing costs for providing services and the growing need for services brought on by the ever increasing senior population we need to raise revenues from somewhere. Local resources have been stretched as thin as they can be. We look to the state as a natural partner in helping us to meet this need. The major benefit for the state comes from assisting seniors to stay at home in a less restrictive and much less expensive setting, saving dollars that would have to be spent on nursing home care if our services are not available.

Thank you for your time. I would be happy to answer any questions you might have.

North Dakota Senior Service Providers
c/o Ken Tupa, APT
PO Box 2264
Bismarck, ND 58502-2264
Phone 701-224-1815 Extension 2
Cell 701-319-6666
E-mail: ktupa@aptnd.com

September 2010

Organizations that are members of North Dakota Senior Service Providers:

1. Williston/Region I Senior Services
2. Minot Commission on Aging
3. Kenmare Wheels and Meals
4. Tri County Meals and Services, Rugby
5. Souris Basin Transportation, Minot
6. Cavalier County Meals and Services, Langdon
7. Nutrition United, Rolla
8. Benson County Transportation, Maddock
9. Senior Meals and Services, Devils Lake
10. North Central Planning Council, Devils Lake
11. Walsh County Nutrition Program, Park River
12. Pembina County Meals and Services, Drayton
13. Greater Grand Forks Senior Citizens Association
14. Valley Senior Services, Fargo
15. Dickey County Senior Citizens, Ellendale
16. James River Senior Services, Jamestown
17. South Central Adult Services, Valley City
18. West River Transit, Bismarck
19. Mandan Golden Age Services
20. Burleigh County Senior Adults, Bismarck
21. Kidder Emmons Senior Services, Steele
22. Mercer McLean Counties Commission on Aging, Hazen
23. Elder Care, Dickinson
24. Southwest District Health Unit, Dickinson
25. Southwest Transit, Bowman
26. Legal Assistance of North Dakota, Bismarck

Providing Home Delivered and Congregate Meals, Outreach, Health Maintenance, and Legal Assistance Services for Older Adults in 198 North Dakota Communities

- Attachment NINE

Testimony
Senate Bill 2012 – Department of Human Services
Aging Services Budget
House Appropriations Committee
March 8, 2011

Chairman Pollert and members of the committee, my name is Pat Hansen. I am the executive director of South Central Adult Services and I am also president of the North Dakota Senior Service Providers that provide Older Americans Act Services to the senior population of this state.

Brian Arett's testimony explained the statewide situation regarding meals for seniors. I would like to provide you with information concerning my project. South Central Adult Services provides congregate and home delivered meals, outreach and transportation to Region VI which includes the counties of Barnes, LaMoure, Foster, Logan, McIntosh, Griggs, Stutsman, Dickey, Wells and Sheridan. South Central provided 107,184 congregate meals, 75,359 home delivered meals, 13,038 billable units of outreach and 83,652 rides in 2010. **We provided 13,947 meals with no federal/state reimbursement.** At the $3.50 meal reimbursement rate for 2010 this is a shortfall of $48,815.

I am very appreciative of the increase we received during the last legislative session. We have, to date, been able to maintain the same level of service we were providing in 2008. We were able to keep all of our rural meal sites open and increased our contracted rate to the cafes by $.50 per meal. We do, however, need to receive reimbursement for **all** of the meals we provide. It is increasingly

becoming more difficult to obtain the additional local funds we need to provide these non-reimbursed meals.

Today, in our region, 34% of all meals are provided to people age 85 and older, and 43% of all home delivered meal participants are age 85 and older. The meals are a necessity for these people. For those of you who are familiar with nursing home admission criteria, people who have deficits in two or more Activities of Daily Living (ADLs) are eligible for nursing home admission. In my region alone we are serving 230 people who meet or exceed that criteria. If in-home services were not available and these people required nursing home placement it would cost in excess of $13 million dollars each year for their care, just for Region VI. Of those 230 people, 81 of them are already low-income and would likely be receiving Medicaid reimbursement for their care when they entered a nursing home.

Statewide statistics on active participants in 2010 indicate that there are a total of 991 people who meet the ADL criteria. Of the 991 people, 310 are already below poverty level and would likely qualify for Medicaid on admission. The increase in Medicaid funding for those individuals would exceed $18.5 million dollars per year.

I have a difficult time placing dollar values on the quality of life we provide for our elderly. I would ask that you consider what your desire is for your care or the care of your family members. Do you want to continue to live in your own home,

surrounded by members of your community? Or do you want to live in an institutional setting when a few relatively inexpensive services could keep you at home? We all know that nursing homes and assisted living facilities are necessary when we cannot care for ourselves, but let's not hurry the process.

We really believe in what we do and are dedicated to helping to make North Dakota the best place possible to grow old in. We need your help to do that and ask that you give SB2012 a Do Pass recommendation. If you have any questions, I would be happy to answer them. I have included 2 attachments for your individual review. The first is a listing of the number of clients in each county with 2 or more ADLs. The second is an explanation of what the ADLs consist of. Thank you for your time in consideration of this testimony.

Older Americans Act Clients served with 2 or more ADL's from 10/1/09 - 9/15/10

	County	Clients with 2 or more ADLs	Age 60-74	Age 75-84	Age 85+	Living Alone	Below Poverty	Male	Female
1	Adams	6	0	3	3	2	**1**	4	2
2	Barnes	62	11	20	31	39	**19**	19	43
3	Benson	11	3	2	6	7	**5**	2	9
4	Billings	1	0	0	1	0	**1**	0	1
5	Bottineau	6	1	1	4	0	**3**	2	4
6	Bowman	0	0	0	0	0	**0**	0	0
7	Burke	1	0	0	1	0	**0**	0	1
8	Burleigh	37	5	18	14	9	**9**	25	12
9	Cass	169	45	51	73	99	**54**	43	126
10	Cavalier	4	1	1	2	1	**0**	1	3
11	Dickey	10	2	5	3	5	**4**	2	8
12	Divide	1	0	1	0	1	**1**	0	1
13	Dunn	5	2	0	3	2	**1**	0	5
14	Eddy	6	1	2	3	3	**3**	1	5
15	Emmons	20	5	8	7	9	**10**	8	12
16	Foster	5	2	2	1	0	**0**	2	3
17	Golden Valley	2	0	1	1	1	**0**	1	1
18	Grand Forks	19	5	8	6	5	**4**	5	14
19	Grant	5	2	2	1	1	**1**	4	1
20	Griggs	9	1	4	4	4	**5**	2	7
21	Hettinger	1	1	0	0	1	**1**	0	1
22	Kidder	31	4	14	13	14	**13**	5	26
23	LaMoure	13	2	7	4	5	**3**	5	8
24	Logan	3	1	0	2	1	**2**	1	2
25	McHenry	3	1	0	2	1	**2**	0	3
26	McIntosh	9	3	1	5	0	**1**	4	5
27	McKenzie	5	4	0	1	1	**1**	2	3
28	McLean	40	8	10	22	24	**14**	14	26
29	Mercer	36	9	13	14	21	**14**	14	22
30	Morton	18	1	10	7	9	**5**	4	14
31	Mountrail	8	1	2	5	2	**5**	2	6
32	Nelson	2	0	1	1	1	**2**	0	2
33	Oliver	3	2	0	1	0	**1**	1	2
34	Pembina	37	7	15	15	16	**5**	13	24
35	Pierce	10	3	3	4	3	**3**	2	8
36	Ramsey	17	2	6	9	9	**5**	4	13
37	Ransom	34	2	16	16	24	**9**	9	25
38	Renville	1	1	0	0	1	**1**	0	1
39	Richland	9	5	1	3	4	**2**		9
40	Rolette	19	12	0	7	9	**7**	8	11
41	Sargent	28	8	10	10	19	**15**	7	21
42	Sheridan	0	0	0	0	0	**0**	0	0
43	Sioux	11	6	2	3	2	**1**	3	8
44	Slope	1	0	0	1	1	**0**	0	1
45	Stark	22	4	9	9	11	**11**	7	15
46	Steele	2	0	0	2	0	**0**	1	1
47	Stutsman	110	17	39	54	70	**47**	32	78
48	Towner	10	0	3	7	5	**1**	3	7
49	Traill	2	0	2	0	0	**0**	1	1
50	Walsh	59	10	27	22	25	**8**	19	40
51	Ward	46	9	20	17	24	**9**	12	34
52	Wells	9	2	3	4	7	**0**	1	8
53	Williams	13	7	3	3	1	**1**	2	11
	TOTALS	**991**	**218**	**346**	**427**	**499**	**310**	**297**	**694**

North Dakota Senior Service Providers

October 2010

Persons are eligible for nursing home admittance if they have 2 or more ADL's. The 310 low-income persons currently being served by Older Americans Act providers would most likely be Medicaid eligible at the beginning of their nursing home stay.

The low income 2 ADL' number of people (310) multiplied by the average most recent yearly nursing home cost of **$ 59,796** (reported at the May meeting of Legislative Interim Long Term Care Committee) comes to the sum of $ 18,536,760 per year of Medicaid Expenses - double it for the biennium = $37,073,520.

Even delaying by one month the nursing home admission of these 310 people would save more than the 1.4 million dollars that Title III providers are asking to be reimbursed for all the Title III services provided.

Activities of Daily Living (ADL)

Self-care activities performed daily without assistance, stand-by assistance, supervision or cues including:

- eating
- bathing
- walking
- dressing
- toileting
- transferring in and out of bed/chair

Instrumental Activities of Daily Living (IADL)

Independent living tasks that typically require mental/cognitive (memory, judgment, intellect) and/or physical ability such as:

- preparing meals
- medication management
- using the telephone
- doing light housework
- shopping for personal items
- managing money
- doing heavy housework
- transportation ability – this refers to the individual's ability to make use of available transportation

- Attachment TEN

House Appropriations Committee
Human Resource Division
Testimony on Senate Bill 2012
Representative Chet Pollert – Chairman
March 8, 2011

Chairman Pollert and members of the House Appropriations Sub-Committee, my name is Larry Bernhardt and I am the Executive Director of Catholic Charities North Dakota (CCND) and I am respectfully asking your committee to include increased funding for corporate guardianship services for people with developmental disabilities into SB2012.

CCND has been providing corporate guardianship services on behalf of people with developmental disabilities since 1987. Corporate guardianship is an integral part of the service system that is in place for individuals with developmental disabilities. It is a fundamental core service – just as we need residential and vocational services, we need guardianship services. The court appoints a guardian if the person is unable to make or communicate responsible decisions. Because a person's decision making skills are compromised, he or she is at risk of neglect, abuse and exploitation. Corporate guardianship services are essential if no one is available or appropriate to serve as guardian. Through the provision of guardianship services, we are able to intervene as necessary to ensure that our wards' basic needs are met, that they have an appropriate place to live, that they have access to ongoing medical care and that they are receiving necessary support services. It is our responsibility, as guardians, to support and assist each ward to be a fully participating member of the community and society.

Corporate guardianship's line item within the DHS budget for next biennium will not meet the needs of our wards in three (3) key areas:

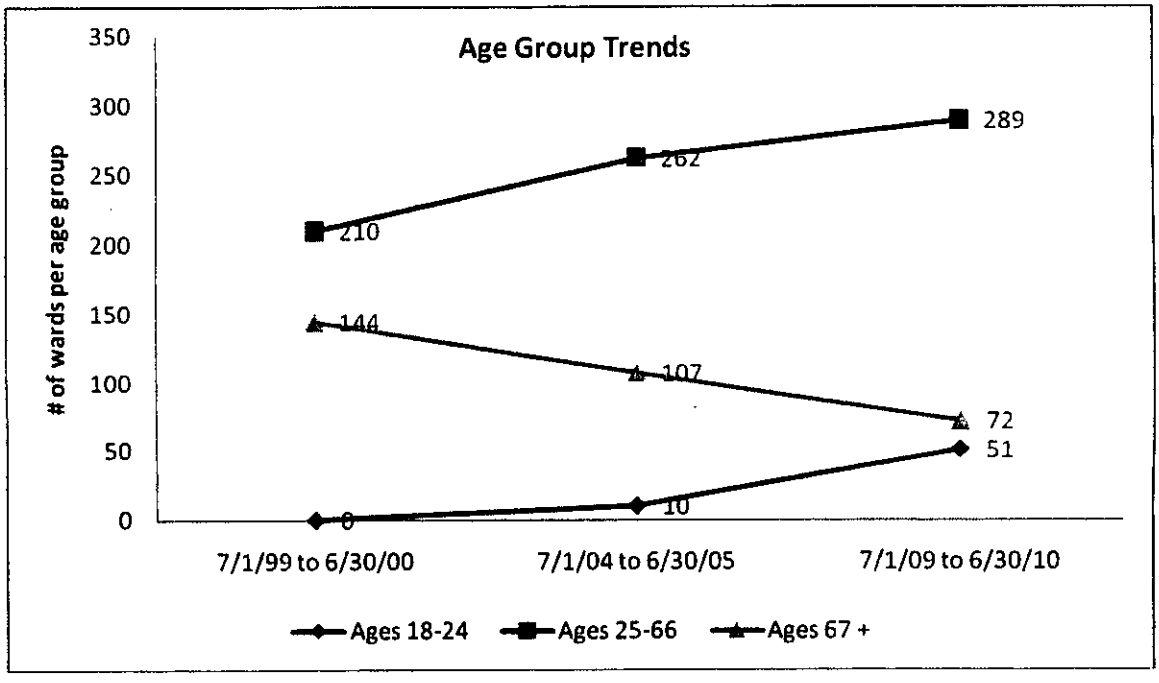
1) Due to the complex needs of our wards, the intensity of their service needs and accreditation standards, a decrease in the size of the caseloads of our guardianship workers is necessary;

2) The 2007 and 2009 legislative appropriation of $29,750 no longer adequately covers the legal costs related to the establishment of guardianships;
3) Because of a great number of referrals, it is highly possible that a waiting list for services will need to be established before the end of this biennium.

1) Increased service needs and caseload size:

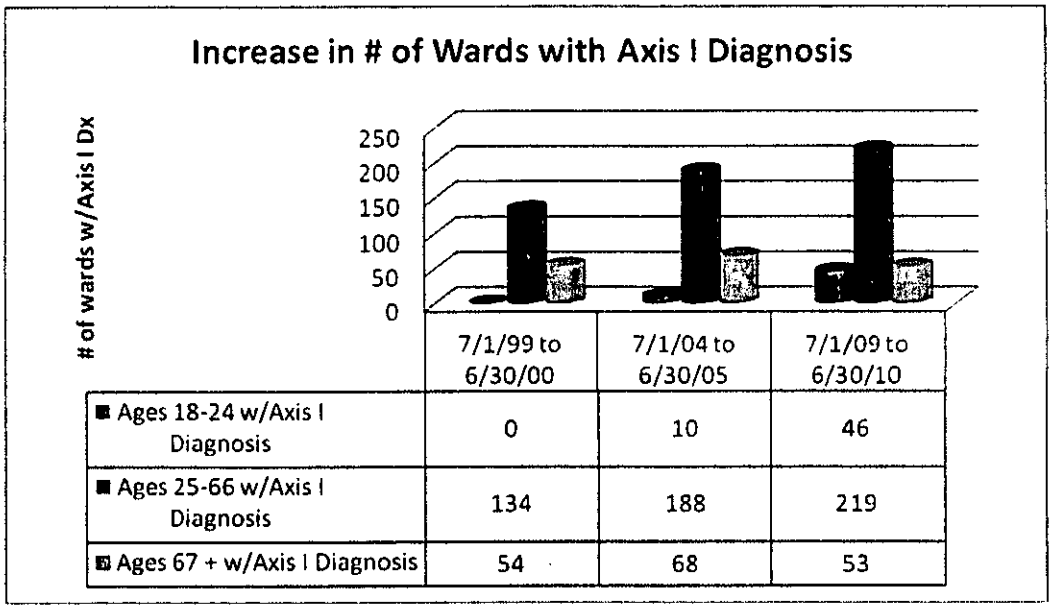
Since 2002, our corporate guardianship program has seen an increase in the behavioral, psychiatric, chemical dependency, sexual health, legal and supervision needs of our wards. This places heavy demands on our guardianship workers.

- From 7/1/99 to 6/30/00, our guardianship program had no wards between the ages of 18 to 24. From 7/1/09 to 6/30/10, we served as guardian for 51 wards between the ages of 18 to 24.



- Wards in this age group typically have needs that are very time intensive because of psychiatric concerns, behavioral difficulties, alcohol/drug use, sexual health and legal issues. Because of complex needs, frequent team meetings are the norm as well as frequent face to face visits.

Guardianship workers can expect numerous contacts with psychiatrists, psychologists, physicians, family members, attorneys, landlords and law enforcement.



(Axis I disorders are clinical mental health conditions that warrant clinical treatment such as anxiety, depression, or Bipolar disorder. These disorders usually disrupt a person's ability to function adequately and left untreated can lead to problems in work, school, family, etc.)

- During the past several years, there has been a significant increase in the number of family members who are upset that the courts have appointed a corporate guardian for their son, daughter or sibling (all ages not just the age group of 18 to 24). Disgruntled family members place a high demand on our guardianship workers in terms of time, effort and energy.
- Overall, the complexity of cases has changed a great deal over the past 23 years. Twenty years ago, the majority of our wards resided at the Developmental Center, nursing homes and group homes. During the past decade, the shift has been to Individualized Supported Living Arrangements (ISLA), Supported Living Arrangements (SLA), Transitional Community Living Facilities (TCLF) and Minimally Supervised Living Arrangements (MSLA) which translates to more

independence and decreased supervision. The shift to increased independence results in more personal autonomy but also more exposure to sexual exploitation or abuse, financial exploitation and abuse, self neglect or abuse and legal problems. Again, this places more demands on our guardianship workers' time.

- During the past decade our accreditation agency (Council on Accreditation) has dramatically increased our paperwork requirements to document accountability and the quality of our services.
- Medicaid changes, special needs trusts, tribal trusts and other complex financial activities have placed considerable responsibilities on our guardianship workers as they must spend numerous hours completing research before a decision can be made.

As guardians, it is our court appointed responsibility to assist our wards in being as independent and autonomous as possible while minimizing their risk of abuse, neglect and exploitation. Our ability to protect our vulnerable wards from harm is compromised because our staff to client ratio is too high. As of 7/1/09, our ratio was 1:40. The Council on Accreditation (our accrediting agency) has set this ratio at 1:20. We feel that a ratio of 1:34 would be much more realistic in terms of meeting our clients' needs and providing quality services. To meet the complex needs of our wards and to take into account the large geographical area that must be covered, we received approval in November 2009 from DHS to hire two (2) half-time guardianship workers utilizing roll up from our contract and an increase in the amount of the allowable guardianship fees through Medicaid for certain wards. This reduced our ratio to 1:36. We are very grateful to Carol Olson, Brenda Weisz, JoAnne Hoesel, John Bole, Michael Marum, Maggie Anderson and Curtis Volesky for authorizing this creative funding solution. We are extremely pleased that funding for the two half-time guardianship workers has been included in the Governor's budget for the next biennium. However, to achieve a caseload of 34 wards per full-time guardianship worker, supplementary funding to hire an additional full-time guardianship worker is requested.

2) Petitioning costs:

The 2007 and 2009 Legislature allocated $29,750 for petitioning costs for indigent people with developmental disabilities who are referred to our program. Petitioning costs include the fees for the petitioning attorney, guardian ad litem attorney, court visitor and, on occasion, a fee for the proposed ward's doctor or psychologist. The actual amount spent on petitioning costs during the 2007-2009 biennium was $37,618.19. Eighteen (18) months into the 2009-2011 biennium, petitioning costs amount to $38,742.83 on behalf of 38 wards. At this rate, it is projected that petitioning costs may exceed $51,657 ($38,742.83 ÷ 18 months X 24 months) this biennium. There are two primary reasons for the increased petitioning costs: more guardianship cases are contested by the proposed ward or their family causing the attorneys and court visitors to spend more billable hours on those particular cases; and, in general, attorney and court visitor fees have increased for routine guardianship cases. To offset the increase in petitioning expenses, we are respectfully requesting that the appropriation for petitioning costs be increased from $29,750 to $51,657.

3) Need for additional openings:

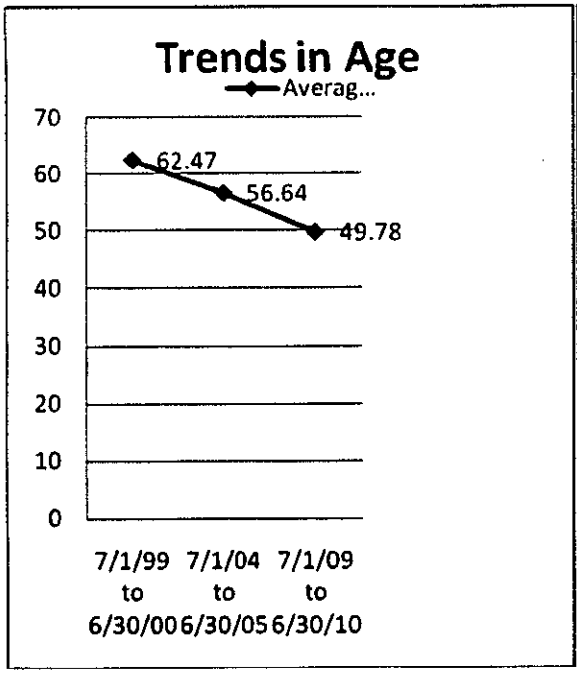
The 2007 Legislature approved funding for 35 additional openings for corporate guardianship services for people with developmental disabilities – a total of 414 wards. This eliminated a long waiting list of people needing our services. The following is a breakdown of admissions and terminations from 7/1/07 to 12/31/10.

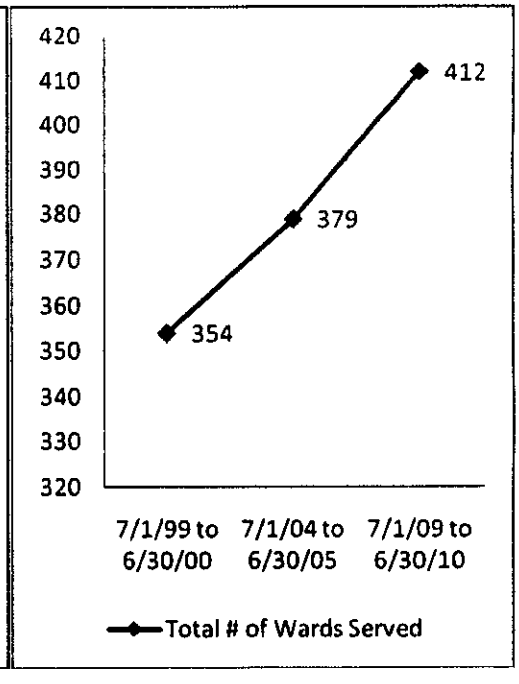
Time Period	Admissions	Terminations	Net cases
7/1/07 to 6/30/08	24	18	6
7/1/08 to 6/30/09	25	17	8
7/1/09 to 6/30/10	24	18	6
7/1/10 to 12/31/10	17	8	9

The following chart illustrates the projected net growth of the number of wards served from 6/30/08 to 6/30/13.

Date	Net Number of Wards for Full Fiscal Year	Number of Active Cases on Final Day of Fiscal Year
6/30/08	6	380
6/30/09	8	388
6/30/10	6	394
6/30/11	16 (projected)	410 (projected)
6/30/12	10 (projected)	420 (projected)
6/30/13	10 (projected)	430 (projected)

From 9/1/10 to 12/31/10, an unprecedented number of 19 individuals with developmental disabilities were referred for corporate guardianship services, bringing our current referral total to 20 individuals. It is highly possible that our program will reach its capacity of 414 wards by the end of the current biennium which will result in a waiting list for services. Please note that if a person with developmental disabilities is in a life-threatening situation, we immediately accept that referral and provide guardianship services once the court makes that appointment. To insure corporate guardianship services are available for vulnerable adults who are in crisis and at risk of abuse or harm, we are requesting funding for fifteen (15) additional openings which increases our capacity to 429 wards.





In closing, I respectfully ask for your support of funding for corporate guardianship services as outlined in SB 2012 and the following increases:

1. One additional FTE to lower caseloads	**$141,814**
2. Increased rise in legal petitioning costs	**$ 21,907**
3. Fifteen (15) additional guardianship slots	**$ 67,342**
Total:	**$231,063**

With your help, the good and essential work of the corporate guardianship program can continue to provide persons with developmental disabilities the appropriate level of protection while fostering the highest degree of independence and self-growth possible. Thank you for the opportunity to stand before you today and I would be happy to try to answer any questions you may have.

- Attachment Eleven

March 8, 2011

-SB 2012 - Bernie Zander, DCIL

To Chairman Pollert and Members of the House Appropriations Committee- Human Resources Divisions:

My name is Tonia Johnston and I am writing to ask you to please continue your financial support for Centers for Independent Living with Senate Bill 2012.

The Centers for Independent Living are such an important part of many individuals lives and without their continuous support and services many of us would not be able to live so independently.

I have Biploar Disorder and Parkinson's Disease and before I received services from the Center for Independent Living, living on my own and trying to raise my children was very difficult. I was not aware of what help was available to me or even where to begin to find that information.

Their help and understanding has made a difficult situation easier to handle. They were able to allow me to try a medication machine to see if it would help me before I had to go out and spend money on it, they gave me the information on places I could contact if I wanted someone to come to my home and fill my medication machine and refill my medications, they helped me to fill out the paperwork needed to make my home handicap accessible and even helped me to rent a scooter when I was not able to walk because of my illnesses. These are just a few examples of the help they have provided to me just on my physical disability.

People do not realize how difficult it can be to deal with a mental illness. You lose a lot of support from family and friends because of the stigma around it. The Centers for Independent Living make sure all of my bills get paid and on time. If it were not for them I may not have a home today. I have almost been evicted before, had my lights turned off and not had enough money for food for the kids. I can not tell you where the money went, but it made life very difficult. Since they have been handling it I have not had a problem

once. They allow me to be as involved as I choose to be in making my budget and writing the checks. It still allows me a great sense of independence but the security that if my illnesses are more out of control my family and I will still be okay.

It is not only their ability to help you handle your day to day life but they support you and listen to you and really care about you as a person. If you have any questions or you are not sure where to find information they make the time to help you find the answers.

I have had their services for almost four years now and even though we still have our ups and downs, my children have enjoyed more stability. Because of their help we now own our own home, I was able to get my driver's license again and I am able to continue with my education.

Something as simple as tying your own shoes doesn't seem like it should be an accomplishment until you wake up one day and can not do it by yourself. It is the little things in life that make you feel independent and worth something and when you can be allowed to do those with some help you feel a sense of pride. The Centers for Independent Living have helped me to realize that having these disabilities does not make me any less of a person but I think it makes me a better person and with your continued support they can continue to help others stay independent and be proud of who they are too.

Thank you,

Tonia Johnston
4005 19th St Lot 218
Bismarck, ND 58503
(701) 527-4995

March 8, 2011

Chairman Pollert and Members of the House Appropriations – Human Resources Division

My name is Peter Wald and I have been working with Dakota Center for Independent Living for approximately seven years. I have been getting help with paper work and getting my bills paid on time. Without this type of service I would feel totally lost and feel that I couldn't live independently.

Please continue financial support for Centers for Independent Living SB 2012.

Peter Wald
600 South 9th Street Lot 23
Bismarck, ND 58504
701-323-7777

March 8, 2011

RE: Senate Bill 2012

Dear Chairman Pollert and Members of the House Appropriations – Human Resources Division,

As a disabled resident of North Dakota, I'm writing to share with you about my feelings about Senate Bill 2012 and why you should continue your financial support for Independent Living Centers.

For the last twenty years, I have been a consumer of the Dakota Center for Independent Living. I received the following services:

Independent living skills training, Advocacy Services, Information and Referral Services, and Social Activities to developed new friendships. Today, I live in my own apartment and live independently. Currently, I volunteer at the Dakota Center for Independent Living.

I urge you to support on Senate Bill 2012 so the disabled North Dakotan may have the opportunity to live independently.

THANK-YOU, for your support on Senate Bill 2012.

Sincerely,

Carlos Joseph Garza
3001 Ohio St. Apt. 16
Bismarck, ND 58501

March 8, 2011

SB: 2012

Hello Chairman Pollert and Members of the House Appropriations – Human Resources Division,

My name is Randee Sailer. I'm 27 year old; I've had a mental disability since I was 10 months and am 90% blind in my left eye since the age of 15 years old, it's also very sensitive to sun and wind, fore that I have to wear sunglasses outdoors. I could not have accomplished being on my own without Dakota Center for Independent Living help. DSCIL has helped me with the CAT bus, learning me ways around Bismarck, cooking skills, social activities, along with helping me fill out my income taxes. The Counselors here have helped me to stay strong, cuz I was very scared to be on my own.

Because of their help. They've been able to help so many other people the same way they've Helped me. For that, I am asking to please continue funding Centers for Independent Livings Senate Bill 2012. That way they can continue the education needed.

Sincerely,

Randee Sailer
33 W Interstate Ave. Apt. 8
Bismarck, ND 58503
701-214-2671

March 3, 2011

Chairman Pollert and Members of the House AppropriationsCommittee/Human Resource Division:

My name is Charmaine Yvette Boehler; I am a lady with many disabilities. I have been a client and volunteer of Centers for Independent Living since 2006. They have helped me in many areas of my life. The counselors encouraged me and gave me hope for the future. I have earned an Associate in Applied Science degree as an Administrative Assistant Medical at Bismarck State College and graduated in 2009. I am proud to be a productive member of society, helping people in our state and local communities. I am able to work part-time and am a member of Workers with Disabilities. I pay federal, state, Medicare taxes and am proud to be a productive citizen of society.

Please, continue to give Centers for Independent Living financial support, which is desperately needed to continue the education and hope to put people back in the communities and live happy, full Independent Productive Lives.

Please approve Senate Bill 2012.

Thankyou.

Sincerely,

Charmaine Y. Boehler

Charmaine Y. Boehler
4111 Lockport Street #109
Bismarck, ND 58503
(701) 223-6563

- March 8, 2011
- Attachment TWELVE

Testimony on SB 2012
Hose Appropriations Human Resources Division

Mr. Chairman and members of the committee my name is Chuck Stebbins and I am with the Qualified Service Providers Association of ND (QSPAND.org).

I am in support of anything that improves the HCBS system in SB 2012. A key part of the HCBS system is independent QSP's. We have heard a lot about oil and how much money the state has, and of course how much you all want to tuck away for a rainy day. We have heard a lot from legislators and the governor about investing more in the infrastructure of this state. But that conversation on infrastructure does not include people or services. As you well know the DHS is about people and services. It is the largest budget that you people have to deal with. But as organizations come before you and argue the points on how many children are still not insured in this state, you do not raise the poverty level to a point that would cover more kids, and yet you would not hesitate to put as much money as you need to get the maximum amount of federal dollars to improve roads. This is a misplaced priority in my opinion and I believe that you really need to think more seriously about the infrastructure of people and services. Investing in QSP's is one way you can improve that infrastructure. A rate increase of .50 is a good step forward but it is no where near what these people are worth. Every independent QSP that is working for someone in this state is working for someone who would normally have had to go to a nursing home to get the care that they need. I guarantee you when you crunch the numbers on what it costs for most of those independent QSP's to keep a consumer in their own home will be no where near the cost of a nursing home. That investment in Independent QSP infrastructure translates to saving this state money on the rising costs of institutional care. You've seen the numbers, and you have dealt with this funding for a number of sessions, and you have made decisions to improve HCBS over the years, but the gap between nursing home costs and HCBS costs still remains at around 90% to 10% respectively. This gap has got to begin to close, please invest more in HCBS....thank you.

Hello. My name is Tiffany Bauman and I am a QSP and I have been running an Adult Family Foster Care home for over a year now and we have 2 clients. The maximum we can make a day is $70.07 and I believe that maximum should be increased because we are here with them 24 hours a day which really calculates out to be $2.91 per hour which is way below minimum wage. If this rate was increased more people could continue to be QSP's and for the work we do we are not being fairly compensated.

Thank you,

Tiffany Bauman
QSP
Hope House

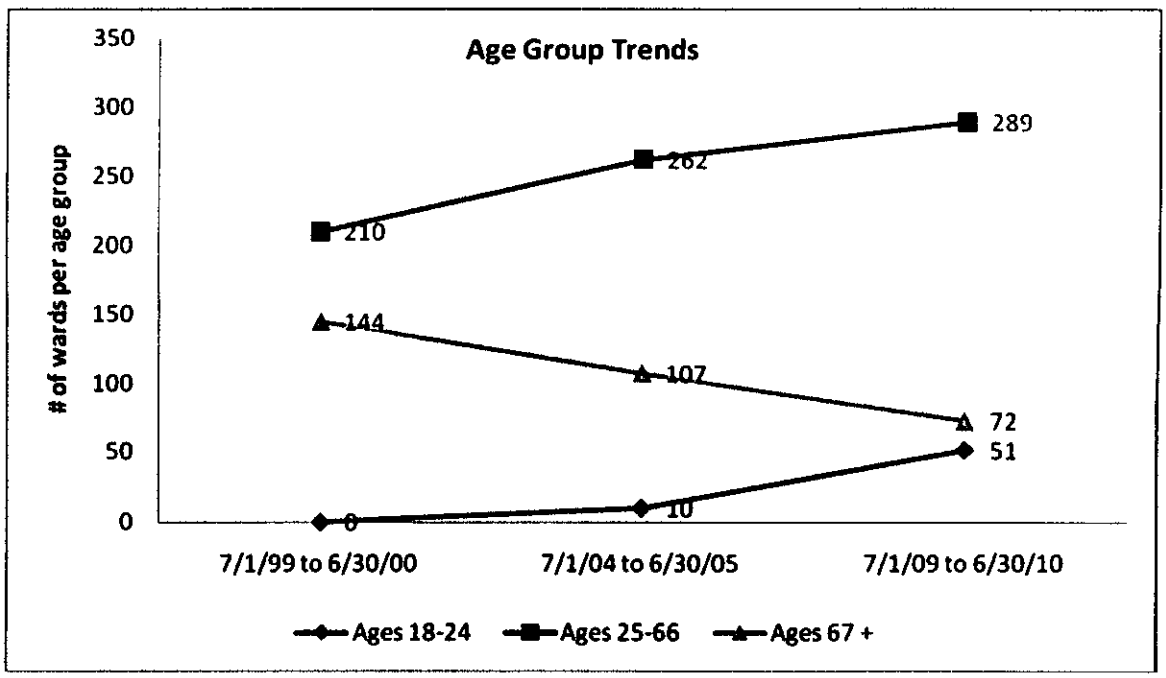
-SB 2012
-Mar. 8 PM

2) The 2007 and 2009 legislative appropriation of $29,750 no longer adequately covers the legal costs related to the establishment of guardianships;
3) Because of a great number of referrals, it is highly possible that a waiting list for services will need to be established before the end of this biennium.

1) Increased service needs and caseload size:

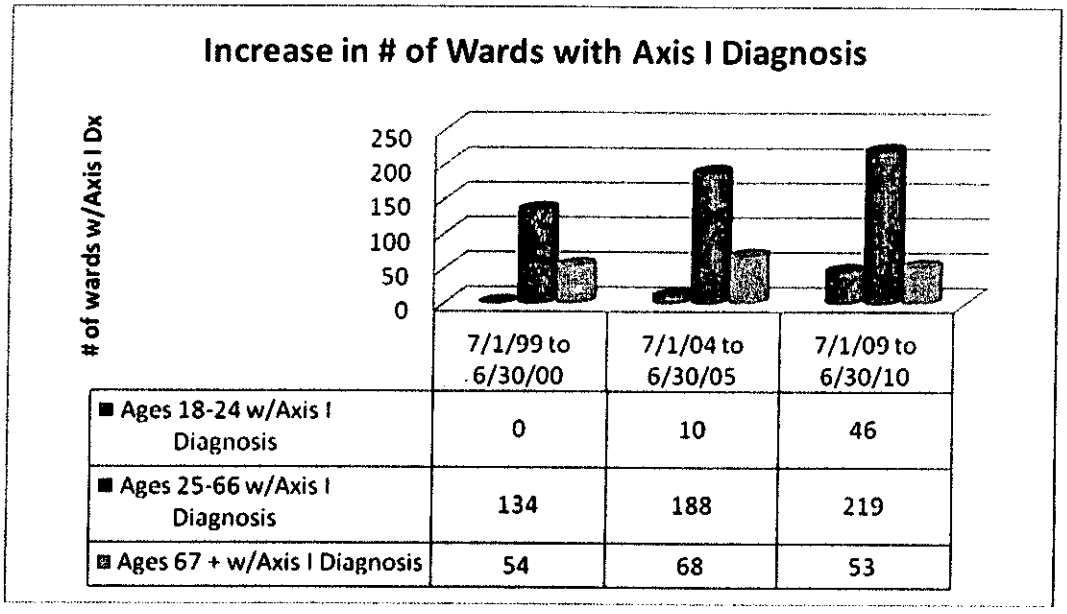
Since 2002, our corporate guardianship program has seen an increase in the behavioral, psychiatric, chemical dependency, sexual health, legal and supervision needs of our wards. This places heavy demands on our guardianship workers.

- From 7/1/99 to 6/30/00, our guardianship program had no wards between the ages of 18 to 24. From 7/1/09 to 6/30/10, we served as guardian for 51 wards between the ages of 18 to 24.



- Wards in this age group typically have needs that are very time intensive because of psychiatric concerns, behavioral difficulties, alcohol/drug use, sexual health and legal issues. Because of complex needs, frequent team meetings are the norm as well as frequent face to face visits.

Guardianship workers can expect numerous contacts with psychiatrists, psychologists, physicians, family members, attorneys, landlords and law enforcement.



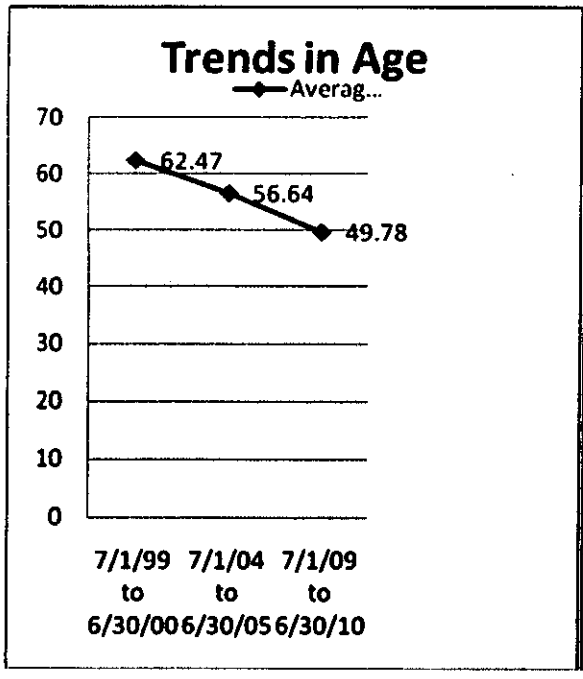
	7/1/99 to 6/30/00	7/1/04 to 6/30/05	7/1/09 to 6/30/10
Ages 18-24 w/Axis I Diagnosis	0	10	46
Ages 25-66 w/Axis I Diagnosis	134	188	219
Ages 67 + w/Axis I Diagnosis	54	68	53

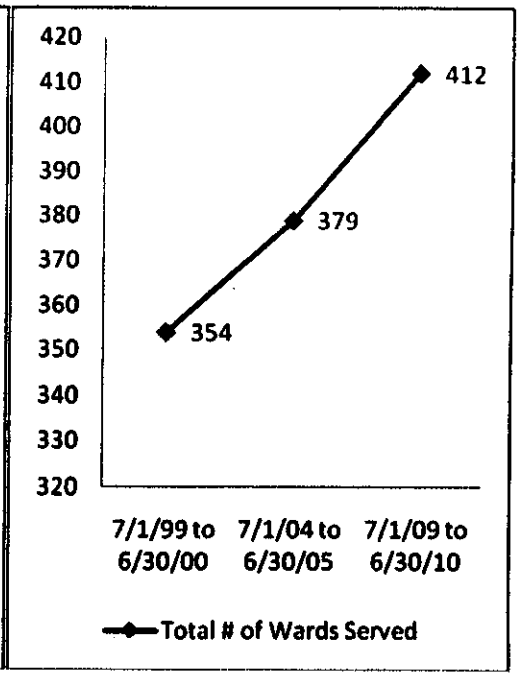
(Axis I disorders are clinical mental health conditions that warrant clinical treatment such as anxiety, depression, or Bipolar disorder. These disorders usually disrupt a person's ability to function adequately and left untreated can lead to problems in work, school, family, etc.)

- During the past several years, there has been a significant increase in the number of family members who are upset that the courts have appointed a corporate guardian for their son, daughter or sibling (all ages not just the age group of 18 to 24). Disgruntled family members place a high demand on our guardianship workers in terms of time, effort and energy.
- Overall, the complexity of cases has changed a great deal over the past 23 years. Twenty years ago, the majority of our wards resided at the Developmental Center, nursing homes and group homes. During the past decade, the shift has been to Individualized Supported Living Arrangements (ISLA), Supported Living Arrangements (SLA), Transitional Community Living Facilities (TCLF) and Minimally Supervised Living Arrangements (MSLA) which translates to more

Date	Net Number of Wards for Full Fiscal Year	Number of Active Cases on Final Day of Fiscal Year
6/30/08	6	380
6/30/09	8	388
6/30/10	6	394
6/30/11	16 (projected)	410 (projected)
6/30/12	10 (projected)	420 (projected)
6/30/13	10 (projected)	430 (projected)

From 9/1/10 to 12/31/10, an unprecedented number of 19 individuals with developmental disabilities were referred for corporate guardianship services, bringing our current referral total to 20 individuals. It is highly possible that our program will reach its capacity of 414 wards by the end of the current biennium which will result in a waiting list for services. Please note that if a person with developmental disabilities is in a life-threatening situation, we immediately accept that referral and provide guardianship services once the court makes that appointment. To insure corporate guardianship services are available for vulnerable adults who are in crisis and at risk of abuse or harm, we are requesting funding for fifteen (15) additional openings which increases our capacity to 429 wards.





- Attachment 5/X
- Mar 8, 2011

PRAIRIE ST. JOHN'S™

- SB 2012

March 7, 2011

Dear Committee Members:

I am Dr. Emmet M. Kenney, Jr., a Child and Adolescent and General Psychiatrist. I am here today to speak on behalf of Prairie St. John's and the North Dakota Hospital Association, of which I am a member of the Governing Board. We are here to speak in strong support for Senate Bill 2012 and recommend your passage of this bill.

I wish to speak specifically to the mental health and substance abuse portions of this bill. Under the leadership of Executive Director Carol Olson, the Department of Human Services undertook Stakeholders' Meetings in both the eastern and western parts of the state beginning last winter. They carefully considered the input of providers and consumers of mental health and addictions treatment in making recommendations to Governor Dalrymple for his budget proposal. Governor Dalrymple's budget contains a realistic affirmation of where we are currently at in the State of North Dakota in the provision of psychiatric and addictions care and where we need to go. Highlights of this bill as it pertains to mental health and addictions:

1. Supports community-based treatment. Community-based treatment is less expensive and more accessible to North Dakota citizens than the alternative of simply funding treatment at the Jamestown State Hospital or various Human Service Centers. It is more respectful of patient choice, and leverages the available resources in communities beyond those currently provided by DHS HSCs.

2. It provides for services to be according to the patient's level of need. Therefore, expanded services such as residential treatment or crisis services could be offered as an alternative to the more expensive and more time constrictive hospital services that currently fill the gap when clinic level care alone is not appropriate for the patient populations.

Switchboard
701.476.7200
Administration
701.476.7228
[redacted]76.7261
[redacted]0 4th Street South
PO Box 2027
Fargo, ND 58107-2027

www.prairie-stjohns.com

[redacted]ing Hope
[redacted] Healing to
[redacted]ose Suffering
from Psychiatric
Conditions and
Addictions

3. Operates in fairness to providers already providing mandated care without payment, so they have an opportunity to partake in a contractual relationship for providing these services to North Dakota citizens.

In summary, we strongly urge you to issue a "do pass" recommendation on this important legislation of Senate Bill 2012. I am happy to address any questions that you may have.

Sincerely,

Emmet M. Kenney, Jr., M.D.

- Attachment FIVE

Testimony
Senate Bill 2012 - Human Resource Division
House Appropriations Committee
Representative Chet Pollert – Chairman
March 8, 2011

Chairman Pollert and members of the Human Resources Division of the House Appropriations Committee, my name is Susan Rae Helgeland. I am Executive Director of Mental Health America of ND (MHAND). Our non-profit is 59 years old in ND and 102 years old nationally. Our Mission is to promote mental health through advocacy, education, understanding and access to quality care for all individuals.

An average of one individual dies by suicide every four days in ND. Suicide is the fourth leading cause of death in ND preceded only by cancer, heart disease and accidental deaths. (CDC Report). People are dying because help is not available due to the stigma that still surrounds mental illness and the barriers to access behavioral (mental illness and substance use) health services.

I recently received a letter from someone in a ND county jail who says he has a diagnosis of paranoid schizophrenia. He has been denied medication. If he had diabetes, would he be denied insulin? The question I have is, why is this happening in ND? Why are there so many people with behavioral health issues in prison in the first place?

I want to share a personal story with you of an individual that came to my attention a couple of weeks ago. He gave me his permission to use his name only to help others and to talk to legislators. He is a member of the Myrt Armstrong Center (MAC) in Fargo. It is a recovery center that the ND Legislature funds to help provide community support for people with mental illness who are participating in recovery.

Brian Speaker, Fargo, writes, "*I have tried everything on an honorable and honest level to convince the people who I trust with my care to pay attention when I tell them things are headed towards self Injury. I have a new case manager who is probably one of the hardest working people I know, who have even tried to get help and a new advocate who is a Social Worker. Great people who fully understand how important it is for me to avoid impulse and seek and get help with safety when I'm really in trouble.*

Today I was failed by 3 doctors/systems and could not get access:
1) the doctor didn't know me well enough to understand how imperative it was to get the support needed when faced with the last option;
2) a crowded system to the point where people occupy crisis beds for 3-4 weeks at a time (A serious lack of access);
3) dealing with an undereducated ER Doc who is communicating my situation to a doctor who knows me, but loses the message along the way resulting in No Admit.

I today also failed myself. 19 months erased. 11 cuts, none requiring stitches. Why am I still home? My case manager and advocate will have been made aware of this failure on my part by the time you see this. I'm almost certain of the severity of the consequences even though I was loud and clear with my needs that were not met.

I guess I am asking for a clue being the providers lately I have made decisions to put their blinders on until the act was done. Now it would be punishment for me to endure a hospitalization even though the event has passed. It wouldn't surprise me in the least that I would be sent inpatient even though it's way too late for that."

I bring you these two stories that recently have come to my attention to demonstrate the behavioral health crisis that exists in our state. MHAND, though grant support, has produced a documentary. We have presented it in several venues and it will be statewide on cable public access television. The documentary is called, *Resolana: Voice of the People. Resolana: Voice of the People*, a documentary recently produced by MHAND, is about personal testimonies by real rural ND behavioral health consumers and providers telling their stories. Every one of the eight who were interviewed for the documentary talked about the weeks and sometimes months of waiting to see a provider. After a diagnosis is made, the individuals interviewed said there are very little to no case management services to help support recovery in the community and to help the individual stay out of the hospital or jail.

I have been involved in advocacy since 1964 when, as a senior in Social Work at UND, I visited the ND State Hospital. I saw over 2000 people segregated in the state hospital and "zoned out" in what, at that time, were the drugs of choice, Haldol and Thorazine. I was shocked to see that individuals, through no fault of their own, were warehoused in this way. I was so shocked that it has motivated me to be an advocate for the last 47 years. I was hoping that by now I would have worked myself out of a job. But sadly, that is not the case.

Deinstitutionalization happened in the 70's. It happened without a comprehensive transition plan for individuals to be able to be successful and live independently in the community after leaving the various state hospitals. There were no community-based or support services in place. Now we have, in my words, reverse deinstitutionalization, prison. For example more that 65% of people in the ND Corrections System have, or are experiencing behavioral health symptoms. ND is critically short of behavioral health services including in-patient care. The State Hospital has a waiting list as well as many of our regional human service centers.

Community based out-patient and support services are under-funded when compared to people with intellectual disabilities, nursing home services and, of course, all other medical illness like diabetes, arthritis, heart disease, etc.

Governor Dalrymple has included funding to help meet the current needs of people with behavioral health issues in his budget. MHAND applauds and supports the Department of Human Services budget as it relates to specific line items for behavioral health issues.

However, MHAND is concerned about systemic change and therefore supports the OAR request, # 703, for the MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT. Psychiatric care delivered in general hospitals and freestanding psychiatric hospitals is an integral component of community-based care for people with mental illnesses. With a 30% decline in inpatient psychiatric beds over the past two decades, it is hard to find beds for individuals needing mental health care services. Individuals with mental health needs are diverted to emergency rooms or travel long distances to receive care.

In a June 1, 2009, Government Accountability Office report (GAO-09-347) on hospital emergency departments, it was reported that difficulties in transferring, admitting, or discharging psychiatric patients from the emergency department were a factor contributing to emergency department overcrowding.

Medicaid is vital for people with mental disorders, funding more than 50% of state and local spending on behavioral health services. Community-based psychiatric hospitals could help relieve this access problem; however, due to a Medicaid provision called the Institution for Mental Disease exclusion, patients receiving care in these hospitals are not covered for their care if the patients are between the ages of 22-64.

The Medicaid Emergency Psychiatric Demonstration Project will expand the number of options available in communities by establishing a three-year demonstration project. Among other things the demonstration will allow states to cover patients in non-governmental freestanding psychiatric hospitals and receive Federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms and improve the efficiency and cost-effectiveness of inpatient psychiatric care.

Key immediate issues are:

1. Three-year demonstration/Medicaid dollars became available 10/1/10.
2. States must contribute their $1.2 million match dollars to the $1.4 million Federal match.
3. States may apply to the HHS Secretary for approval on a competitive basis.
4. The Centers for Medicare and Medicaid Services is developing a Request for Proposal, which may be made available in the Federal Register by April 2011, demonstration projects chosen by summer, and money provided to demonstrations in October 2011.

The IMD Demonstration Project is part of the solution to the over-crowding of the ND State Hospital and it will increase access to crisis beds in the communities.

While MHAND supports the Governor's Budget, we ask you to make a long term decision by supporting an amendment attached for your consideration. Thank you for the opportunity to testify today.

I will be happy to answer any questions.

National organizations endorsing the IMD Demonstration Project:

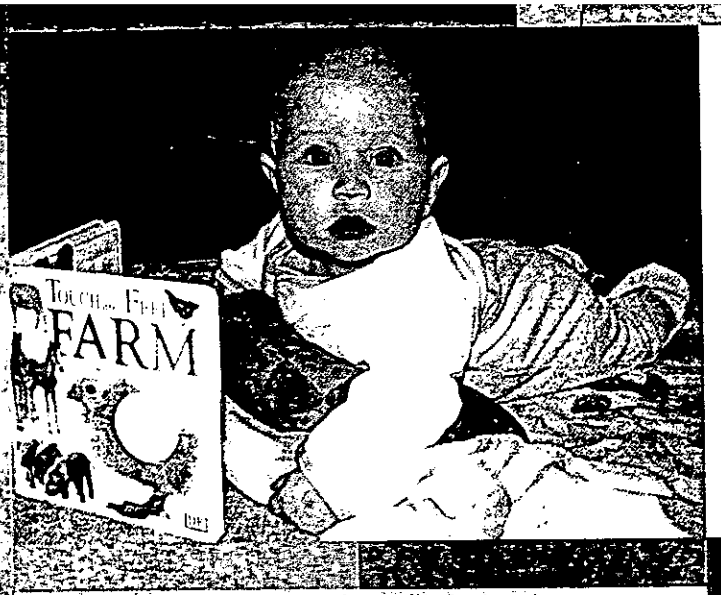
American Academy of Child and Adolescent Psychiatry * American Association for Geriatric Psychiatry * American Association for Marriage and Family Therapy * American Association of Pastoral Counselors *American College of Emergency Physicians * American Counseling Association * American Group Psychotherapy Association * American Hospital Association * American Mental Health Counselors Association * American Psychiatric Association * American Psychiatric Nurses Association * Anxiety Disorders Association of America * Association for Ambulatory Behavioral Healthcare * Association for Behavioral Health and Wellness * Child Welfare League of America * Children and Adults with Attention-Deficit/Hyperactivity Disorder * Clinical Social Work Association * Eating Disorders Coalition * Emergency Nurses Association* Federation of American Hospitals * National Alliance on Mental Illness* National Association for Children's Behavioral Health * National Association of County Behavioral Health and Developmental Disability Directors * National Association of Psychiatric Health Systems *National Association of Rural Mental Health * National Association National Association of Rural Mental Health * National Association of Anorexia Nervosa and Associated Disorders * National Coalition of Mental Health Professionals and Consumers, Inc.* National Foundation for Mental Health* Therapeutic Communities of America.



ll **Prevent Child Abuse** America Chapters
nare the Vision of a culture (and a *cultural*
ttitude) wherein the well-being of children is
niversally understood and valued; and where
aising children in surroundings which ensure
ealthy, safe and nurturing experiences is
upported by the actions of every individual
nd every community.

t is a Vision in which it becomes the norm for
ll parents and caregivers to seek and accept
ualified support regarding the knowledge
nd skills required for effective parenting and
hild development; and for the general public
o become educated and engaged in
upporting the well-being of children.

And it is a Vision wherein "preventing child
buse" no longer describes the cause we each
upport; but rather, begins to define the effect
of everything we do to help children and
amilies.



Contact us at:

418 East Rosser Avenue Suite 110
PO Box 1213
Bismarck, North Dakota 58502-1213

Phone: 701-223-9052
ND Toll Free: 1-800-403-9932
Fax: 701-355-4362
Email: info@pcand.org

We work in partnership with the ND Department of Human Services, whose financial support helps us maintain our free to low-cost programs and services.

Prevent Child Abuse
North Dakota

www.P D.org

Prevent Child Abuse
North Dakota



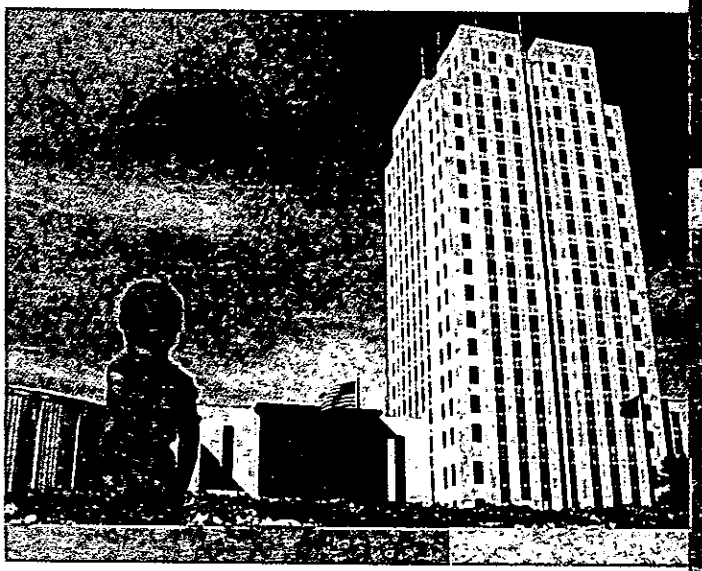
You can make a difference in the life of a child!

A Chapter of
Prevent Child Abuse America

Prevent Child Abuse

North Dakota

is committed to a safe and nurturing environment, free from abuse and neglect for all children.



About us:

Prevent Child Abuse North Dakota (PCAND) is an independent 501(c)3 nonprofit, that has been working to improve the lives of children and families since 1978.

We do this through:

- Public Awareness and Education
- Training and Technical Assistance
- Coordination of Services
- Strategic Partnerships
- Advocacy

Our Programs

The Wakanheza Project teaches community members to appreciate, assure and help parents particularly when they are trying to deal with a child's tantrum. Trainers also offer site-specific advice to turn areas of common child power struggles, like checkout lanes and waiting rooms, into kid-friendly environments.

The Happiest Baby on the Block works to prevent child abuse and neglect associated with excessive infant crying, colic and parental exhaustion, providing simple tools to help combat post partum depression, bonding failure, marital stress and shaken baby syndrome.

Authentic Voices provides opportunities for survivors of child maltreatment to educate adults and protect children by sharing their Voice. Members receive training and logistical support as they advocate for children and families at events across North Dakota.

Circle of Parents provides a friendly, supportive environment led by parents and other caregivers. It's a place where anyone in a parenting role can openly discuss the successes and challenges of raising children. Where they can find and share support.

Community Outreach

Services:

- Educational booklets, posters and magnets
- Video and book lending library
- Newsletters
- Program assistance
- On-site consultations
- Presentations and training



CAP Month

April is Child Abuse Prevention (CAP) Month, a time which reminds us of our important individual and collective responsibilities to help raise North Dakota's children. This month's symbol, the pinwheel, stands for hope, health and happiness – bright futures all children deserve. PCAND provides materials, funding and support to coalitions of volunteers as they bring public awareness events to their communities.

- Attachment TWO

Testimony
SB 2012- Department of Human Services
House Appropriations Human Resource Committee
March 8, 2012

Chairman Pollert and members of the House Appropriations Human Resource Committee, my name is Shari Doe. I am the Director of Burleigh County Social Services here in Bismarck. I'm also the President of the ND Association of County Social Service Directors and I am here to speak in support of Senate Bill 2012.

Local county Social Service agencies are instrumental in carrying out the work of the Department of Human Services. In North Dakota's state supervised, county administered system, the Department depends on county social service agencies to provide services. Counties depend on the department for direction and resources to carry-out this work. I wish to speak to a few issues that are important to the counties and how those issues fit within SB 2012.

- The FMAP decrease has a significant increase on the Department's budget, $171.4 million, I believe. The FMAP decrease means that North Dakota has a growing economy and rising personal incomes. It seems counter intuitive then that at the same time the FMAP rates goes down, the number of Medicaid recipients are increasing. In Burleigh County, the number of Medicaid/SNAP recipients has increased over 25% in the past three years – the fastest growing Economic Assistance program we administer. Counties pay for the workers needed to determine Medicaid eligibility, and the non-federal share of our Medicaid reimbursed programs such as, Targeted Case Management for Child Welfare case management. Counties bill Medicaid for the full amount of the service. The state then turns around and bills the counties for the non-federal share. With the FMAP decrease, the amount counties are billed (the non-federal share) will increase proportionally to the Medicaid cost increases realized by the state.

- The federal Health Care Reform legislation as it currently stands calls for an expansion of the Medicaid Program to all individuals at 133% of poverty. And though this implementation is a couple of years away, we are beginning to look at how determining eligibility for all the newly eligible Medicaid recipients will affect counties. Currently, county Eligibility Workers

determine client eligibility for Medicaid. Counties are wondering how continued increases in Medicaid cases will impact staffing, technology and space needs. The "word on the street" has been that North Dakota could expect up to 30,000 individuals newly eligible for Medicaid. With such a significant increase in Medicaid recipients, counties would have to add additional workers to meet the increased demand and additional space to house the workers. That is, unless the health insurance exchange takes over the determination of Medicaid eligibility. In that case, counties may actually be able to reduce the number of workers responsible for determining Medicaid eligibility because the health insurance exchange will take over that function. What happens in Washington D.C. and here the North Dakota Legislature will ultimately determine how we move ahead with the implementation of the Patient Protection and Affordable Care Act. However, when North Dakota does adopt legislation to meet federal requirements, consideration must be given to the role counties play in the administration of Medicaid benefits.

- Computer technology in the administration of programs is a key area in which counties depend on the Department of Human Services. A continuing need for county social service agencies has been for a comprehensive Eligibility Computer System to determine eligibility for all programs including: the Medicaid Program, the Supplemental Nutritional Assistance Program (SNAP formerly known as Food Stamps), Temporary Assistance to Needy Families Program (TANF), Low Income Home Energy Assistance Program (LIHEAP), Foster Care Payment Program and Child Care Assistance Program. At this time, county eligibility workers must enter data in four different aged computer systems (NATL, TECS, VISION, and CCWIPS) to determine eligibility for a single combined case. And though EW's are quite adept at making these systems work, having to work within four different computer systems is inefficient, difficult to learn and prone to error. The Eligibility System re-write did not make it into the Governor's budget. I understand, however, that the Industry, Business and Labor Committee is considering legislation on behalf of the Insurance Commissioner's office (HB 1126) regarding establishment of a Health Insurance Exchange in accordance with the Patient Protection and Affordable Care Act. An amendment has been offered for the Eligibility System re-write so that Medicaid and Healthy Steps (Children's Health Insurance Program) are able to interact with the Health Care Exchange. Although this is a round-about-way to address the aging and cumbersome Eligibility System, we very much support the state's efforts to move ahead with an Eligibility System re-write. In this

day of continuous program changes, more complex policies and high quality performance standards, a computer system that allows workers to deliver timely and accurate benefits is essential. And just to clarify, the MMIS system will not address the eligibility issues I've just described. MMIS is a Medicaid payment and benefits management system and not intended for eligibility determination.

- Another important computer system needing attention is Frame. Frame is the North Dakota's child welfare data management system. Frame was created by Information Technology Division in collaboration with the Department of Human Services and counties for foster care and child abuse neglect case management purposes. It combined two functioning systems (CCWHIPs and the Child Abuse and Neglect data-base system) so child welfare workers would have a less complicated system for case documentation and the state would have a single source for data collection. Additionally, the system was designed to meet reporting and documentation requirements of the Children and Family Services Performance Improvement Plan. Frame is relatively new. It was rolled out as a pilot in Burleigh County in September 2009 and implemented state-wide shortly after that. We applaud the Department's efforts to improve the child welfare computer system, but enhancements to the system are necessary to make Frame the single source of documentation and data-collection as originally intended. The project was under-funded so critical programming had to be eliminated due to budget constraints. Enhancements to Frame will improve efficiency at the state, regional and county level. We strongly encourage additional resources be directed towards Frame enhancements.

- In the area of child welfare, counties are constantly in "putting out fires" mode. And though we all talk about the value of prevention services, the reality is that the "in your face" emergencies and the "deep end" families take up the majority of our resources. Services such as home visiting programs, parent resources centers, early intervention case management, intensive in-home services, family team/group decision making all significantly impact on a family's ability to provide safe, nurturing parenting. Family Preservation services such as safety and permanency funds, parent aides, and case management are often the critical difference between being able to keep a child at risk in the home, or taking custody away from a parent and placing the child in foster care. Early intervention with a family in stress is much more efficient and cost-effective

than working with a family already in the system. The problem is that the child welfare workers are so busy with the "really bad" cases; we do not have the time or resources to do the prevention work we'd like. The Department of Children and Family Services is very committed to prevention as an overall strategy but that does not address the fact that some secondary prevention services are not available throughout the state. Burleigh County and Cass County will be able to offer family team decision making services to every family at risk of losing custody of their child. This service is not available anywhere else. The Minot region has access to Family Group Decision-Making and the Bismarck Region does not. Grand Forks and Burleigh/Morton have access to Healthy Families, a home visiting program. Efforts to enhance funding for these child abuse and neglect prevention services were defeated on the Senate side. We understand the Department's limitations in making these resources available to more North Dakota families, but we must invest more in prevention and intervention services. These children are our future.

In conclusion, all aspects of the human service budget, impact the citizens of our counties. As I stand up here and speak about computer systems and health care reform and lack of resources it's easy to forget that what we do is about improving the lives of people.

Chairman Pollert and members of the Committee thank you for the opportunity to provide testimony on SB 2012 and I would be happy to address any questions you may have.



ADVANTAGES OF PARTICIPATING IN NORTHLAND PACE SENIOR CARE SERVICES INCLUDE:

- Dedicated, qualified healthcare professionals
- Long-Term Care Services
- Coordinated care 24 hours a day, 365 days a year
- Support for family caregivers
- Personalized individual care

THE COST

The **Northland PACE Senior Care Services** program accepts Medicare and Medicaid.

There are no hidden costs, co-payments or deductibles for any **PACE** services. Your Care Team will determine what medications, services and supplies are necessary for your care. The cost for these services are paid for and provided by **Northland PACE Senior Care Services.**

PARTICIPATION AND DISENROLLMENT:

- Participants receive all of their health care from Northland PACE, except for emergency services.
- Because PACE provides and is responsible for all of your care, you may be held financially responsible for any care you receive outside the program that is not approved by the PACE program.
- Participants may disenroll from the program at any time.
- Northland PACE offers Medicare Part D prescription drug coverage. If you are in a PACE program, you don't need to join a separate Medicare drug plan. If you do, you will lose your PACE health and prescription drug benefits. If you enroll in another Part D program, it will result in your disenrollment from PACE.

Mission Statement

Northland PACE Senior Care Services promotes independence through the coordination of all health services, allowing participants to continue living safely and with dignity at home.

Northland PACE Bismarck
201 N. 24th Street • Bismarck, ND 58501
701-751-3050

In Bismarck, we serve the following zip codes:
58501-58502-58503-58504-58554-58558

Northland PACE Dickinson
830 2nd Ave. East, Suite 212
Dickinson, ND 58601 • 701-456-7387

In Dickinson, we serv[illegible]ollowing zip codes:
58601-58602-5[illegible]8655-58680

NORTHLAND PACE

Senior Care Services

Program of All-Inclusive Care for the Elderly



DEDICATED TO
PROVIDING
THE *highest level* OF CARE
TO SENIORS IN OUR [illegible]MUNITY



Northland PACE

Senior Care Services

(Program of All-inclusive Care for the Elderly)

HOME. It is where we want to be. Home is where the heart is. It is where people who love each other gather, and it is where older adults want to live out their days.

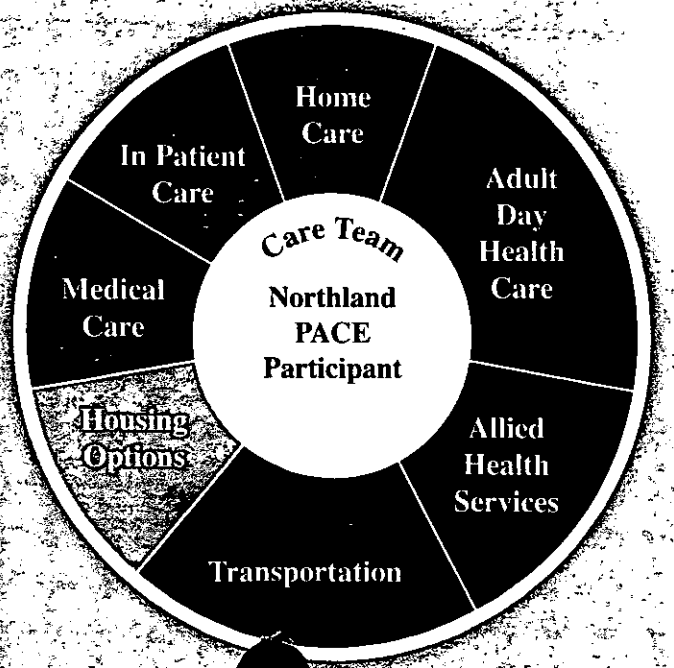
Northland PACE Senior Care Services is designed to keep seniors who are at risk for nursing home care, living independently at home by providing the highest level of healthcare. This includes health-care appointments to help participants remain as healthy and independent as possible.

The program includes medications, eye glasses, hearing aids and other assistance that **PACE** doctors may prescribe. Additional services may include in-home assistance ... personal care such as bathing, dressing, housecleaning, meals and nutritional counseling.

THE TEAM APPROACH

Northland PACE Senior Care Services employs a group of professionals called a Care Team that coordinates all aspects of healthcare and in-home services for **PACE** participants. This team of specialists includes a physician, nurse practitioner, registered nurse, social worker, health aides and several others who will assist in your healthcare. Families are encouraged to be actively involved in decision making.

As a participant's needs change, their care plan will change to meet any new situation. If hospitalization or nursing home placement is required, **Northland PACE Senior Care Services** covers the cost.



ELIGIBILITY REQUIREMENTS

- Be at least 55 years old
- Be in need of long-term care services
- Be able to live safely at home
- Live within an area served by **Northland PACE**

RANGE OF SERVICES

These services are based on the needs of each individual. Additional services may be necessary to maintain and improve the health of the individual. These are determined by the Care Team.

- Primary Care and Specialty Medical Care
- All Prescription drugs
- Adult Day Center with therapists
  • Physical • Occupational • Recreational
- Healthcare Specialists
  • Audiology • Dentistry • Optometry
- Dietary Services
  • Meals and Nutritional Counseling
- In-Home Support and Care
- Rehabilitation and Restorative Therapies
  • Speech Therapy • Physical Therapy
  • Recreation Therapy • Occupational Therapy
- Social Services
- Transportation
- Hospital Emergency Care and Nursing Home Care when necessary

north dakota department of human services

Fact Sheet

March 2009

Program of All-inclusive Care for the Elderly (PACE)

Background:

- The Balanced Budget Act of 1997 established the PACE model for both Medicaid and Medicare programs.
- PACE providers receive a set amount of money on a monthly basis for each eligible Medicare and Medicaid enrollee to provide patient-centered and coordinated care to frail elderly individuals living in the community.
- PACE has been approved by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidenced based model of care.

What is PACE?

PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

Who Can Participate?

Participants must:

- Be a Medicare or Medicaid enrollee who is age 55 or older,
- Be eligible for nursing home level of care, and
- Live in a PACE service area.

PACE Services:

The emphasis of the PACE program is on enabling participants to remain in their community and enhancing their quality of life. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services if necessary). Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. The services are provided primarily in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs. PACE is a voluntary program.

Location:

The Northland Healthcare Alliance has developed two PACE organizations in North Dakota. They are located in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

Contact Information:

For information about PACE and how to enroll into the program, contact Northland PACE:

- Bismarck 701-751-3050
- Dickinson 701-456-7387
- Toll Free 1-888-883-8959

Estimated State Expense - 2-year Site Expansion

Year 1: 1-Site

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 1 PPTs
James - # of PPTs	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	***12***
M/Caid-Jmst	$4,500	$9,000	$13,500	$18,000	$22,500	$27,000	$31,500	$36,000	$40,500	$45,000	$49,500	$54,000	**$351,000**
Medicare	$2,000	$4,000	$6,000	$8,000	$10,000	$12,000	$14,000	$16,000	$18,000	$20,000	$22,000	$24,000	**$156,000**
Total Expense	**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$45,500**	**$52,000**	**$58,500**	**$65,000**	**$71,500**	**$78,000**	**$507,000**

Year 2: 2-Sites

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Year 2 PPTs
James - # of PPTs	*13*	*14*	*15*	*15*	*16*	*16*	*17*	*17*	*17*	*18*	*18*	*18*	***18***
Fargo - # of PPTs	*2*	*4*	*6*	*8*	*10*	*12*	*14*	*16*	*18*	*20*	*22*	*24*	***24***
M/Caid-Jmst	$58,500	$63,000	$67,500	$67,500	$72,000	$72,000	$76,500	$76,500	$76,500	$81,000	$81,000	$81,000	**$873,000**
M/Caid-Fargo	$9,550	$19,100	$28,650	$38,200	$47,750	$57,300	$66,850	$76,400	$85,950	$95,500	$105,050	$114,600	**$744,900**
Medicare	$30,000	$36,000	$42,000	$46,000	$52,000	$56,000	$62,000	$66,000	$70,000	$76,000	$80,000	$84,000	**$700,000**
Total Expense	**$98,050**	**$118,100**	**$138,150**	**$151,700**	**$171,750**	**$185,300**	**$205,350**	**$218,900**	**$232,450**	**$252,500**	**$266,050**	**$279,600**	**$2,317,900**

2-Year Totals

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL PPTs
# of PPTs	*15*	*18*	*21*	*23*	*26*	*28*	*31*	*33*	*35*	*38*	*40*	*42*	*42*
Medicaid	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Medicare	$32,000	$40,000	$48,000	$54,000	$62,000	$68,000	$76,000	$82,000	$88,000	$96,000	$102,000	$108,000	**$856,000**
Total Expense	**$104,550**	**$131,100**	**$157,650**	**$177,700**	**$204,250**	**$224,300**	**$250,850**	**$270,900**	**$290,950**	**$317,500**	**$337,550**	**$357,600**	**$2,824,900**

Estimated Savings: PACE vs. Nursing Home

2-Year Totals

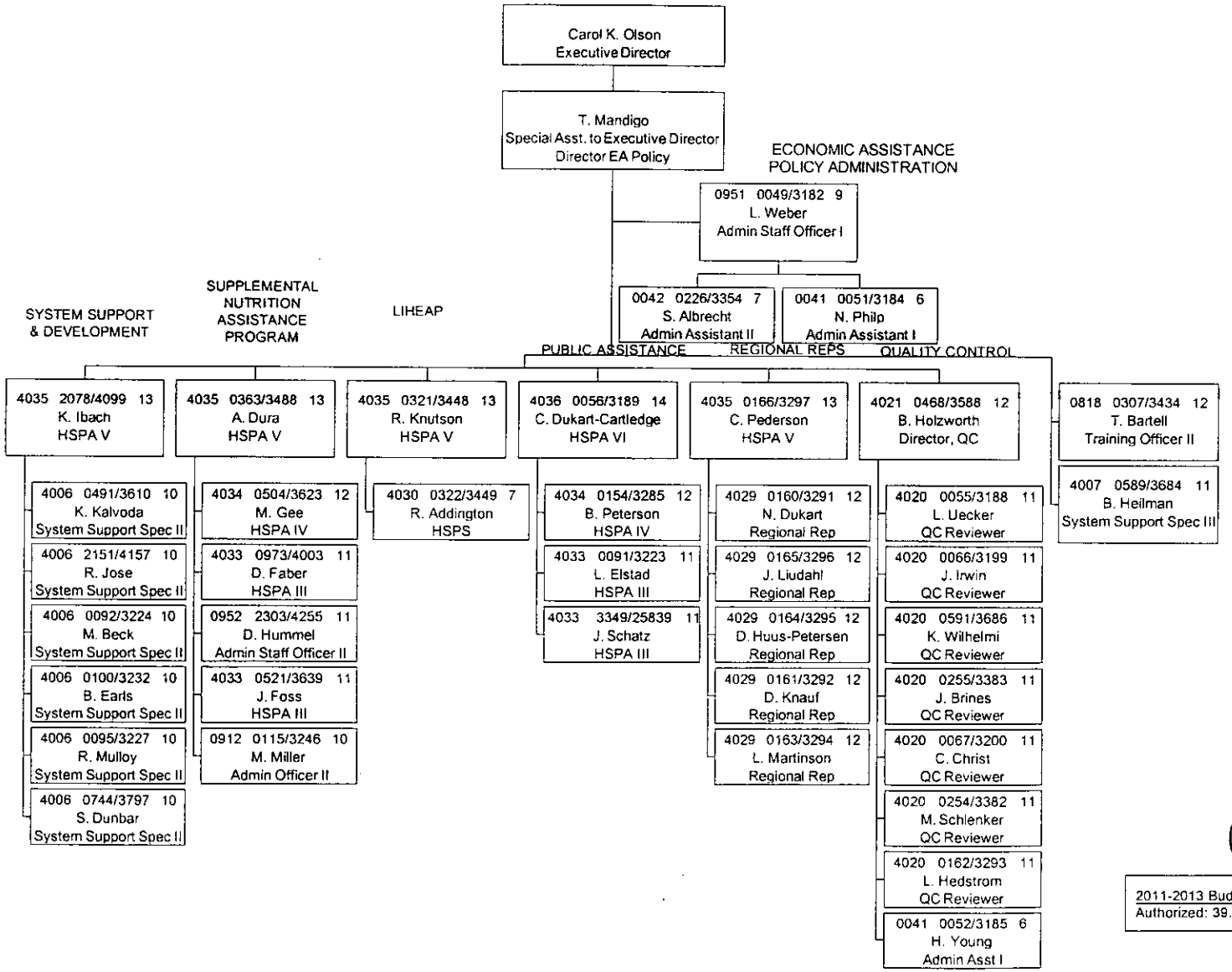
	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	TOTAL
SNF	$101,680	$127,100	$152,520	$171,585	$197,005	$216,070	$241,490	$260,555	$279,620	$305,040	$324,105	$343,170	**$2,719,940**
PACE	$72,550	$91,100	$109,650	$123,700	$142,250	$156,300	$174,850	$188,900	$202,950	$221,500	$235,550	$249,600	**$1,968,900**
Total Savings	**$29,130**	**$36,000**	**$42,870**	**$47,885**	**$54,755**	**$59,770**	**$66,640**	**$71,655**	**$76,670**	**$83,540**	**$88,555**	**$93,570**	**$751,040**

Current Average Savings:

**** 15 % of 56 PPTS are in SNF**

SNF Avg Cost =	$53,340	($6355 average per month)
PACE Avg Cost =	$35,860	($4269 average per month)
	$17,480	**Current avg. savings per month**

North Dakota Department of Human Services
Economic Assistance Policy Division



- March 9, 2011
- Attachment ONE
- SB 2012
- James Flemming
Tave Mandigo

Revised 2/25/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-01 ECONOMIC ASSISTANCE POLICY - GRANTS											
S101		FULL-TIME EQUIVALENTS (FTEs)		39.800	38.800	0.000	1.000	0.000	39.800	0.000	39.800
32510	B	511000	Salaries - Permanent	3,138,214	3,738,507	1,681,185	(1,900)	0	3,736,607	0	3,736,607
32510	B	513000	Temporary Salaries	21,551	51,744	17,354	(5,951)	0	45,793	0	45,793
32510	B	514000	Overtime	14,585	28,392	4,754	24	0	28,416	0	28,416
32510	B	516000	Fringe Benefits	1,103,789	1,417,675	638,891	(33)	1	1,417,643	0	1,417,643
32510	B	599110	Salary Increase	0	0	0	0	165,516	165,516	0	165,516
32510	B	599160	Benefit Increase	0	0	0	0	27,990	27,990	0	27,990
32510	B	599161	Health Increase	0	0	0	0	56,950	56,950	0	56,950
32510	B	599162	Retirement Increase	0	0	0	0	37,920	37,920	0	37,920
32510	B	599163	EAP Increase	0	0	0	0	110	110	0	110
			Subtotal:	4,278,139	5,236,318	2,342,184	(7,860)	288,487	5,516,945	0	5,516,945
32510	F	F_1991	Salary - General Fund	1,571,312	1,920,349	886,199	(31,108)	123,401	2,012,642	0	2,012,642
32510	F	F_1992	Salary - Federal Funds	2,704,491	3,315,969	1,455,985	23,008	165,086	3,504,063	0	3,504,063
32510	F	F_1993	Salary - Other Funds	2,336	0	0	240	0	240	0	240
			Subtotal:	4,278,139	5,236,318	2,342,184	(7,860)	288,487	5,516,945	0	5,516,945
32530	B	521000	Travel	92,271	198,969	56,946	5,796	0	204,765	0	204,765
32530	B	531000	Supplies - IT Software	16,795	13,146	8,550	3,372	0	16,518	0	16,518
32530	B	532000	Supply/Material-Professional	6,750	2,385	947	555	0	2,940	0	2,940
32530	B	535000	Miscellaneous Supplies	0	0	0	20	0	20	0	20
32530	B	536000	Office Supplies	10,213	10,035	5,028	(869)	0	9,166	0	9,166
32530	B	541000	Postage	7,413	6,537	2,954	154	0	6,691	0	6,691
32530	B	542000	Printing	150,641	193,444	38,022	8,536	0	201,980	0	201,980
32530	B	553000	Office Equip & Furniture-Under	18,059	6,045	5,963	4,334	0	10,379	0	10,379
32530	B	561000	Utilities	541	580	218	342	0	922	0	922
32530	B	581000	Rentals/Leases-Equip & Other	1	0	0	0	0	0	0	0
32530	B	582000	Rentals/Leases - Bldg/Land	79,961	86,937	40,082	2,523	0	89,460	0	89,460
32530	B	591000	Repairs	4,759	4,415	2,048	131	0	4,546	0	4,546
32530	B	601000	IT - Data Processing	2,353	4,027	2,887	145	0	4,172	0	4,172
32530	B	602000	IT-Communications	12,675	14,514	6,583	2,918	0	17,432	0	17,432

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Subdivision: 300-01 ECONOMIC ASSISTANCE POLICY - GRANTS											
32530	B	611000 Professional Development		27,579	59,706	17,261	(12,607)	0	47,099	0	47,099
32530	B	621000 Operating Fees and Services		9,858,417	11,111,151	5,209,034	(23,800)	0	11,087,351	0	11,087,351
32530	B	623000 Fees - Professional Services		0	0	0	120	0	120	0	120
			Subtotal:	10,288,428	11,711,891	5,396,523	(8,330)	0	11,703,561	0	11,703,561
32530	F	F_3991 Operating - General Fund		491,544	548,362	294,329	(130)	0	548,232	0	548,232
32530	F	F_3992 Operating - Federal Funds		9,201,610	10,848,175	4,962,094	(48,643)	0	10,799,532	0	10,799,532
32530	F	F_3993 Operating - Other Funds		20,424	0	0	39	0	39	0	39
32530	F	F_3995 Operating - County Funds		574,850	315,354	140,100	40,404	0	355,758	0	355,758
			Subtotal:	10,288,428	11,711,891	5,396,523	(8,330)	0	11,703,561	0	11,703,561
32550	B	683000 Other Capital Payments		197	0	0	0	0	0	0	0
			Subtotal:	197	0	0	0	0	0	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		97	0	0	0	0	0	0	0
32550	F	F_5992 Land & Cptl Imprv - Fed Funds		100	0	0	0	0	0	0	0
			Subtotal:	197	0	0	0	0	0	0	0
32560	B	712000 Grants, Benefits & Claims		211,174,326	334,441,734	131,297,027	(3,190,164)	0	331,251,570	0	331,251,570
			Subtotal:	211,174,326	334,441,734	131,297,027	(3,190,164)	0	331,251,570	0	331,251,570
32560	F	F_6991 Grants - General Fund		2,558,926	8,207,776	4,477,424	670,622	0	8,878,398	0	8,878,398
32560	F	F_6992 Grants - Federal Funds		186,845,862	308,510,331	122,904,743	(4,527,005)	0	303,983,326	0	303,983,326
32560	F	F_6993 Grants - Other Funds		6,925,815	3,320,992	1,067,346	401,219	0	3,722,211	0	3,722,211
32560	F	F_6994 Grants - Retained Funds		14,843,723	14,402,635	2,847,514	265,000	0	14,667,635	0	14,667,635
			Subtotal:	211,174,326	334,441,734	131,297,027	(3,190,164)	0	331,251,570	0	331,251,570

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2011 - 2013

Class FB	Budget Account Code	Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-01 ECONOMIC ASSISTANCE POLICY - GRANTS									
	Subdivision Budget Total:	225,741,090	351,389,943	139,035,734	(3,206,354)	288,487	348,472,076	0	348,472,076
	General Funds:	4,621,879	10,676,487	5,657,952	639,384	123,401	11,439,272	0	11,439,272
	Federal Funds:	198,752,063	322,674,475	129,322,822	(4,552,640)	165,086	318,286,921	0	318,286,921
300-01 ECONOMIC ASSISTANCE POLICY - GRANTS	**Other Funds:**	6,948,575	3,320,992	1,067,346	401,498	0	3,722,490	0	3,722,490
	SWAP Funds:	14,843,723	14,402,635	2,847,514	265,000	0	14,667,635	0	14,667,635
	County Funds:	574,850	315,354	140,100	40,404	0	355,758	0	355,758
	IGT Funds:	0	0	0	0	0	0	0	0
	Subdivision Funding Total:	225,741,090	351,389,943	139,035,734	(3,206,354)	288,487	348,472,076	0	348,472,076

Economic Assistance & Policy - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Office Rent Diane Knauf NEHSC - Regional Rep			2,237	3,355		5,592
Office Rent Nancy Dukart BLHSC - Regional Rep			1,524	2,287		3,811
Office Rent Linda Martinson LRHSC - Regional Rep			1,794	2,692		4,486
System Support & Development Rent at Northbrook Mall	1,701.00	12.35	20,153	24,631		44,784
Office Rent James Brines BLHSC - Quality Control			2,437	2,536		4,973
Office Rent Joan Irwin NCHSC - Quality Control			1,287	1,340		2,627
Office Rent Ken Wilhelmi LRHSC - Quality Control			2,842	2,959		5,801
Office Rent Colleen (Kelly Buckingham) NEHSC - Quality Control			2,920	3,040		5,960
Office Rent Leslie Uecker SCHSC - Qualtiy Control			3,149	3,277		6,426
Booth/Room Rental for Meetings for Training			1,800	3,200		5,000
Total Rental / Leases			**$ 40,143**	**$ 49,317**	**$ -**	**$ 89,460**

Note: Square footage and rate per square foot will be covered by presentation of the HSC's.

Economic Assistance & Policy - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Years of Service/Retirement Awards	1,470	2,681		4,150
PERM (Payment Error Rate Measurement)	213,643	592,343		805,986
Spring Showcase Speaker Fees	12,500	12,500		25,000
County Contract Staff - Testing	11,745	14,355		26,100
New Hires National Database Information	394	5,238		5,632
Alternative to Abortion 211 Service		11,400		11,400
Alternative to Abortion Provider Services		388,600		388,600
Alternative to Abortion Advertising Contract		100,000		100,000
SNAP Outreach GPFB (Great Plains Food Bank)		173,091		173,091
SNAP Employment & Training Program		203,698		203,698
E-Funds EBT Card Contractor	52,266	463,078	355,758	871,102
TANF Special Project - PRIDE		946,515		946,515
JOBS Client Services		7,203,623		7,203,623
JOBS Support Services		299,077		299,077
Other Miscellaneous Fees & Services	4,747	18,630		23,377
Total Operating Fees and Services	**$ 296,765**	**$ 10,434,828**	**$ 355,758**	**$ 11,087,351**

Department of H[illegible]vices
Economic Assista[illegible]cy Division
Grants Summary 20[illegible]-2013 Biennium

Dept Desc	Bgt Acct Desc	Current Budget 2009 - 2011	Continued Program Changes	Cost Changes	Caseload Changes	Remove One-Time Funding	Total Budget Changes	To the House 2011 - 2013
Child Care	**Grants**	**22,359,834**		**(490,902)**	**(1,314,080)**		**(1,804,982)**	**20,554,852**
Child Care	General Fund	350,197		(76,930)	(20,581)		(97,511)	252,686
Child Care	Federal Funds	15,746,276		(1,413,565)	(925,403)		(2,338,968)	13,407,308
Child Care	Other Funds	6,263,361		999,593	(368,096)		631,497	6,894,858
Indian County Allocation	**Grants**	**3,924,148**	**1,066,213**				**1,066,213**	**4,990,361**
Indian County Allocation	General Fund	1,959,541	1,066,213				1,066,213	3,025,754
Indian County Allocation	Other Funds	1,964,607						1,964,607
JOBS-Support Services	**Grants**	**777,338**		**(114,871)**	**(363,390)**		**(478,261)**	**299,077**
JOBS-Support Services	Federal Funds	777,338		(114,871)	(363,390)		(478,261)	299,077
JOBS-Transportation	**Grants**	**2,821,875**		**564,375**	**843,600**		**1,407,975**	**4,229,850**
JOBS-Transportation	Federal Funds	2,821,875		541,258	843,600		1,384,858	4,206,733
JOBS-Transportation	Other Funds			23,117			23,117	23,117
Kinship Care	**Grants**	**420,000**		**23,100**	**(20,816)**		**2,284**	**422,284**
Kinship Care	Federal Funds	420,000		23,100	(20,816)		2,284	422,284
Low Inc Home Enrgy Assist Prgm	**Grants**	**52,562,722**	**(5,952,495)**	**(10,891,940)**	**3,717,990**		**(13,126,445)**	**39,436,277**
Low Inc Home Enrgy Assist Prgm	Federal Funds	52,562,722	(5,987,217)	(10,891,940)	3,717,990		(13,161,167)	39,401,555
Low Inc Home Enrgy Assist Prgm	Other Funds		34,722				34,722	34,722
SNAP - Benefits	**Grants**	**211,436,375**		**15,735,901**	**21,680,881**	**(6,910,661)**	**30,506,121**	**241,942,496**
SNAP - Benefits	Federal Funds	211,436,375		15,735,901	21,680,881	(6,910,661)	30,506,121	241,942,496
SNAP - Charitable Food Asst	**Grants**	**365,408**				**(365,408)**	**(365,408)**	
SNAP - Charitable Food Asst	General Fund	350,000				(350,000)	(350,000)	
SNAP - Charitable Food Asst	Federal Funds	15,408				(15,408)	(15,408)	
SNAP - E&T Particip Pymts	**Grants**	**32,160**	**103,840**				**103,840**	**136,000**
SNAP - E&T Particip Pymts	General Fund	16,080	51,920				51,920	68,000
SNAP - E&T Particip Pymts	Federal Funds	16,080	51,920				51,920	68,000
SNAP - Nutrition Educ Plan	**Grants**	**3,500,000**	**(606,593)**				**(606,593)**	**2,893,407**
SNAP - Nutrition Educ Plan	Federal Funds	3,500,000	(606,593)				(606,593)	2,893,407
Supplmntl Nutrition Asst Prgm	**Grants**	**2,759,339**				**(2,759,339)**	**(2,759,339)**	
Supplmntl Nutrition Asst Prgm	Federal Funds	2,759,339				(2,759,339)	(2,759,339)	
TANF Diversion Benefit	**Grants**	**5,733,190**		**933,310**	**(6,522,500)**		**(5,589,190)**	**144,000**
TANF Diversion Benefit	General Fund	1,604,268		364,866	(1,825,134)		(1,460,268)	144,000
TANF Diversion Benefit	Federal Funds	2,338,269		321,918	(2,660,187)		(2,338,269)	
TANF Diversion Benefit	Other Funds	1,790,653		246,526	(2,037,179)		(1,790,653)	
TANF Recipient-Workers Comp	**Grants**	**20,280**	**9,720**				**9,720**	**30,000**
TANF Recipient-Workers Comp	Federal Funds	20,280	9,720				9,720	30,000
TANF Regular Benefit	**Grants**	**18,254,732**		**(1,101,440)**	**(470,326)**	**(510,000)**	**(2,081,766)**	**16,172,966**
TANF Regular Benefit	General Fund	3,927,690		1,564,372	(104,104)		1,460,268	5,387,958
TANF Regular Benefit	Federal Funds	6,622,036		(4,637,570)	(162,000)	(510,000)	(5,309,570)	1,312,466
TANF Regular Benefit	Other Funds	7,705,006		1,971,758	(204,222)		1,767,536	9,472,542
TANF Subsidized Employment Prg	**Grants**	**9,474,333**				**(9,474,333)**	**(9,474,333)**	
TANF Subsidized Employment Prg	Federal Funds	9,474,333				(9,474,333)	(9,474,333)	

Total Economic Assistance Policy	**Grants**	**334,441,734**	**(5,379,315)**	**4,657,533**	**17,551,359**	**(20,019,741)**	**(3,190,164)**	**331,251,570**
	General Fund	8,207,776	1,118,133	1,852,308	(1,949,819)	(350,000)	670,622	8,878,398
	Federal Funds	308,510,331	(6,532,170)	(435,769)	22,110,675	(19,669,741)	(4,527,005)	303,983,326
	Other Funds	17,723,627	34,722	3,240,994	(2,609,497)	-	666,219	18,389,846

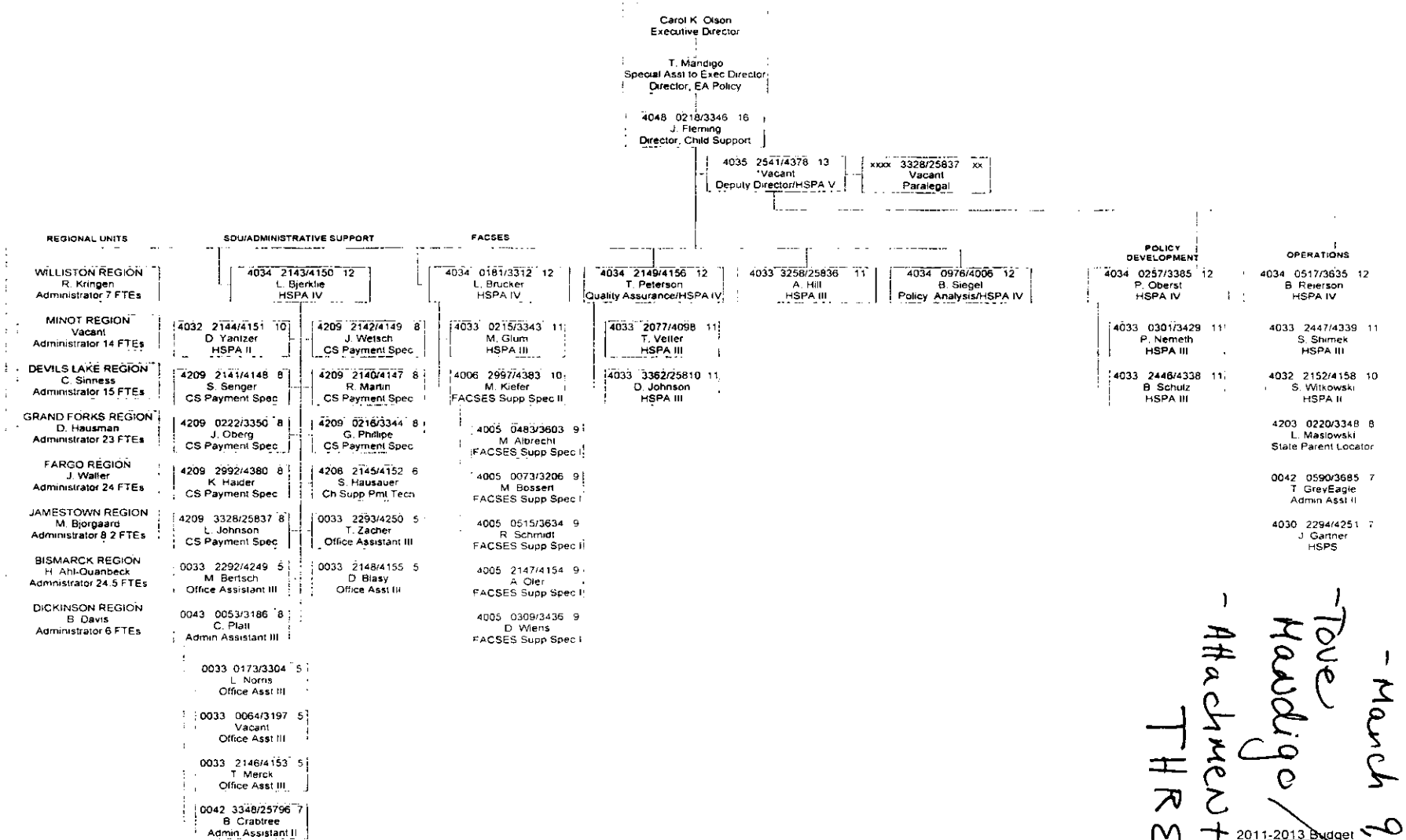
- SB 2012
- March 9, 2011
- Debra McDermott
- Attachment TWO

TANF Block Grant
Revenue / Estimated Expenditures
To House
2011-2013

	TANF Block Grant	Estimated Expenditures 2011-2013	Estimated CarryForward to 2013-2015
REVENUE			
FY 2011 - Estimated Carryover	13,026,305	13,026,305	
FY 2011 - 25% of Grant Award	6,599,952	6,599,952	
FY 2012	26,399,809	26,399,809	
FY 2013 - 75% of Grant Award	19,799,857	11,266,823	8,533,034
Transfer to CCDBG	(500,000)	-	(500,000)
Total Est Expenditures & Transfers	**65,325,923**	**57,292,889**	**8,033,034**

	Total	Federal	General	Other
ESTIMATED EXPENDITURES				
TANF Benefits	16,769,250	1,764,750	5,531,958	9,472,542
TANF Job Preparation	12,978,142	12,955,025		23,117
Formation & Maintenance of Families				
Family Preservation Services	4,925,679	3,848,796		1,076,883
Child Abuse & Neglect Investigations	4,747,706	4,747,706		
Foster Care	21,850,387	21,850,387		
Subtotal	31,523,772	30,446,889		1,076,883
Other				
Systems Maint. & Operations	2,096,783	2,096,783		
Alternatives to Abortion	500,000	500,000		
County Direct Services	1,821,004	1,821,004		
DHS Administration	3,773,701	3,773,701		
County Administration	3,934,737	3,934,737		
Subtotal	12,126,225	12,126,225		
Child Care MOE	2,034,072			2,034,072
Total Estimated Expenditures	**75,431,461**	**57,292,889**	**5,531,958**	**12,606,614**

North Dakota Department of Human Services
Child Support Division



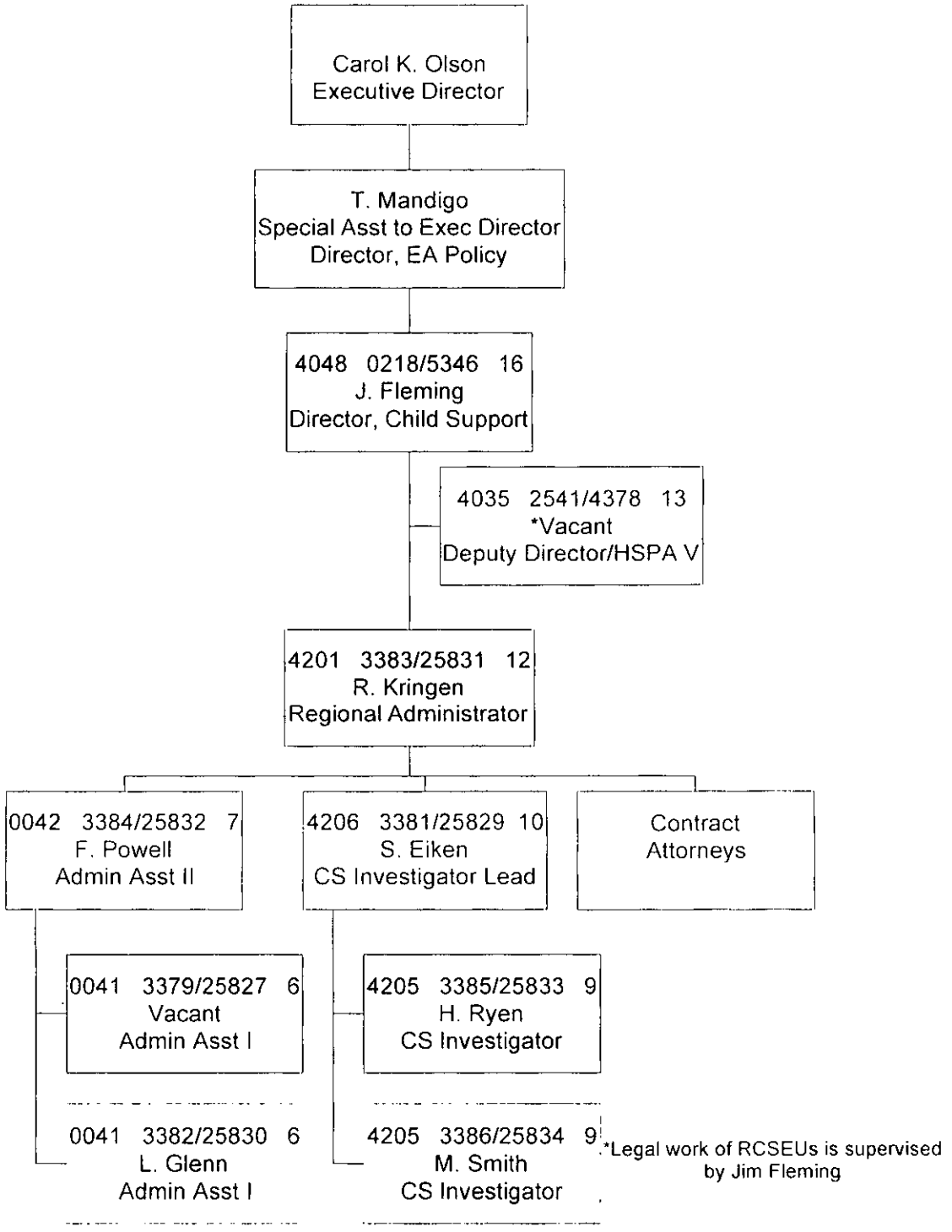
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2011-2013 Budget
Authorized: 165.2 FTEs

-SB 2012
-March 9, 2011
-Tove Mandigo / Jane Fleming
-Attachment THREE

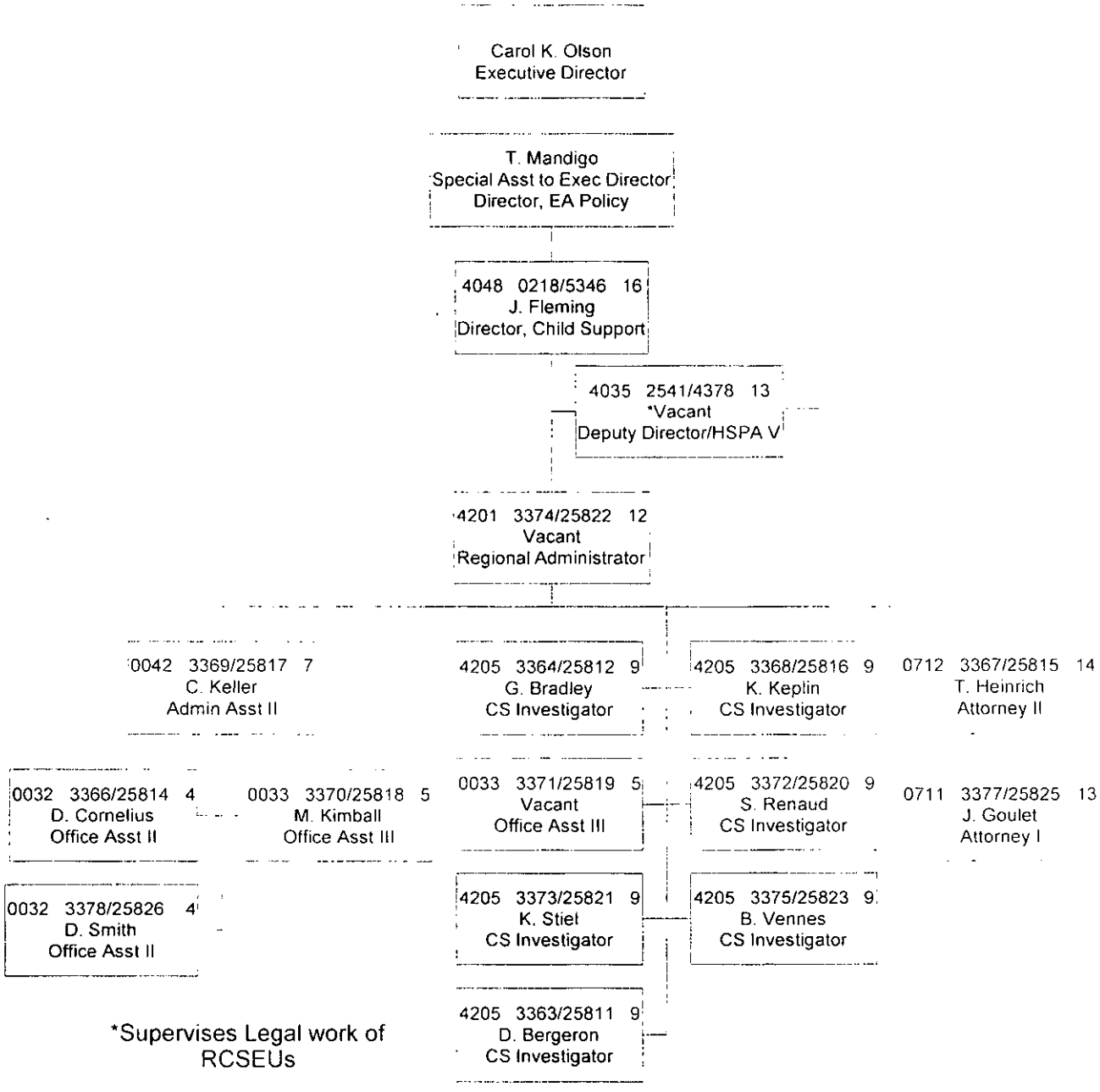
Revised 3/4/11

North Dakota Department of Human Services
Child Support Division
Williston Region



Revised 12/15/10

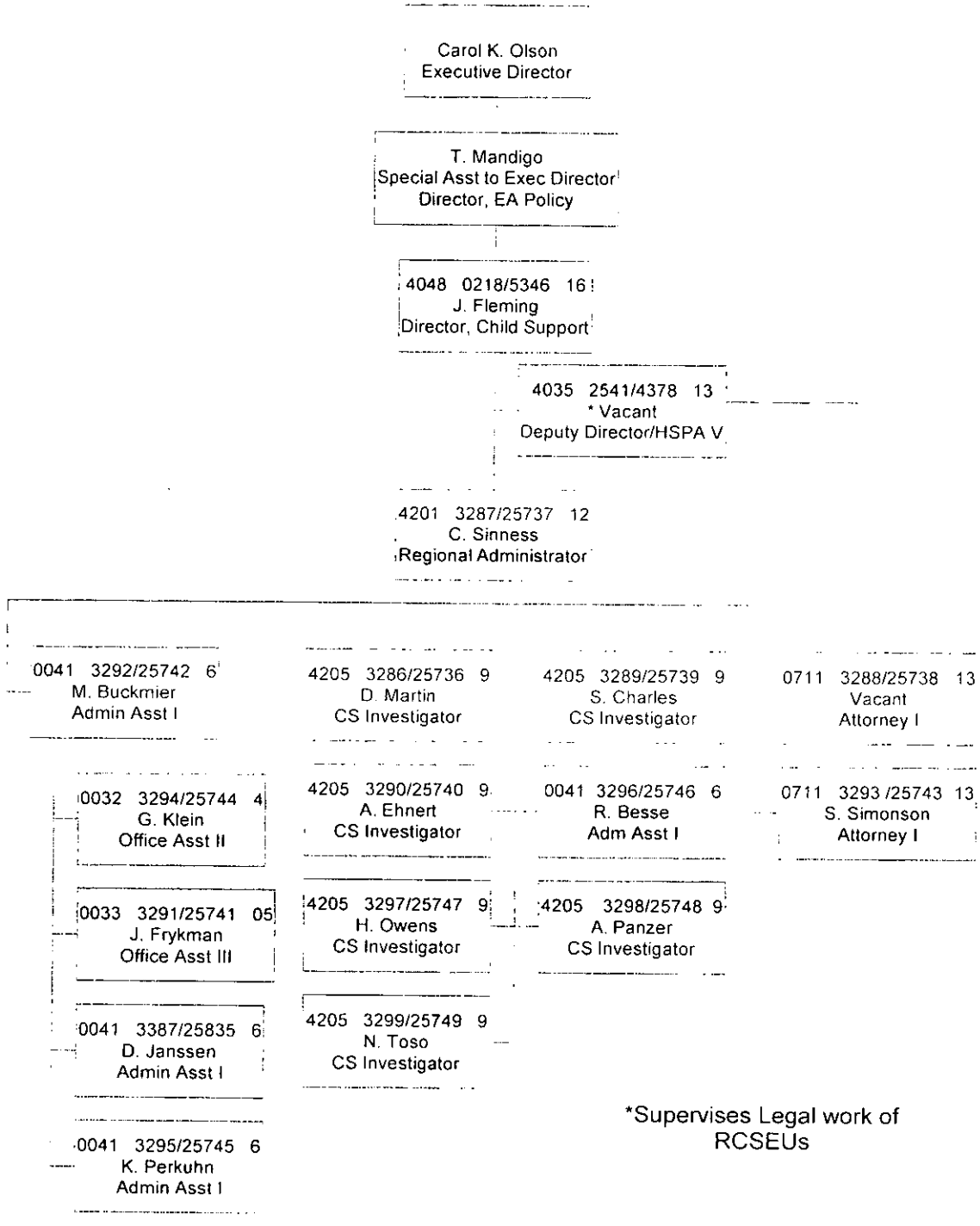
North Dakota Department of Human Services
Child Support Division
Minot Region



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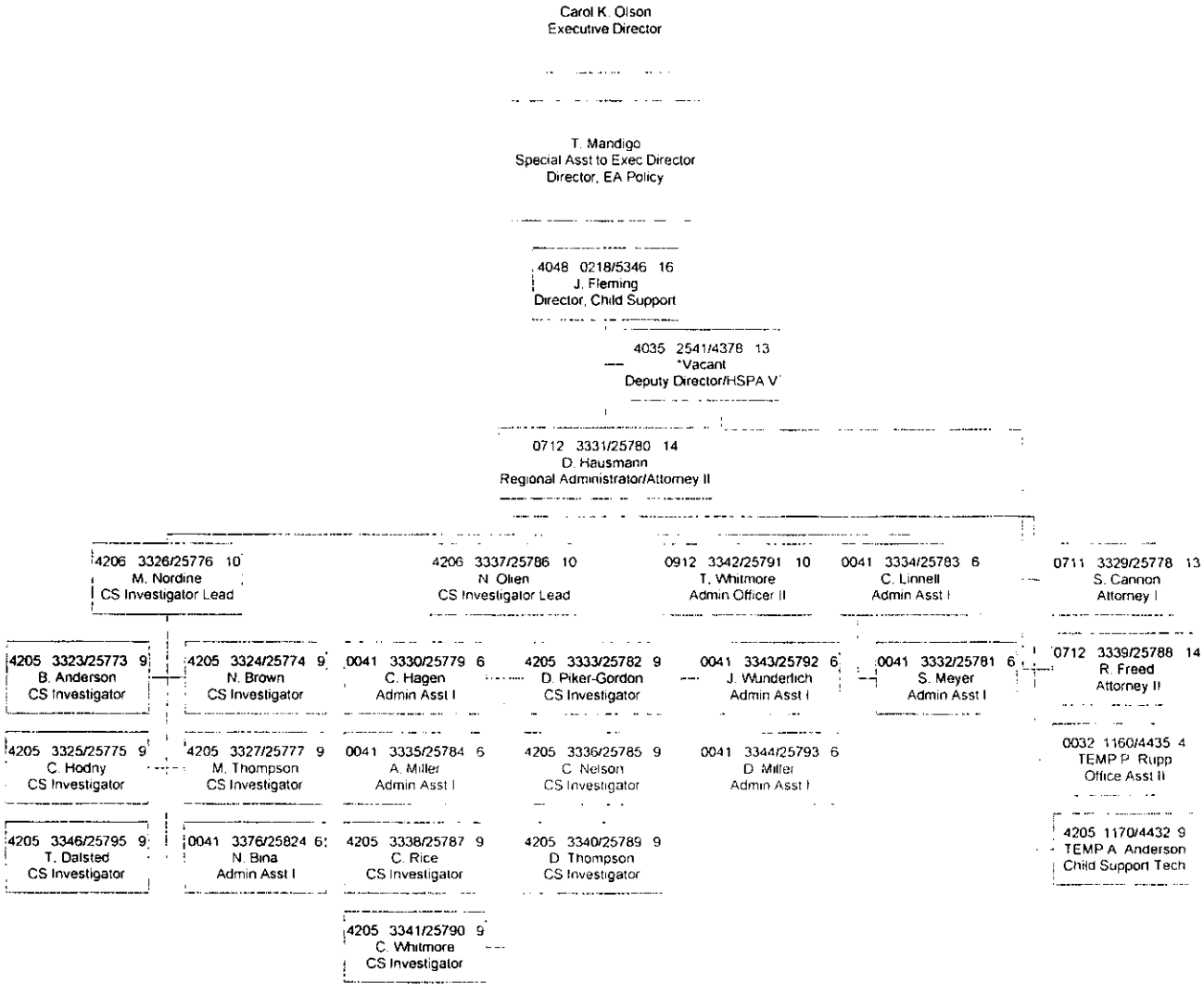
North Dakota Department of Human Services
Child Support Division
Devils Lake Region



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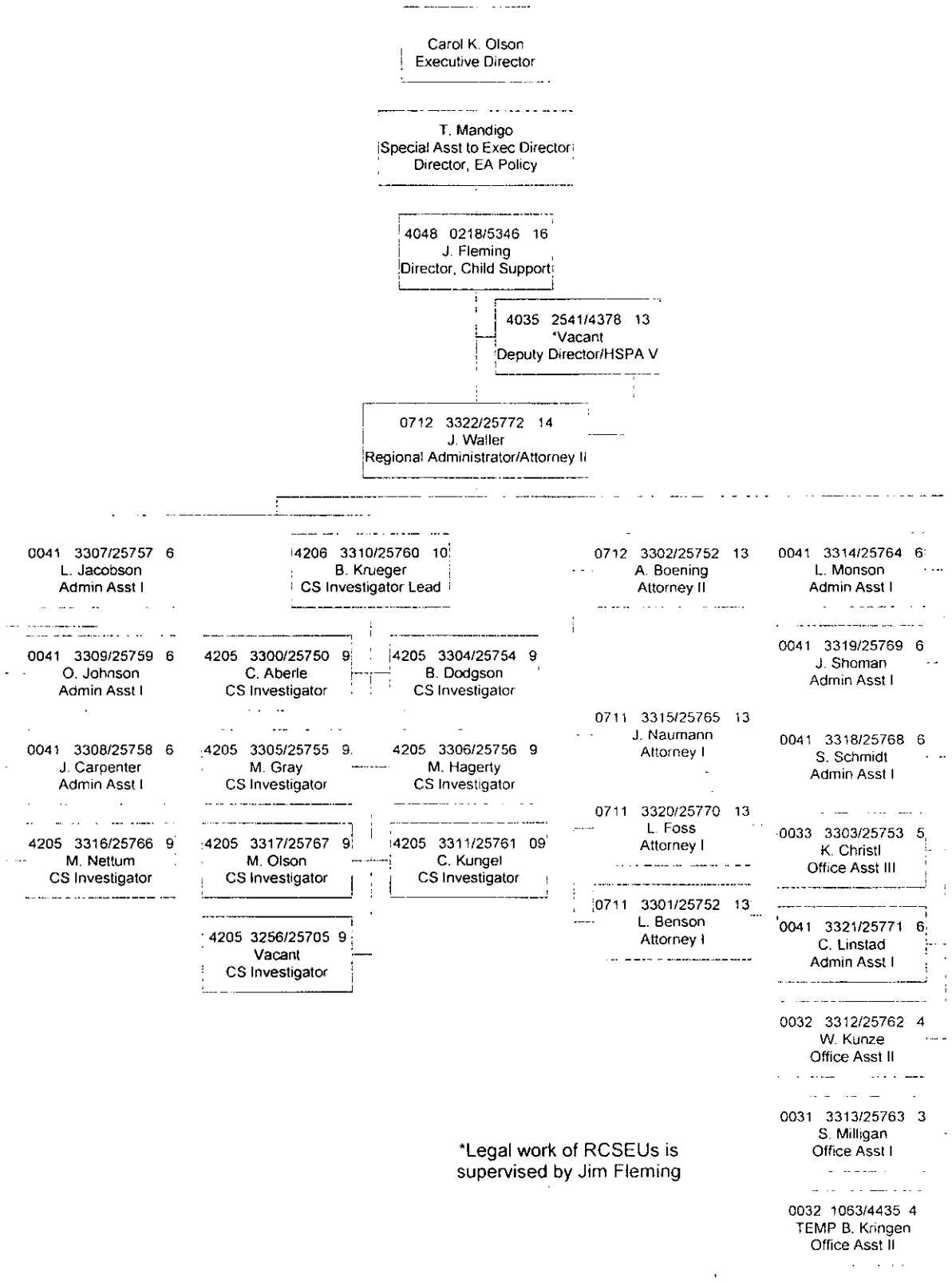
North Dakota Department of Human Services
Child Support Division
Grand Forks Region



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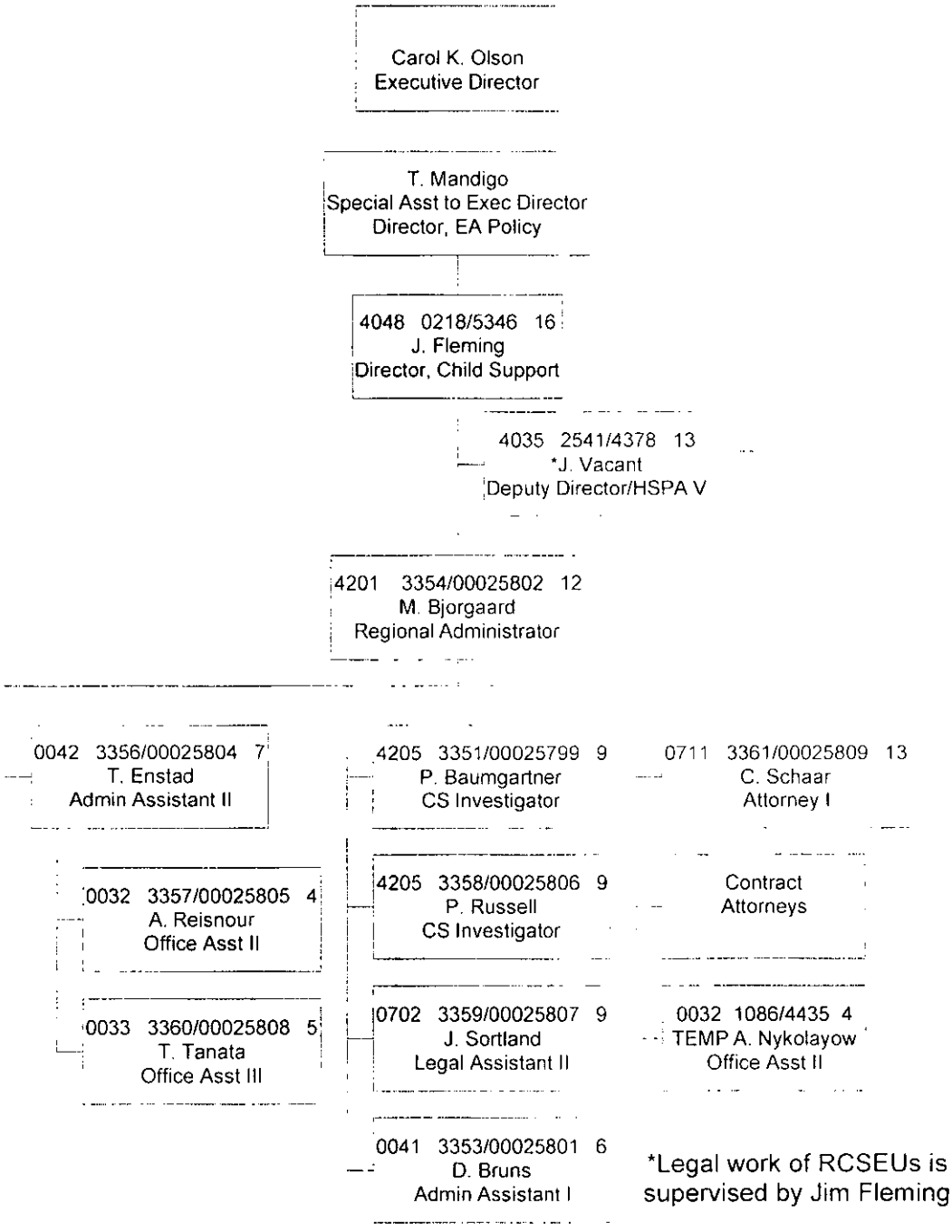
North Dakota Department of Human Services
Child Support Division
Fargo Region



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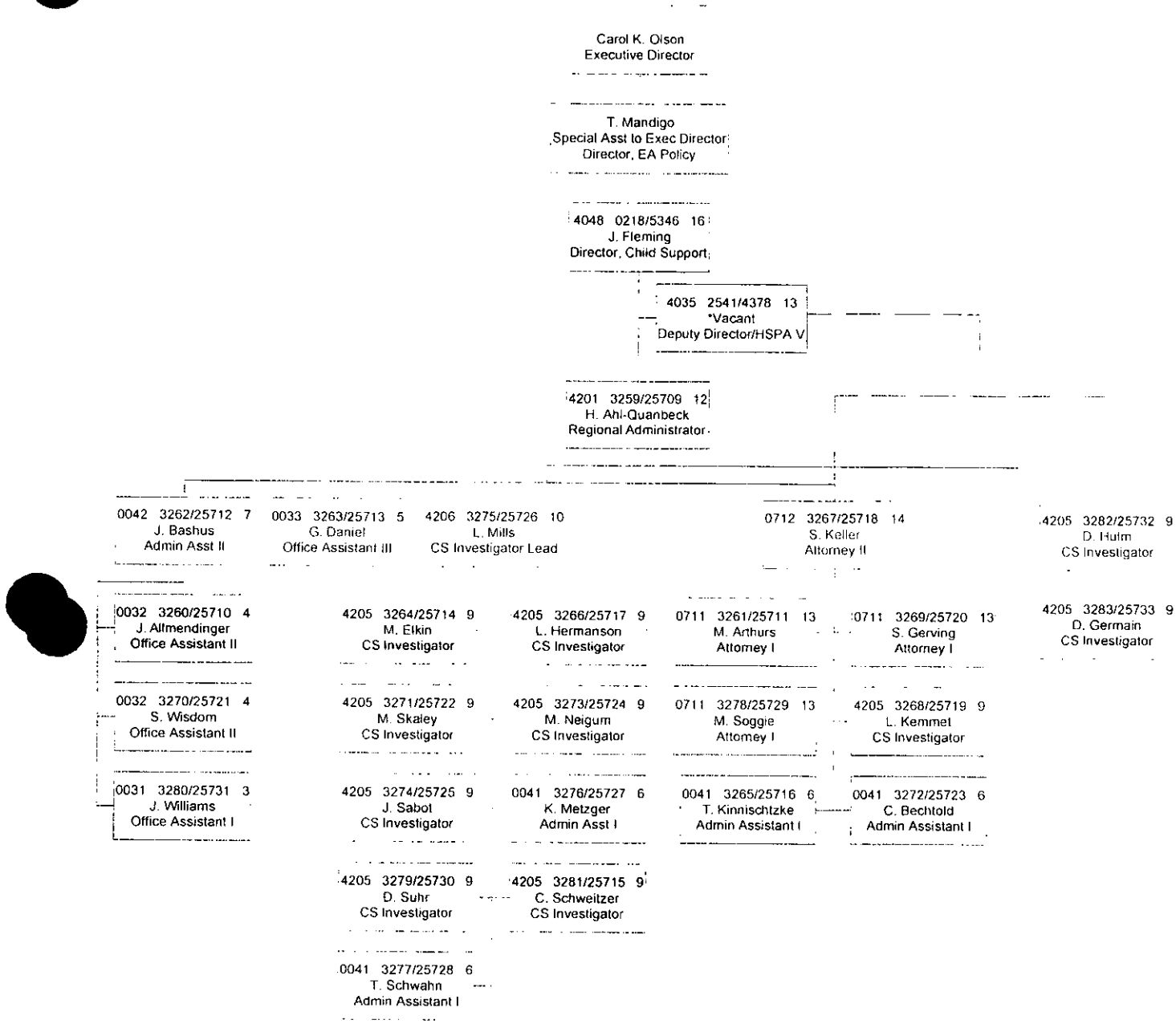
Revised 2/8/11

North Dakota Department of Human Services
Child Support Division
Jamestown Region



Revised 2/8/11

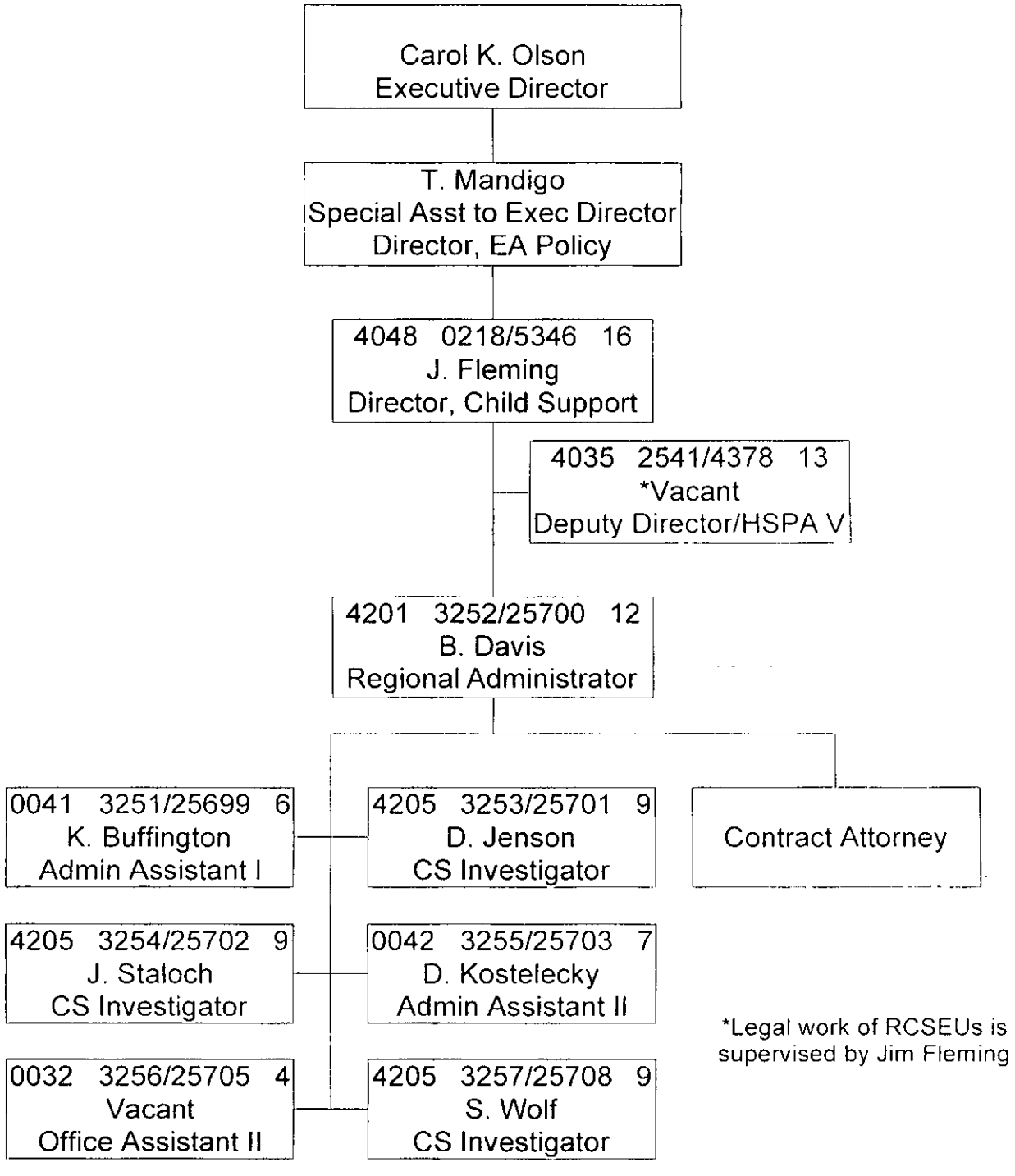
North Dakota Department of Human Services
Child Support Division
Bismarck Region



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Revised 12/15/10

North Dakota Department of Human Services
Child Support Division
Dickinson Region



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Revised 12/15/10

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-02 CHILD SUPPORT ENFORCEMENT											
S101		FULL-TIME EQUIVALENTS (FTEs)		172.200	164.200	0.000	1.000	0.000	165.200	0.000	165.200
32510	B	511000	Salaries - Permanent	11,478,204	13,367,523	6,275,490	482,940	0	13,850,463	0	13,850,463
32510	B	513000	Temporary Salaries	42,520	109,392	10,771	0	0	109,392	0	109,392
32510	B	514000	Overtime	25,170	57,312	2,728	1	0	57,313	0	57,313
32510	B	516000	Fringe Benefits	4,361,685	5,636,384	2,642,805	88,641	(2)	5,725,023	0	5,725,023
32510	B	599110	Salary Increase	0	0	0	0	624,293	624,293	0	624,293
32510	B	599160	Benefit Increase	0	0	0	0	105,708	105,708	0	105,708
32510	B	599161	Health Increase	0	0	0	0	243,087	243,087	0	243,087
32510	B	599162	Retirement Increase	0	0	0	0	142,849	142,849	0	142,849
32510	B	599163	EAP Increase	0	0	0	0	476	476	0	476
			Subtotal:	15,907,579	19,170,611	8,931,794	571,582	1,116,411	20,858,604	0	20,858,604
32510	F	F_1991	Salary - General Fund	1,160,786	2,854,705	771,206	2,879,128	372,793	6,106,626	0	6,106,626
32510	F	F_1992	Salary - Federal Funds	9,587,322	14,130,183	6,145,376	(2,784,733)	743,618	12,089,068	0	12,089,068
32510	F	F_1993	Salary - Other Funds	5,159,471	2,185,723	2,015,212	477,187	0	2,662,910	0	2,662,910
			Subtotal:	15,907,579	19,170,611	8,931,794	571,582	1,116,411	20,858,604	0	20,858,604
32530	B	521000	Travel	46,708	151,105	23,013	(27,767)	0	123,338	0	123,338
32530	B	531000	Supplies - IT Software	53,693	61,640	22,101	1,503	0	63,143	0	63,143
32530	B	532000	Supply/Material-Professional	15,252	25,751	11,054	(14,933)	0	10,818	0	10,818
32530	B	534000	Bldg, Grounds, Vehicle Supply	412	0	0	0	0	0	0	0
32530	B	535000	Miscellaneous Supplies	8,187	6,200	5,400	0	0	6,200	0	6,200
32530	B	536000	Office Supplies	60,828	90,681	21,564	(25,302)	0	65,379	0	65,379
32530	B	541000	Postage	269,089	286,808	143,865	37,044	0	323,852	0	323,852
32530	B	542000	Printing	80,579	121,601	32,569	(42,039)	0	79,562	0	79,562
32530	B	551000	IT Equip under $5,000	2,234	725	0	0	0	725	0	725
32530	B	552000	Other Equip under $5,000	11,819	0	0	0	0	0	0	0
32530	B	553000	Office Equip & Furniture-Under	33,877	34,894	9,333	3,206	0	38,100	0	38,100
32530	B	571000	Insurance	793	1,048	170	(208)	0	840	0	840
32530	B	581000	Rentals/Leases-Equip & Other	41,510	55,047	24,205	(4,555)	0	50,492	0	50,492
32530	B	582000	Rentals/Leases - Bldg/Land	976,779	1,054,565	518,575	45,842	0	1,100,407	0	1,100,407

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-02 CHILD SUPPORT ENFORCEMENT											
32530	B	591000	Repairs	72,858	83,840	44,184	6,563	0	90,403	0	90,403
32530	B	601000	IT - Data Processing	41,073	46,972	20,312	2,741	0	49,713	0	49,713
32530	B	602000	IT-Communications	22,025	7,176	5,129	6,378	0	13,554	0	13,554
32530	B	603000	IT Contractual Services and Re	568	0	0	0	0	0	0	0
32530	B	611000	Professional Development	49,518	51,216	19,102	11,968	0	63,184	0	63,184
32530	B	621000	Operating Fees and Services	1,655,172	2,712,607	840,355	(610,000)	0	2,102,607	0	2,102,607
32530	B	623000	Fees - Professional Services	85	2,500	126	(2,500)	0	0	0	0
			Subtotal:	3,443,059	4,794,376	1,741,057	(612,059)	0	4,182,317	0	4,182,317
32530	F	F_3991	Operating - General Fund	172,269	730,666	83,791	37,532	0	768,198	0	768,198
32530	F	F_3992	Operating - Federal Funds	2,545,294	3,460,924	1,353,854	(374,795)	0	3,086,129	0	3,086,129
32530	F	F_3993	Operating - Other Funds	725,496	602,786	303,412	(274,796)	0	327,990	0	327,990
			Subtotal:	3,443,059	4,794,376	1,741,057	(612,059)	0	4,182,317	0	4,182,317
32560	B	712000	Grants, Benefits & Claims	174,400	0	0	0	0	0	0	0
			Subtotal:	174,400	0	0	0	0	0	0	0
32560	F	F_6991	Grants - General Fund	41	0	0	0	0	0	0	0
32560	F	F_6992	Grants - Federal Funds	173,649	0	0	0	0	0	0	0
32560	F	F_6993	Grants - Other Funds	710	0	0	0	0	0	0	0
			Subtotal:	174,400	0	0	0	0	0	0	0
			Subdivision Budget Total:	19,525,038	23,964,987	10,672,851	(40,477)	1,116,411	25,040,921	0	25,040,921
			General Funds:	1,333,096	3,585,371	854,997	2,916,660	372,793	6,874,824	0	6,874,824
			Federal Funds:	12,306,265	17,591,107	7,499,230	(3,159,528)	743,618	15,175,197	0	15,175,197
300-02 CHILD SUPPORT ENFORCEMENT			**Other Funds:**	5,885,677	2,788,509	2,318,624	202,391	0	2,990,900	0	2,990,900
			SWAP Funds:	0	0	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	19,525,038	23,964,987	10,672,851	(40,477)	1,116,411	25,040,921	0	25,040,921

Child Support Enforcement - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Century Center - Office Space	7,316.00	14.50	77,377	134,787		212,164
Century Center - Storage/Filing Area	393.00	5.00	1,376	2,555		3,930
Williston Regional Child Support Office (US Bank)	3,374.00	6.80	15,594	30,270		45,864
Minot Regional Child Support Office (BB Prosper Properties)	4,200.00	13.50	17,010	74,844	21,546	113,400
Devils Lake Regional Child Support Office (AG Spreading)	4,800.00	10.50	34,272	66,528		100,800
Grand Forks Regional Child Support Office (GF County)	4,544.00	13.15	40,632	78,875		119,507
Fargo Regional Child Support Office (JPR Investments)	5,511.00	16.00	59,960	116,392		176,352
Jamestown Regional Child Support Office (Richard LaQua)	3,840.00	7.50	19,584	38,016		57,600
Bismarck Regional Child Support Office (Burleigh County)	7,294.00	12.50	9,118	16,412	156,821	182,350
Dickinson Regional Child Support Office (Tru Bet Realty)	2,233.00	9.31	14,132	27,433		41,565
North Dakota Outgoing Interstate Center Office (GF County)	1,231.00	13.15	11,008	21,368		32,375
High Intensity Enforcement Unit Office (Burleigh County)	550.00	12.50	4,675	9,075		13,750
Rental of Parking Space for Grand Forks Office	N/A	N/A	255	495		750
Total Rental / Leases			**$ 304,992**	**$ 617,048**	**$ 178,367**	**$ 1,100,407**

Child Support Enforcement - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
FIDM (Financial Institution Data Matching)	43,534	84,507		128,041
Attorney Bar Licenses, Notary Licenses, CLE Reporting, CPA License, Tribal Court Licer	4,614	9,517	3,282	17,413
Locate Tools	2,366	4,594		6,960
Service Awards - Years of Service/Retirement	3,472	6,651	1,228	11,350
Health Insurance Data Matches - Health Management Services	32,300	62,700		95,000
ND Supreme Court - Judicial/Referee Services and Clerks of Court		1,276,057		1,276,057
States Attorneys - Criminal Prosecutions		40,000		40,000
Contract Attorneys - Civil Litigation	23,190	45,016		68,206
Genetic Testing - LabCorp	23,077	48,763	13,270	85,110
Access and Vistation Services		200,000		200,000
Sheriff, Private Firm and Publication Service Fees	27,278	54,454	40,778	122,509
CSLN (Child Support Lien Network)	8,160	15,840		24,000
Other Miscellaneous Fees & Services	7,443	15,570	4,948	27,961
Total Operating Fees and Services	**$ 175,434**	**$ 1,863,668**	**$ 63,505**	**$ 2,102,607**

- Paul Kramer
- Attachment FOUR
- SB 2012
- March 9 2011

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request To House

	FTE Count
Administration / Support	
Legislatively Authorized	73.60
From DC - new attorney	1.00
2011-13 Biennium Request	**74.60**
Information Technology Services	
Legislatively Authorized	35.75
From Child Support for Central Office Desktop	0.50
From DC for CT at DC	0.25
From DC - Business Analyst position	1.00
From DC - Business Analyst positions	1.00
From DC - convert temp meeting criteria	3.00
2011-13 Biennium Request	**41.50**
Economic Assistance Policy Grants	
Legislatively Authorized	38.80
Healthcare Reform	1.00
2011-13 Biennium Request	**39.80**
Child Support	
Legislatively Authorized	164.70
To ITS	(0.50)
Healthcare Reform	1.00
2011-13 Biennium Request	**165.20**
Medical Services	
Legislatively Authorized	67.50
To DD Division	(1.00)
From CFS for Deputy	1.00
From DC convert temp meeting criteria	1.00
Healthcare Reform	5.00
2011-13 Biennium Request	**73.50**
DD Council	
Legislatively Authorized	1.00
2011-13 Biennium Request	**1.00**
Aging Services	
Legislatively Authorized	10.00
2011-13 Biennium Request	**10.00**
Children and Family Services	
Legislatively Authorized	18.00
To Medical Services	(1.00)
2011-13 Biennium Request	**17.00**

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request
To House

	FTE Count
Mental Health & Substance Abuse	
Legislatively Authorized	18.00
From DC: Prevention Coord.	6.00
2011-13 Biennium Request	**24.00**
Vocational Rehabilitation	
Legislatively Authorized	34.00
From LRHSC for VR Director	1.00
2011-13 Biennium Request	**35.00**
Developmental Disabilities Division	
Legislatively Authorized	8.00
From Medical Services	1.00
2011-13 Biennium Request	**9.00**
Northwest HSC	
Legislatively Authorized	44.75
From DC: Addiction Counselor	1.00
2011-13 Biennium Request	**45.75**
North Central HSC	
Legislatively Authorized	116.78
From DC: Psychiatrist	1.00
2011-13 Biennium Request	**117.78**
Lake Region HSC	
Legislatively Authorized	62.00
To VR for Director	(1.00)
To NEHSC	(1.00)
2011-13 Biennium Request	**60.00**
Northeast HSC	
Legislatively Authorized	137.10
From LRHSC	1.00
From SEHSC	0.20
2011-13 Biennium Request	**138.30**
Southeast HSC	
Legislatively Authorized	182.35
To NEHSC	(0.20)
2011-13 Biennium Request	**182.15**
South Central HSC	
Legislatively Authorized	85.50
2011-13 Biennium Request	**85.50**

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request
To House

	FTE Count
West Central HSC	
Legislatively Authorized	135.30
2011-13 Biennium Request	**135.30**
Badlands HSC	
Legislatively Authorized	72.70
2011-13 Biennium Request	**72.70**
State Hospital - Traditional	
Legislatively Authorized	381.06
To State Hospital - Secure Services	(0.61)
From DC - Telepharmacy	1.00
2011-13 Biennium Request	**381.45**
State Hospital - Secure Services	
Legislatively Authorized	85.45
From State Hospital - Traditional	0.61
2011-13 Biennium Request	**86.06**
Developmental Center	
Legislatively Authorized	444.54
To ITS	(0.25)
To Administration / Support	(1.00)
To ITS	(1.00)
To NWHSC	(1.00)
To ITS	(4.00)
To Medical Services	(1.00)
To NCHSC	(1.00)
To MH/SA	(6.00)
To State Hospital - Telepharmacy	(1.00)
Unfunded	(27.53)
2011-13 Biennium Request	**400.76**
TOTAL	**2,196.35**

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Accountancy, Board of			2701 S Columbia Rd	Grand Forks	ND	58201	1,003	$12,540	$12.50
Administrative Hearings, Office of			1707 N 9th St	Bismarck	ND	58501-1882	2,145	$31,103	$14.50
Agriculture Dept	Ag Mediation (AMS)	Berg Ins Bldg	112 Main St	McVille	ND	58254	555	$2,400	$4.32
Agriculture Dept	AMS, Plant Industries	Eckroth bldg/15th Street Holdings, LLC	1221 West Divide Ave, Suite 201	Bismarck	ND	58501	2,640	$38,301	$14.51
Arts, Council on the			1600 E Century Ave, Suite 6	Bismarck	ND	58503-0649	1,450	$19,575	$13.50
Attorney General	BCI			Fargo	ND	58103	3,475	$45,175	$13.00
Attorney General	BCI	Williams Ctr Law Enforcement Ctr	223 E Broadway	Williston	ND	58801	1,172	$8,790	$7.50
Attorney General	BCI	Stutsman Co Law Enforcement Ctr	205 6th St SE	Jamestown	ND	58401	392	$4,394	$11.21
Attorney General	BCI	Lake Region Law Enforce Ctr	222 W Walnut St	Devils Lake	ND	58301	443	$2,848	$6.43
Attorney General	BCI	& Treatment Ctr	110 Industrial Rd	Rugby	ND	58368	118	$1,180	$10.00
Attorney General	BCI-Fire Marshal	City Center Plaza	136 Sims, Ste 212	Dickinson	ND	58601	2,186	$26,232	$12.00
Attorney General		Professional North Bldg	4205 N State St	Bismarck	ND	58503	15,735	$167,578	$10.65
Attorney General		Gateway Professional Bldg		Bismarck	ND	58503	8,300	$107,900	$13.00
Attorney General		Professional Bldg Limited	500 N 9th St	Bismarck	ND	58503	10,000	$96,000	$9.60
Attorney General		Professional North Bldg-Addition	4205 N State St	Bismarck	ND	58503	4,420	$53,040	$12.00
Attorney General		GPC Properties	3rd St SE #7	Minot	ND	58701	1,547	$15,099	$9.76
Auditor's Office		Front Office Bldg	3217 Fiechtner Dr	Fargo	ND	58103	2,620	$27,379	$10.45
Auditor's Office		First Community Credit Union	425 N 5th St, 3rd Flr	Bismarck	ND	58501	1,003	$11,535	$11.50
Barley Council			505 40th St SW Ste E	Fargo	ND	58103-1184	2,968	$35,912	$12.10
Beef Commission		Ag Foundation Bldg	4023 State St	Bismarck	ND	58501	1,165	$9,900	$8.50
Commerce Dept	Economic Dev/Fin-Ag Products Util Comm		1600 E Century Ave, Ste#2 & #143	Bismarck	ND	58503	15,368	$211,310	$13.75
Commerce Dept		City Center Plaza	135 Sims St, Ste #207	Dickinson	ND	58601	568	$6,300	$11.09
Commerce Dept		EERC, Rm 105	15 N 23rd St	Grand Forks	ND	58203	193	$4,842	$25.15
Commerce Dept			106 6th Ave NE #B1	Medina	ND	58467	504	$4,800	$9.52
Commerce Dept		Smith Bldg first floor, School for the Deaf	1401 College Dr	Devils Lake	ND	58301-1596	150	$1,500	$10.00
Corn Growers Association		Carlson Properties Inc	1411 32nd St S, Ste 2	Fargo	ND	58103	1,416	$18,408	$13.00
Corrections & Rehabilitation	Adult Serv		461 34th S S	Fargo	ND	58102	7,291	$94,783	$13.00
Corrections & Rehabilitation	Adult Serv			Grand Forks	ND	58201	2,819	$33,828	$12.00
Corrections & Rehabilitation	Adult Serv		103 S 3rd St, Ste 5	Bismarck	ND	58501	3,545	$33,677	$9.50
Corrections & Rehabilitation	Adult Serv	Arrowhead Shopping Ctr	1600 2nd Ave SW, Ste 14	Minot	ND	58701	1,722	$20,232	$11.75
Corrections & Rehabilitation	Adult Serv		417 1st Ave E, Ste 1	Williston	ND	58801	1,600	$12,600	$7.88
Corrections & Rehabilitation	Adult Serv	City Center Plaza	135 Sims St, Ste #205	Dickinson	ND	58601	1,166	$12,120	$10.39

- March 9, 2011 - OMB - SB 2012 - Attachment FIVE

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Corrections & Rehabilitation	Adult Serv	Marcil Mgmt	221 1st Ave N	Jamestown	ND	58401	1,260	$10,092	$8.01
Corrections & Rehabilitation	Adult Serv	JK Enterprises	114 E Main Ave	Rolla	ND	58367	750	$7,650	$10.20
Corrections & Rehabilitation	Adult Serv	Dakota Rental	709 Dakota Ave, Ste D	Wahpeton	ND	58075	750	$6,600	$8.80
Corrections & Rehabilitation	Adult Serv	Lake Region Law Enforce Ctr	222 W Walnut St	Devils Lake	ND	58301	894	$8,256	$7.00
Corrections & Rehabilitation	Adult Serv	City Hall	115 S 5th St, Ste A	Oakes	ND	58474	275	$1,320	$4.80
Corrections & Rehabilitation	Adult Serv	McLean Co Courthouse	712 5th Ave, Parole-Probation Rm; 2nd Flr	Washburn	ND	58577	378	$1,200	$3.17
Corrections & Rehabilitation	Adult Serv	Heart of America Correctional & Treatment Ctr	110 Industrial Rd	Rugby	ND	58368	102	$1,024	$10.00
Corrections & Rehabilitation	Field Serv		300 1st St NW	Mandan	ND	58554	950	$7,440	$7.83
Corrections & Rehabilitation	Juvenile Serv		921 S 9th St, Ste 110	Bismarck	ND	58504	1,779	$22,440	$12.61
Corrections & Rehabilitation	Juvenile Serv		461 34th S S	Fargo	ND	58101	1,518	$19,734	$13.00
Corrections & Rehabilitation	Juvenile Serv	Rivers Edge	311 4th St, Ste 113	Grand Forks	ND	58201	1,450	$18,600	$12.83
Corrections & Rehabilitation	Juvenile Serv	Mill Square Bldg	301 3rd St N, Ste 202	Grand Forks	ND	58203	1,500	$18,345	$12.23
Corrections & Rehabilitation	Juvenile Serv	Ramsey Nation Bank & Trust Co Building	302 4th St S, Ste 2	Devils Lake	ND	58301	2,000	$15,380	$7.69
Corrections & Rehabilitation	Juvenile Serv	Putver Hall, Dickinson State Univ		Dickinson	ND	58601	1,134	$13,608	$12.00
Corrections & Rehabilitation	Juvenile Serv		1408 20th Ave SW, Ste 7	Minot	ND	58701	1,200	$13,200	$11.00
Corrections & Rehabilitation	Juvenile Serv	Education Station Building	214 6th Ave NE, Ste A	Jamestown	ND	58401	1,012	$10,116	$10.00
Corrections & Rehabilitation	Juvenile Serv	Old Post Office Bldg	322 N Main St, Ste 103, PO Box 103	Williston	ND	58802	700	$7,385	$10.55
Education Standards & Practics Board (ESPB)			2718 Gateway Ave, Ste 303	Bismarck	ND	58503-0585	960	$8,640	$9.00
Educational Technology Council			1510 12th Ave N	Fargo	ND	58105	144	$1,539	$10.69
Electrical Board		Northbrook	1929 N Washington St, Ste A-1	Bismarck	ND	58507-7335	2,322	$30,186	$13.00
Financial Institutions		Meadowlark Hill 2nd Addition to the City of Bismarck; Dakoll Inc dba Dakota Collectibles	2000 Schafer St	Bismarck	ND	58501	3,649	$49,260	$13.50
Financial Institutions			2534 17th Ave S, Ste 1D	Grand Forks	ND	58201	904	$13,650	$15.10
Financial Institutions			3310 Feichtner Dr, Ste 104	Fargo	ND	58106	800	$12,176	$15.22
Health Dept	Disease Control		500 E Front Ave	Bismarck	ND	58504	120	$1,114	$9.28
Health Dept	Emerg. Preparedness	Jobber's Moving & Storage	1200 Industrial Dr	Bismarck	ND	58503	23,520	$123,888	$5.27
Health Dept	Emerg. Preparedness		1929 N Washington St, Ste FF	Bismarck	ND	58503	527	$6,000	$11.39
Health Dept	Environmental Services & Emerg. Preparedness	Gold Seal Ctr	918 E Divide Ave	Bismarck	ND	58501	40,025	$476,292	$11.90
Health Dept	Local Health & Disease Control		122 2nd St NW	Jamestown	ND	58402-0880	720	$10,224	$14.20
Health Dept	Waste Mgmt	City of Fargo	2301 8th Ave N	Fargo	ND	58102	500	$4,750	$9.50
Health Dept	Water Quality		314 W Main	Towner	ND	58788	190	$2,700	$14.21
Highway Patrol			374 34th St S, Ste A	Fargo	ND	58103	4,002	$54,027	$13.50

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Highway Patrol			1100 47th St N	Grand Forks	ND	58203	3,211	$43,348	$13.50
Highway Patrol		Design Wizards	4007 State St Ste HP	Bismarck	ND	58501	1,836	$22,950	$12.50
Highway Patrol		Double Z Broadcasting	318 W Walnut St	Devils Lake	ND	58301	2,400	$15,840	$6.60
Highway Patrol			2201 6th St SE, Ste B	Minot	ND	58701	3,600	$14,400	$4.00
Highway Patrol		Stutsman Co Law Enforcement Ctr	205 6th St SE	Jamestown	ND	58401	1,376	$13,044	$9.48
Highway Patrol		DOT	1700 3rd Ave W, Ste 102	Dickinson	ND	58601	941	$12,826	$13.63
Highway Patrol			223 E Broadway, Ste 304	Williston	ND	58801	1,611	$12,083	$7.50
Highway Patrol		DOT/Permit Section	600 E Blvd Avenue	Bismarck	ND	58501	763	$5,837	$7.65
Housing Finance Agency	Rent Assistance	Black Building	118 Broadway, Suite 604	Fargo	ND	58102	985	$10,540	$10.70
Housing Finance Agency			2624 Vermont Ave	Bismarck	ND	58504	13,760	$213,280	$15.50
Human Services	Badlands HSC	708 1st Avenue SW	108 1st Ave SW	Bowman	ND	58623	400	$3,000	$7.50
Human Services	BLHSC	Pulver Hall, Dickinson State Univ	300 13th Ave W, Ste #1	Dickinson	ND	58601	19,145	$220,458	$11.52
Human Services	BLSHC	CAP	990 3rd Avenue West	Dickinson	ND	58601	320	$2,820	$8.81
Human Services	BLSHC	Beach Medical Clinic	95 2nd St NW	Beach	ND	58621	105	$960	$9.14
Human Services	Central Office	Century Center	1600 E Century Ave, Ste #5, #7 & Rm 144	Bismarck	ND	58503	9,251	$124,889	$13.50
Human Services	Central Office	Northbrook Professional Building	1929 N Washington St	Bismarck	ND	58503	2,915	$34,000	$11.66
Human Services	CSE	Provident Life Bldg	316 N 5th St, Ste 300	Bismarck	ND	58501	7,844	$94,128	$12.00
Human Services	CSE	JPR Investments	4950 13th Avenue S, Ste 22	Fargo	ND	58103	5,136	$82,176	$16.00
Human Services	CSE		151 S 4th St, Ste N101	Grand Forks	ND	58206-5756	5,775	$75,941	$13.15
Human Services	CSE		325 28th Ave SW, Ste C	Minot	ND	58701	4,200	$52,080	$12.40
Human Services	CSE	1820 Walnut St. E, Suite 4	1820 Walnut St E, Ste 4	Devils Lake	ND	58301-3411	4,800	$48,000	$10.00
Human Services	CSE	Richard Laqua; L2 B1, Began's College Park	Lot 2 Block 2 Began's College Park	Jamestown	ND	58401	3,840	$23,508	$6.12
Human Services	CSE	City Center Plaza	135 Sims St, Ste #202	Dickinson	ND	58601-5141	2,233	$21,648	$9.69
Human Services	CSE		202 Main St, lower level	Williston	ND	58801	3,374	$21,000	$6.22
Human Services	HSC	Capitol Lanes Plaza	1237 W Divide Ave, Ste 5	Bismarck	ND	58501-1208	58,950	$828,248	$14.05
Human Services	HSC	Capitol Lanes Plaza	1237 W Divide Ave, Ste 5	Bismarck	ND	58501-1208	5,210	$83,360	$16.00
Human Services	LRHSC		W Walnut St	Devils Lake	ND	58301	18,236	$140,417	$7.70
Human Services	LRHSC	North Country Investors	113 Main Ave E	Rolla	ND	58367	1,958	$21,000	$10.73
Human Services	LRHSC	North Country Investors	113 Main Ave E	Rolla	ND	58367	391	$1,800	$4.60
Human Services	NCHSC	Minot Town & Country Investors	1015 S Broadway, Ste 18	Minot	ND	58701	42,911	$412,800	$9.62
Human Services	NCHSC		210 South Main Street	Rugby	ND			$4,500	na
Human Services	NCHSC	War Memorial Bldg		Stanley	ND	58784		$1,200	na
Human Services	NCHSC		228 Eagle Dr	New Town	ND	58763		$200	na

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Human Services	NEHSC		151 S 4th St	Grand Forks	ND	58206	40,040	$526,526	$13.15
Human Services	NWHSC		316 2nd Ave W	Williston	ND	58802	23,365	$198,603	$8.50
Human Services	NWHSC		109 5th St SW	Watford City	ND	58854	336	$4,200	$12.50
Human Services	Rehab Consult Serv		117 1st St E	Dickinson	ND	58601-5212	3,514	$35,140	$10.00
Human Services	SCHSC		520 3rd St NW	Jamestown	ND	58401	27,577	$285,973	$10.37
Human Services	SCHSC		520 3rd St NW	Jamestown	ND	58402	2,340	$11,723	$5.01
Human Services	SEHSC	Liffrig Family Investments	1122 1st Ave N	Fargo	ND	58102	9,129	$108,299	$11.86
Human Services		Gary Lokken Bldg Acct	109 Main	Crosby	ND	58730	500	$3,000	$6.00
Industrial Commission	Geological Survey		1016 E Calgary Ave	Bismarck	ND	58503	6,116	$89,218	$14.59
Industrial Commission	Oil & Gas		1016 E Calgary Ave	Bismarck	ND	58503	9,175	$133,827	$14.59
Industrial Commission	Oil & Gas		7 3rd St SE, Ste 204	Minot	ND	58701	575	$6,182	$10.75
Industrial Commission	Oil & Gas		314B 3rd Ave W	Dickinson	ND	58601-4938	1,400	$5,544	$3.96
Industrial Commission	Oil & Gas		11 E Broadway, Ste 201	Williston	ND	58801	978	$5,148	$5.26
Information Tech Dept	EduTech	Regional Technology Center	415 Winter Show Road – Suite 2	Valley City	ND	58072	4,100	$21,607	$5.27
Information Tech Dept	EduTech	NDSU Dept 4510	PO Box 6050	Fargo	ND	58108-6050	1,146	$15,000	$13.09
Information Tech Dept	EduTech	ND School for the Deaf	1401 College Drive N - Room 336	Devils Lake	ND	58301	560	$4,704	$8.40
Information Tech Dept		Northbrook	1929 N Washington St	Bismarck	ND	58501	17,077	$220,635	$12.92
Information Tech Dept		ND Association of Counties Bldg	PO Box 877	Bismarck	ND	58502-0877	12,000	$180,000	$15.00
Information Tech Dept		DCN Building	1615 Capitol Way	Bismarck	ND	58501	4,630	$58,153	$12.56
Information Tech Dept		MDU Building	308 1st Street NW	Mandan	ND	58554	1,815	$50,413	$27.78
Insurance			1701 S 12th St	Bismarck	ND	58501	4,800	$63,600	$13.25
Job Service		NP Development LLC	325 2nd St NW	Valley City	ND	58072	1,131	$7,500	$6.63
Job Service		Better B's Café	206 Main St	New Town	ND	58763	925	$7,200	$7.78
Job Service			119 E Main St	Beulah	ND	58523	552	$5,520	$10.00
Job Service		Harvey Tire Center	119 9th St W	Harvey	ND	58341	348	$2,700	$7.76
Job Service		Allen Enterprises	1307 12th Ave NE, Ste 3	Jamestown	ND	58401	2,905	$2,179	$0.75
Job Service		South East Region Career/Tech Center	924 S 7th St	Oakes	ND	58474	150	$600	$4.00
Judicial Branch	District Court	Centennial Plaza LLC	116 4th St	Bismarck	ND	58501	11,156	$118,700	$10.64
Judicial Branch, Supreme Court	Disciplinary Board	Parkade Bldg	515 1/2 E Broadway Ave, Ste 102	Bismarck	ND	58501	700	$7,800	$11.14
Land Dept			1707 N 9th St	Bismarck	ND	58503	5,792	$58,036	$10.02
Legal Counsel for Indigents, ND Commission on			11 1st Ave SW	Minot	ND	58701	2,544	$30,000	$11.79
Legal Counsel for Indigents, ND Commission on		Courtview Inc	912 3rd Ave S	Fargo	ND	58102	2,900	$24,600	$8.48

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Legal Counsel for Indigents, ND Commission on			314 E Thayer Ave	Bismarck	ND	58501	1,810	$24,435	$13.50
Legal Counsel for Indigents, ND Commission on		H & H Properties	405 Bruce Ave, Ste 101	Grand Forks	ND	58206	2,000	$21,000	$10.50
Legal Counsel for Indigents, ND Commission on			16 E Broadway	Williston	ND	58801	2,080	$14,880	$7.15
Legal Counsel for Indigents, ND Commission on			2517 W Main St	Valley City	ND	58702	1,500	$13,440	$8.96
Legal Counsel for Indigents, ND Commission on		City Center Plaza	135 Sims, Ste 221	Dickinson	ND	58601	1,100	$12,000	$10.91
Management & Budget, Office of	Central Serv	Apple Creek LLP	Igoe Industrial Park, B 2, L 5-6	Bismarck	ND	58501	18,000	$35,500	$1.97
Management & Budget, Office of	Risk Mgmt		1600 E Century Ave, Ste #4, Office #172 & Rm 146	Bismarck	ND	58503	1,630	$22,005	$13.50
Nursing Board		Kirkwood Office Tower	919 S 7th St, Ste 504	Bismarck	ND	58504-5881	2,626	$30,240	$11.52
Parks & Recreation			1600 E Century Ave, Ste 3	Bismarck	ND	58503	5,426	$73,251	$13.50
Plumbing Board		RSTS Inc	1110 College Dr, Ste 210	Bismarck	ND	58501	770	$9,240	$12.00
Protection & Advocacy	Region I		14 E Broadway	Williston	ND	58801	1,206	$9,600	$7.96
Protection & Advocacy	Region II	Mt Vernon Office Bldg	900 N Broadway, Ste 210	Minot	ND	58701	223	$2,340	$10.49
Protection & Advocacy	Region III	Smith Bldg Rm 9, School for the Deaf	1401 College Dr	Devils Lake	ND	58301	270	$2,160	$8.00
Protection & Advocacy	Region IV	Rivers Edge	311 S 4th St, Ste 112	Grand Forks	ND	58208	540	$6,000	$11.11
Protection & Advocacy	Region V	The Butler Center	1351 Page Dr, Ste 303	Fargo	ND	58103	866	$10,392	$12.00
Protection & Advocacy	Region VI	LRC Building	2509 Circle Dr	Jamestown	ND	58401	571	$3,420	$5.99
Protection & Advocacy	Region VII	Dakota Northwestern Bldg	400 E Broadway Ave, Ste 409	Bismarck	ND	58501	4,661	$50,805	$10.90
Protection & Advocacy	Region VIII	City Center Plaza	135 Sims, Ste 206	Dickinson	ND	58601	350	$3,780	$10.80
Protection & Advocacy	Turtle Mt		129 Sandra Birdsell Ave, Office #2	Belcourt	ND	58316	256	$6,600	$25.78
Public Employees Retirement System		Dakota Northwestern Bldg	400 E Broadway Ave, Ste 503, 505, & 515	Bismarck	ND	58502-1657	6,442	$89,866	$13.95
Public Employees Retirement System		Dakota Northwestern Bldg	400 E Broadway Ave, Ste 300	Bismarck	ND	58502-1657	1,514	$21,120	$13.95
Public Employees Retirement System		Dakota Northwestern Bldg	400 E Broadway Ave, vacated suite near Ste 505	Bismarck	ND	58502-1657	1,088	$10,880	$10.00
Public Instruction, Dept of	Child Nutrition & Food Distribution Programs	Gateway Professional Bldg		Bismarck	ND	58507	3,155	$27,606	$8.75
Public Instruction, Dept of	Child Nutrition & Food Distribution Programs	Mayville State University		Mayville	ND	58257	173	$1,200	$6.94
Public Instruction, Dept of	Special Education	North Central Human Service Ctr		Minot	ND	58701	162	$1,698	$10.46
Real Estate Commission			200 E Main Ave, Ste 204	Bismarck	ND	58501	1,265	$13,800	$10.91
Reg Board of Prof Engineers & Land Surveyors			723 W Memorial Hwy	Bismarck	ND	58504	1,771	$19,476	$11.00
Retirement & Investment			1930 Burnt Boat Dr	Bismarck	ND	58507-7100	5,569	$74,513	$13.38
School for the Blind			1015 S Broadway, Ste 21	Minot	ND	58702	421	$4,409	$10.46

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
School for the Blind			300 2nd Ave NE, Ste 208	Jamestown	ND	58401	452	$3,164	$7.00
School for the Blind			2624 9th Ave SW	Fargo	ND	58103	114	$2,280	$20.00
School for the Blind		City Center Plaza	418 E Broadway Ave	Bismarck	ND	58501	320	$2,040	$6.38
School for the Deaf		City Center Plaza	418 E Broadway, Ste 228	Bismarck	ND	58501	310	$2,688	$8.67
School for the Deaf		ND DHS- NE Human Serv Ctr	151 S 4th St, Ste 401	Grand Forks	ND	58201-4735		$2,652	na
School for the Deaf		South Plaza Properties	1510 12th Ave N	Fargo	ND	58105	63	$1,260	$20.00
Securities Dept		Rivers Edge	311 S 4th St, Ste 116	Grand Forks	ND	58201	480	$5,280	$11.00
Soybean Council			1411 32nd St S, Ste 3	Fargo	ND	58103	1,892	$24,700	$13.05
Tax Dept			3217 Fiechtner Dr S	Fargo	ND	58103	1,436	$16,227	$11.30
Tax Dept		Arrowhead Shopping Ctr	1600 2nd Ave SW, Ste 11	Minot	ND	58701-3459	600	$5,700	$9.50
Tax Dept		City Center Plaza	135 Sims, Ste 211	Dickinson	ND	58602-0766	224	$2,820	$12.59
Tax Dept		Hemmp Exe Suites	1407 24th Ave S	Grand Forks	ND	58208-4435	384	$2,280	$5.94
Tax Dept		Park Plaza	1137 2nd Ave W, Ste 103	Williston	ND	58802-1701	180	$1,800	$10.00
Tax Dept			1307 12th Ave NE, Ste 3	Jamestown	ND	58402-0444	120	$1,200	$10.00
Transportation, Dept of	Drivers License	Forum Communications Co Inc	518 Hwy 2 E	Devils Lake	ND	58301	1,150	$12,600	$10.96
Transportation, Dept of	Drivers License	Jamestown Business Ctr	300 2nd Ave NE, Ste 139	Jamestown	ND	58401	815	$10,188	$12.50
Transportation, Dept of	Drivers License	Arrowhead Shopping Ctr	1600 2nd Ave SW	Minot	ND	58701	1,000	$9,500	$9.50
Transportation, Dept of	Drivers License	Grafton Developmental Ctr	701 W Sixth St, Rm 305,307,311	Grafton	ND	58237	1,097	$2,743	$2.50
Transportation, Dept of	Drivers License	National Guard Armory	747 7th St SE	Valley City	ND	58072	1,200	$2,100	$1.75
Transportation, Dept of	Maintenance		2301 University Dr (2 Spaces for Hanger Storage in Bldg #5)	Bismarck	ND	58504	513	$243	$0.47
Veteran's Affairs		S & D Mgmt	4201 38th St SW, Ste.104	Fargo	ND	58106-9003	2,485	$25,357	$10.20
Veteran's Affairs		Northbrook	1929 N Washington St, Ste LL	Bismarck	ND	58501	490	$6,232	$12.72
Wheat Commission			2401 46th Ave SE, Ste 104	Mandan	ND	58554-4829	4,000	$48,000	$12.00
Workforce Safety & Insurance			2601 12th Ave SW	Fargo	ND	58103	3,348	$47,709	$14.25
Workforce Safety & Insurance		Great River Energy	1600 E Century Ave, Ste 1	Bismarck	ND	58503-0644	1,511	$22,665	$15.00
Workforce Safety & Insurance			3001-B 32nd Ave S, Ste 2B	Grand Forks	ND	58201	1,184	$19,820	$16.74

Fiscal Year Ending June 30, 2011

AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Workforce Safety & Insurance		Arrowhead Shopping Ctr	1600 2nd Ave SW, Ste 10	Minot	ND	58701	983	$11,059	$11.25
Workforce Safety & Insurance		Central Valley Health District	122 2nd St NW	Jamestown	ND	58401	288	$4,090	$14.20
Workforce Safety & Insurance		Association of General Contractor sublease to WSI	2601 12th Ave SW	Fargo	ND	58103	111	$1,575	$14.25
Workforce Safety & Insurance		Job Service	422 1st Ave W	Williston	ND	58801	176	$1,253	$7.12
Workforce Safety & Insurance		Job Service	66 Osborn Dr.	Dickinson	ND	58601-3934	176	$1,253	$7.12
Workforce Safety & Insurance		Job Service	301 S College Dr	Devils Lake	ND	58301-3511	140	$997	$7.12
						TOTALS:	718,154	$8,017,855	$11.16

Top 20 - Fiscal Year Ending June 30, 2011

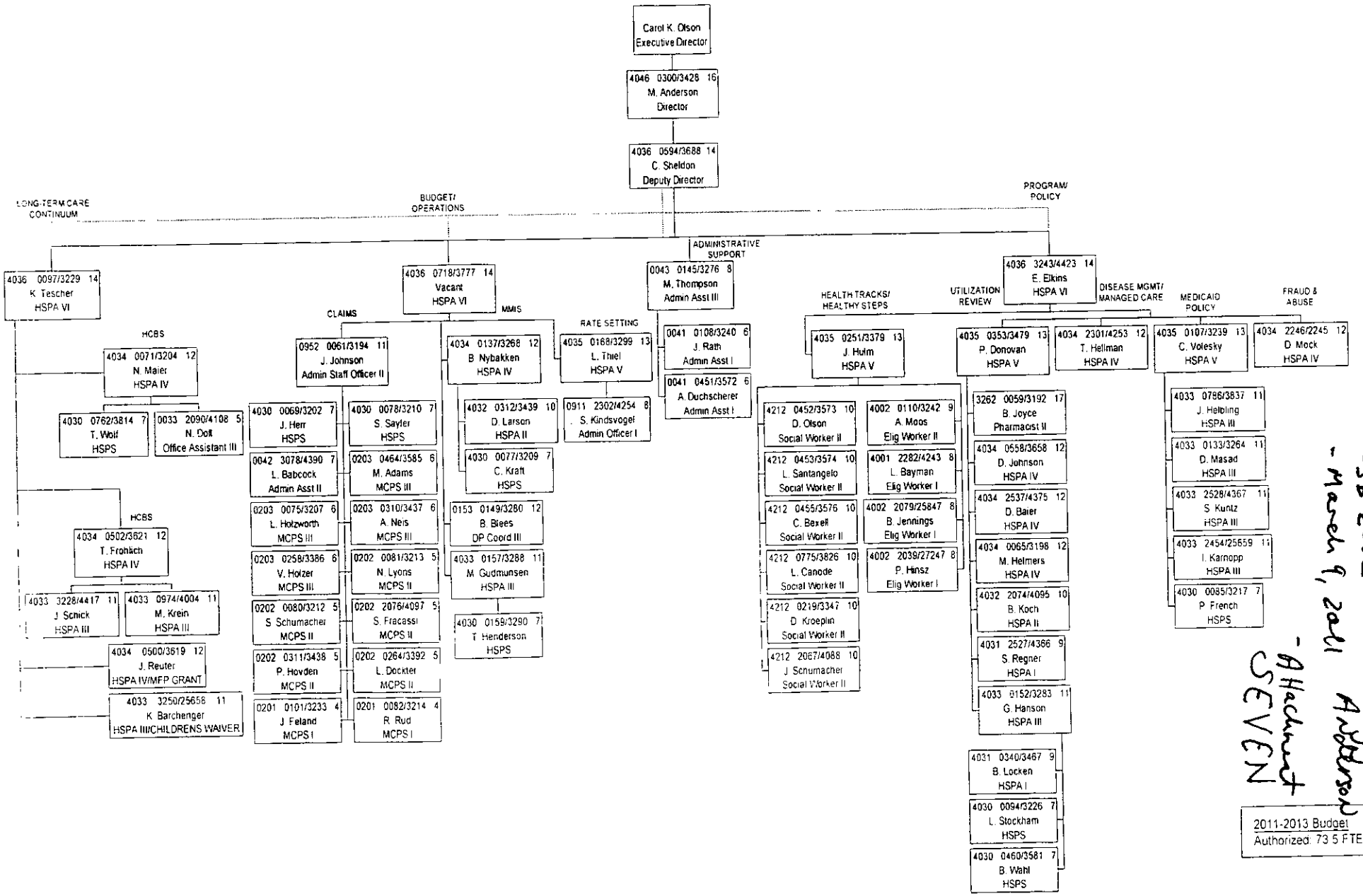
AGENCY NAME	DIVISION	ADDRESS A/BUILDING	PHYSICAL LOCATION	CITY	ST	ZIP	SQUARE FEET	ANNUAL RENT	PER SQ FOOT
Human Services	HSC	Capitol Lanes Plaza	1237 W Divide Ave, Ste 5	Bismarck	ND	58501-1208	58,950	$828,248	$14.05
Human Services	NEHSC		151 S 4th St	Grand Forks	ND	58206	40,040	$526,526	$13.15
Health Dept	Environmental Services. & Emerg. Preparedness	Gold Seal Ctr	918 E Divide Ave	Bismarck	ND	58501	40,025	$476,292	$11.90
Human Services	NCHSC	Minot Town & Country Investors	1015 S Broadway, Ste 18	Minot	ND	58701	42,911	$412,800	$9.62
Human Services	SCHSC		520 3rd St NW	Jamestown	ND	58401	27,577	$285,973	$10.37
Information Tech Dept		Northbrook	1929 N Washington St	Bismarck	ND	58501	17,077	$220,635	$12.92
Human Services	SLHSC	Pulver Hall, Dickinson State Univ	300 13th Ave W, Ste #1	Dickinson	ND	58601	19,145	$220,458	$11.52
Housing Finance Agency			2624 Vermont Ave	Bismarck	ND	58504	13,760	$213,280	$15.50
Commerce Dept	Economic Dev/Fin-Ag Products Util Comm		1600 E Century Ave, Ste#2 & #143	Bismarck	ND	58503	15,368	$211,310	$13.75
Human Services	NWHSC		316 2nd Ave W	Williston	ND	58802	23,365	$198,603	$8.50
Information Tech Dept		ND Association of Counties Bldg	PO Box 877	Bismarck	ND	58502-0877	12,000	$180,000	$15.00
Attorney General		Professional North Bldg	4205 N State St	Bismarck	ND	58503	15,735	$167,578	$10.65
Human Services	LRHSC		W Walnut St	Devils Lake	ND	58301	18,236	$140,417	$7.70
Industrial Commission	Oil & Gas		1016 E Calgary Ave	Bismarck	ND	58503	9,175	$133,827	$14.59
Human Services	Central Office	Century Center	1600 E Century Ave, Ste #5, #7 & Rm 144	Bismarck	ND	58503	9,251	$124,889	$13.50
Health Dept	Emerg. Preparedness	Jobber's Moving & Storage	1200 Industrial Dr	Bismarck	ND	58503	23,520	$123,888	$5.27
Judicial Branch	District Court	Centennial Plaza LLC	116 4th St	Bismarck	ND	58501	11,156	$118,700	$10.64
Human Services	SEHSC	Liffrig Family Investments	1122 1st Ave N	Fargo	ND	58102	9,129	$108,299	$11.86
Attorney General		Gateway Professional Bldg		Bismarck	ND	58503	8,300	$107,900	$13.00
Attorney General		Professional Bldg Limited	500 N 9th St	Bismarck	ND	58503	10,000	$96,000	$9.60
						TOTALS:	424,720	$4,895,622	$11.53

- SB 2012
- March 9, 2011
- Jenny Witham
- Attachment 5

Information Technology Services

2009 - 2011 Budget Account Code 551000 - IT Equipment under $5,000	**$**	**779,187**
Computers The purchase of 927 PCs to replace 50% of all DHS' PCs which will follow a 4 year replacement cycle of which 26% will be laptops vs. 12% in 2009-2011. The increase in laptops is due to increased mobility in the Regional Human Service centers for assisting clients in rural areas.	$	148,583
Network Printers The purchase of 70 printers vs. 71 printers in 2009-2011 to replace older models that are due for replacement. These consist of various models with various pricing.	$	(7,694)
Monitors The purchase of 210 monitors to replace an estimated 20% of the older CRT monitors that are failing due to being 10+ years old.	$	35,616
Scanners and Projectors The purchase of 5 scanners to replace an estimated 25% of all scanners and the purchase of 13 projectors to replace an estimated 32% of all projectors. In 2009-2011 3 scanners and 5 projectors were purchased however, the overall purchase price for this equipment continues to decline. Projectors are primarily used for training and presentations.	$	2,487
Telepharmacy Equipment The purchase of 2 PCs, camera, and fax for the Telepharmacy system.	$	1,859
Total Change in 2011-13 Budget Account Code 551000 - IT Equipment under $5,000	**$**	**180,851**
2011-13 Budget Account Code 551000 - IT Equipment under $5,000	**$**	**960,038**

North Dakota Department of Human Services
Medical Services Division



- SB 2012
- March 9, 2011
- Maggie Anderson
- Attachment SEVEN

Revised 2/25/1

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-03 MEDICAL SERVICES											
S101		FULL-TIME EQUIVALENTS (FTEs)		66.500	67.500	0.000	6.000	0.000	73.500	0.000	73.500
32510	B	511000 Salaries - Permanent		4,826,703	5,455,185	2,681,840	734,329	0	6,189,514	0	6,189,514
32510	B	513000 Temporary Salaries		222,184	362,523	171,182	378,501	0	741,024	0	741,024
32510	B	514000 Overtime		145,586	276,768	114,539	(163,847)	0	112,921	0	112,921
32510	B	516000 Fringe Benefits		1,758,956	2,321,783	1,076,165	278,702	0	2,600,485	0	2,600,485
32510	B	599110 Salary Increase		0	0	0	0	278,791	278,791	0	278,791
32510	B	599160 Benefit Increase		0	0	0	0	47,187	47,187	0	47,187
32510	B	599161 Health Increase		0	0	0	0	105,717	105,717	0	105,717
32510	B	599162 Retirement Increase		0	0	0	0	64,120	64,120	0	64,120
32510	B	599163 EAP Increase		0	0	0	0	212	212	0	212
			Subtotal:	6,953,429	8,416,259	4,043,726	1,227,685	496,027	10,139,971	0	10,139,971
32510	F	F_1991 Salary - General Fund		2,850,722	3,519,382	1,618,855	288,301	217,159	4,024,842	0	4,024,842
32510	F	F_1992 Salary - Federal Funds		4,100,680	4,896,877	2,424,871	936,771	278,867	6,112,515	0	6,112,515
32510	F	F_1993 Salary - Other Funds		2,027	0	0	2,613	1	2,614	0	2,614
			Subtotal:	6,953,429	8,416,259	4,043,726	1,227,685	496,027	10,139,971	0	10,139,971
32530	B	521000 Travel		99,212	165,396	55,405	54,863	0	220,259	0	220,259
32530	B	531000 Supplies - IT Software		28,561	23,952	12,954	1,332	0	25,284	0	25,284
32530	B	532000 Supply/Material-Professional		22,420	23,233	6,345	(13,029)	0	10,204	0	10,204
32530	B	536000 Office Supplies		32,649	37,106	17,742	(7,550)	0	29,556	0	29,556
32530	B	541000 Postage		6,725	752	545	148	0	900	0	900
32530	B	542000 Printing		81,561	55,176	33,448	39,788	0	94,964	0	94,964
32530	B	553000 Office Equip & Furniture-Under		30,631	7,500	4,338	(4,000)	0	3,500	0	3,500
32530	B	571000 Insurance		30	0	0	0	0	0	0	0
32530	B	582000 Rentals/Leases - Bldg/Land		50,761	63,366	30,289	(5,811)	0	57,555	0	57,555
32530	B	591000 Repairs		3,600	2,524	1,735	(498)	0	2,026	0	2,026
32530	B	601000 IT - Data Processing		39,046	45,000	22,822	10,500	0	55,500	0	55,500
32530	B	602000 IT-Communications		2,433	2,673	1,842	(393)	0	2,280	0	2,280
32530	B	603000 IT Contractual Services and Re		526	65,312	61,598	57,968	0	123,280	0	123,280
32530	B	611000 Professional Development		33,215	33,705	21,225	(1,670)	0	32,035	0	32,035

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-03 MEDICAL SERVICES											
32530	B	621000 Operating Fees and Services		21,524,887	23,288,009	9,407,338	10,291,490	0	33,579,499	0	33,579,499
			Subtotal:	21,956,257	23,813,704	9,677,626	10,423,138	0	34,236,842	0	34,236,842
32530	F	F_3991 Operating - General Fund		18,223,286	20,150,936	7,818,645	6,896,375	0	27,047,311	0	27,047,311
32530	F	F_3992 Operating - Federal Funds		3,010,760	2,870,768	1,655,465	3,116,072	0	5,986,840	0	5,986,840
32530	F	F_3993 Operating - Other Funds		722,211	792,000	203,516	410,691	0	1,202,691	0	1,202,691
			Subtotal:	21,956,257	23,813,704	9,677,626	10,423,138	0	34,236,842	0	34,236,842
32573	B	712000 Grants, Benefits & Claims		401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
			Subtotal:	401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
32573	F	F_7391 MA Grants - General Fund		99,940,901	124,849,375	51,709,543	84,056,117	0	208,905,492	567,367	209,472,859
32573	F	F_7392 MA Grants - Federal Funds		280,581,690	357,244,028	194,068,516	63,899,645	0	421,143,673	1,266,990	422,410,663
32573	F	F_7393 MA Grants - Other Funds		11,573,419	15,929,894	10,945,804	(2,224,694)	0	13,705,200	0	13,705,200
32573	F	F_7394 MA Grants - Retained Funds		9,764,838	17,371,688	0	2,589,026	0	19,960,714	0	19,960,714
			Subtotal:	401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
			Subdivision Budget Total:	430,770,534	547,624,948	270,445,215	159,970,917	496,027	708,091,892	1,834,357	709,926,249
			General Funds:	121,014,909	148,519,693	61,147,043	91,240,793	217,159	239,977,645	567,367	240,545,012
			Federal Funds:	287,693,130	365,011,673	198,148,852	67,952,488	278,867	433,243,028	1,266,990	434,510,018
300-03 MEDICAL SERVICES			**Other Funds:**	12,297,657	16,721,894	11,149,320	(1,811,390)	1	14,910,505	0	14,910,505
			SWAP Funds:	9,764,838	17,371,688	0	2,589,026	0	19,960,714	0	19,960,714
			County Funds:	0	0	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	430,770,534	547,624,948	270,445,215	159,970,917	496,027	708,091,892	1,834,357	709,926,249

Medical Services 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Northbrook LLP			13,608	13,608		27,216
Health Tracks - Minot			2,448	2,448		4,896
Health Tracks - Grand Forks			5,610	5,610		11,220
Health Tracks - Fargo			5,875	5,875		11,750
Health Tracks - Dickinson			678	679		1,357
Booth Rental - MFP			572	544		1,116
			$ 28,791	**$ 28,764**	**$ -**	**$ 57,555**

Medical Services 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
ND Healthcare Review	238,468	565,404		803,872
First Data Bank	42,939	128,819		171,758
Dakota Medical Foundation	168,285	481,715		650,000
Chad Jones	56,245	56,245		112,490
Graphic Arts Production	18,412	18,412		36,824
Acumen Fiscal Agent	1,365	1,366		2,731
Myers & Stauffer LC	125,000	125,000		250,000
Health Management Systems	31,500	31,500		63,000
DDM Ascend Management	514,363	810,891		1,325,254
Health Info Design	123,417	370,249		493,666
Child & Adolescent Psych	2,600	7,800		10,400
PA for MRI's and PET Scans	25,000	75,000		100,000
CHIP EQR Contract	71,197	203,803		275,000
Actuary Services	30,000	30,000		60,000
Upper Payment Limit Contract	37,500	37,500		75,000
Comply w/ Healthcare Reform Legislation Contract	50,000	50,000		100,000
Public Notices	10,000	10,000		20,000
Advertising Services	2,030	470		2,500
Research Fees	1,218	282		1,500
IRS - DIFSLA Project	714	715		1,429
Drug Clawback	25,152,575		1,154,904	26,307,479
Misc.	60	60		120
Years of Services Awards	1,280	2,400		3,680
Licensures	772	1,373		2,145
Freight & Express	2,438	4,558		6,996
Subtotal Regular Medical Services	**$ 26,707,378**	**$ 3,013,562**	**$1,154,904**	**$30,875,844**

Description	General Fund	Federal Funds	Other Funds	Total
Options - Interst Resource Center	18,478	48,205		66,683
Independence Inc.	12,640	27,160		39,800
Freedom Resource Center	16,011	35,689		51,700
Dakota Center for Independent Living	13,431	30,792		44,223
US Care Management	5,174	19,026		24,200
DLN Consulting Inc.	12,939	31,200		44,139
Nursing Home Diversion Grant		300,000		300,000
Nurse Quality Assurance Positions	-	57,052		57,052
Transition Coordination Positions	-	888,401		888,401
CIL Outreach	-	172,800		172,800
Housing Supports	-	-	50,400	50,400
Housing Positions	-	839,257		839,257
HCBS Marketing	-	125,000		125,000
Subtotal MFP	**$ 78,673**	**$ 2,574,582**	**$ 50,400**	**$ 2,703,655**
Operating Fees and Services Total	**$ 26,786,051**	**$ 5,588,144**	**$1,205,304**	**$33,579,499**

March 9, 2011

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request
To House

	FTE Count
Administration / Support	
Legislatively Authorized	73.60
From DC - new attorney	1.00
2011-13 Biennium Request	**74.60**
Information Technology Services	
Legislatively Authorized	35.75
From Child Support for Central Office Desktop	0.50
From DC for CT at DC	0.25
From DC - Business Analyst position	1.00
From DC - Business Analyst positions	1.00
From DC - convert temp meeting criteria	3.00
2011-13 Biennium Request	**41.50**
Economic Assistance Policy Grants	
Legislatively Authorized	38.80
Healthcare Reform	1.00
2011-13 Biennium Request	**39.80**
Child Support	
Legislatively Authorized	164.70
To ITS	(0.50)
Healthcare Reform	1.00
2011-13 Biennium Request	**165.20**
Medical Services	
Legislatively Authorized	67.50
To DD Division	(1.00)
From CFS for Deputy	1.00
From DC convert temp meeting criteria	1.00
Healthcare Reform	5.00
2011-13 Biennium Request	**73.50**
DD Council	
Legislatively Authorized	1.00
2011-13 Biennium Request	**1.00**
Aging Services	
Legislatively Authorized	10.00
2011-13 Biennium Request	**10.00**
Children and Family Services	
Legislatively Authorized	18.00
To Medical Services	(1.00)
2011-13 Biennium Request	**17.00**

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request
To House

	FTE Count
Mental Health & Substance Abuse	
Legislatively Authorized	18.00
From DC: Prevention Coord.	6.00
2011-13 Biennium Request	**24.00**
Vocational Rehabilitation	
Legislatively Authorized	34.00
From LRHSC for VR Director	1.00
2011-13 Biennium Request	**35.00**
Developmental Disabilities Division	
Legislatively Authorized	8.00
From Medical Services	1.00
2011-13 Biennium Request	**9.00**
Northwest HSC	
Legislatively Authorized	44.75
From DC: Addiction Counselor	1.00
2011-13 Biennium Request	**45.75**
North Central HSC	
Legislatively Authorized	116.78
From DC: Psychiatrist	1.00
2011-13 Biennium Request	**117.78**
Lake Region HSC	
Legislatively Authorized	62.00
To VR for Director	(1.00)
To NEHSC	(1.00)
2011-13 Biennium Request	**60.00**
Northeast HSC	
Legislatively Authorized	137.10
From LRHSC	1.00
From SEHSC	0.20
2011-13 Biennium Request	**138.30**
Southeast HSC	
Legislatively Authorized	182.35
To NEHSC	(0.20)
2011-13 Biennium Request	**182.15**
South Central HSC	
Legislatively Authorized	85.50
2011-13 Biennium Request	**85.50**

Department of Human Services
FTE Reconciliation
2009 - 2011 Legislatively Approved vs 2011 - 2013 Request
To House

	FTE Count
West Central HSC	
Legislatively Authorized	135.30
2011-13 Biennium Request	**135.30**
Badlands HSC	
Legislatively Authorized	72.70
2011-13 Biennium Request	**72.70**
State Hospital - Traditional	
Legislatively Authorized	381.06
To State Hospital - Secure Services	(0.61)
From DC - Telepharmacy	1.00
2011-13 Biennium Request	**381.45**
State Hospital - Secure Services	
Legislatively Authorized	85.45
From State Hospital - Traditional	0.61
2011-13 Biennium Request	**86.06**
Developmental Center	
Legislatively Authorized	444.54
To ITS	(0.25)
To Administration / Support	(1.00)
To ITS	(1.00)
To NWHSC	(1.00)
To ITS	(4.00)
To Medical Services	(1.00)
To NCHSC	(1.00)
To MH/SA	(6.00)
To State Hospital - Telepharmacy	(1.00)
Unfunded	(27.53)
2011-13 Biennium Request	**400.76**
TOTAL	**2,196.35**

- Paul Kramer
- Attachment ONE
- SB 2012
- March 9, 2011

North Dakota Department of Human Services
Health Care Reform FTEs
Cost to Continue Salaries for the 2013 - 2015 Biennium

	Salaries Included in the 2011 - 2013 Executive Budget (Amounts do not Include Governor's Salary Package)		
Position	**Total Funds**	**General Funds**	**Start Date**
Economic Assistance Policy Trainer	17,058	17,058	April 1, 2013
Child Support Enforcement Attorney	174,612	59,368	July 1, 2011
Medical Services			
Eligibility Policy	110,919	55,460	July 1, 2011
Program Integrity	103,961	51,980	January 1, 2012
Nurse	52,896	13,224	October 1, 2012
SURS Analyst *	24,221	5,888	January 1, 2013
Administrative Support	20,612	11,145	January 1, 2013
Total	**$ 504,279**	**$ 214,123**	

	Salaries for 2013 - 2015 Biennium (full 24 months) **	
Position	**Total Funds**	**General Funds**
Economic Assistance Policy Trainer	137,396	68,698
Child Support Enforcement Attorney	176,060	59,860
Medical Services		
Eligibility Policy	112,368	56,184
Program Integrity	139,921	69,961
Nurse	142,362	35,591
SURS Analyst *	98,114	23,852
Administrative Support	83,832	45,328
Total	**$ 890,053**	**$ 359,474**

	Cost to Continue Salaries for 2013 - 2015	
Position	**Total Funds**	**General Funds**
Economic Assistance Policy Trainer	120,338	51,640
Child Support Enforcement Attorney	1,448	492
Medical Services		
Eligibility Policy	1,449	724
Program Integrity	35,960	17,981
Nurse	89,466	22,367
SURS Analyst *	73,893	17,964
Administrative Support	63,220	34,183
Total	**$ 385,774**	**$ 145,351**

* Surveillance and Utilization Review System (SURS)
** The health insurance cost in the 2011 - 2013 Executive Budget was used for this analysis.

- Debra McDermott
- Attachment TWO
- SB 2012
- March 9, 2011

North Dakota Department of Human Services
Inflationary Increases Compared to Consumer Price Index (CPI) ^
SB 2012

Fiscal Year Beginning	Inflationary Increases Granted by Legislature	**Overall CPI**	CPI for Specific Categories						
			Food	Transportation	Fuels & Utilities	*CPI Medical Categories*			
						Medical Commodities	Professional Services	Medical Care Services	Hospital & Related Services
July 1, 2010	6.0%	**1.2%**	0.9%	5.6%	3.1%	3.2%	2.8%	3.2%	6.3%
July 1, 2009	6% @	**-2.1%**	0.9%	-14.1%	-10.9%	3.2%	2.6%	3.2%	6.5%
July 1, 2008	5.0%	**5.6%**	6.0%	13.4%	16.0%	1.6%	3.6%	4.1%	6.8%
July 1, 2007	4.0%	**2.4%**	4.2%	-0.7%	3.8%	1.1%	3.9%	5.4%	6.4%
July 1, 2006	2.65%	**4.1%**	2.2%	8.4%	10.2%	3.9%	2.5%	4.0%	6.4%
July 1, 2005	2.65%	**3.2%**	2.1%	6.3%	8.1%	2.4%	3.8%	4.8%	5.2%
July 1, 2004	No Inflation ~	**3.0%**	4.0%	4.6%	4.5%	2.4%	4.0%		6.2%
July 1, 2003	No Inflation ~	**2.1%**	2.1%	2.0%	8.6%	2.4%	2.7%		7.4%
July 1, 2002	No Inflation * ~	**1.5%**	1.4%	-0.5%	-5.2%	3.6%	3.3%		8.8%
July 1, 2001	2.2%	**2.7%**							
July 1, 2000	2.0%	**3.5%**		*Information not obtained at this time.*					
July 1, 1999	2.0%	**2.1%**							
July 1, 1998	2.2%	**1.7%**							
July 1, 1997	2.2%	**2.2%**							

^ Consumer Price Index for all Urban Consumers (CPI-U) information was obtained from the US Bureau of Labor Statistics

@ Hospitals, Physicians, Dentists, Ambulance & Chiropractors were rebased therefore they did not receive inflation.

~ Nursing Facilities did receive an inflationary increase since it was required by NDCC. That section was amended by the 2005 Legislative Assembly.

*** Although a 2.2% increase was appropriated, sufficient funding did not exist to provide the increase.**

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation
Various Requested Inflation Scenarios

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 2.5% / 2.5%				Decrease from a 3% / 3% to a 2.5% / 2.5%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	13,837,724	5,810,444	8,027,280	(0)	(2,839,458)	(1,193,672)	(1,645,786)	(0)
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	14,070,144	6,193,037	7,877,107	-	(2,908,251)	(1,281,981)	(1,626,270)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	9,451,636	4,210,360	5,236,210	5,066	(1,472,952)	(655,908)	(816,010)	(1,034)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	3,066,709	1,840,508	1,201,203	24,998	(619,972)	(372,094)	(242,824)	(5,054)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	3,179,288	1,731,041	932,048	516,199	(642,263)	(336,708)	(201,779)	(103,776)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	785,912	663,289	85,319	37,304	(158,605)	(133,838)	(17,225)	(7,542)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,034,407	911,616	111,279	11,512	(206,869)	(182,312)	(22,255)	(2,302)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**45,425,820**	**21,360,295**	**23,470,446**	**595,079**	**(8,848,370)**	**(4,156,513)**	**(4,572,149)**	**(119,708)**

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 2% / 2%				Decrease from a 3% / 3% to a 2% / 2%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	11,061,771	4,645,190	6,416,581	-	(5,615,411)	(2,358,926)	(3,256,485)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	11,235,542	4,943,671	6,291,871	-	(5,742,853)	(2,531,347)	(3,211,506)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	7,603,745	3,387,220	4,212,472	4,053	(3,320,843)	(1,479,048)	(1,839,748)	(2,047)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	2,448,979	1,469,833	959,174	19,972	(1,237,702)	(742,769)	(484,853)	(10,080)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	2,539,132	1,377,356	749,320	412,456	(1,282,419)	(690,393)	(384,507)	(207,519)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	627,779	529,844	68,150	29,785	(316,738)	(267,283)	(34,394)	(15,061)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	827,528	729,294	89,026	9,208	(413,748)	(364,634)	(44,508)	(4,606)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**36,344,476**	**17,082,408**	**18,786,594**	**475,474**	**(17,929,714)**	**(8,434,400)**	**(9,256,001)**	**(239,313)**

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation
Various Requested Inflation Scenarios

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 1.5% / 1.5%				Decrease from a 3% / 3% to a 1.5% / 1.5%			
Provider Groups	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	8,229,951	3,454,850	4,775,101	(0)	(8,447,231)	(3,549,266)	(4,897,965)	(0)
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	8,397,571	3,700,715	4,696,856	-	(8,580,824)	(3,774,303)	(4,806,521)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	5,768,325	2,569,644	3,195,645	3,036	(5,156,263)	(2,296,624)	(2,856,575)	(3,064)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	1,832,943	1,100,057	717,945	14,941	(1,853,738)	(1,112,545)	(726,082)	(15,111)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	1,901,334	1,051,792	542,228	307,314	(1,920,217)	(1,015,957)	(591,599)	(312,661)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	470,120	396,790	51,037	22,293	(474,397)	(400,337)	(51,507)	(22,553)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	620,667	546,992	66,763	6,912	(620,609)	(546,936)	(66,771)	(6,902)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**27,220,911**	**12,820,840**	**14,045,575**	**354,496**	**(27,053,279)**	**(12,695,968)**	**(13,997,020)**	**(360,291)**

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 1% / 1%				Decrease from a 3% / 3% to a 1% / 1%			
Provider Groups	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**	**Total**	**General**	**Federal**	**Other**
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	5,550,153	2,331,418	3,218,735	-	(11,127,029)	(4,672,698)	(6,454,331)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	5,614,565	2,474,178	3,140,387	-	(11,363,830)	(5,000,840)	(6,362,990)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	3,962,139	1,765,097	2,195,019	2,023	(6,962,449)	(3,101,171)	(3,857,201)	(4,077)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	1,219,596	732,064	477,581	9,951	(2,467,085)	(1,480,538)	(966,446)	(20,101)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	1,265,445	686,120	373,815	205,510	(2,556,106)	(1,381,629)	(760,012)	(414,465)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	312,943	264,132	33,987	14,824	(631,574)	(532,995)	(68,557)	(30,022)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	413,764	364,647	44,513	4,604	(827,512)	(729,281)	(89,021)	(9,210)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**18,338,605**	**8,617,656**	**9,484,037**	**236,912**	**(35,935,585)**	**(16,899,152)**	**(18,558,558)**	**(477,875)**

DEPARTMENT OF HUMAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-03 MEDICAL SERVICES										
S101		FULL-TIME EQUIVALENTS (FTEs)	66.500	67.500	0.000	6.000	0.000	73.500	0.000	73.500
32510	B	511000 Salaries - Permanent	4,826,703	5,455,185	2,681,840	734,329	0	6,189,514	0	6,189,514
32510	B	513000 Temporary Salaries	222,184	362,523	171,182	378,501	0	741,024	0	741,024
32510	B	514000 Overtime	145,586	276,768	114,539	(163,847)	0	112,921	0	112,921
32510	B	516000 Fringe Benefits	1,758,956	2,321,783	1,076,165	278,702	0	2,600,485	0	2,600,485
32510	B	599110 Salary Increase	0	0	0	0	278,791	278,791	0	278,791
32510	B	599160 Benefit Increase	0	0	0	0	47,187	47,187	0	47,187
32510	B	599161 Health Increase	0	0	0	0	105,717	105,717	0	105,717
32510	B	599162 Retirement Increase	0	0	0	0	64,120	64,120	0	64,120
32510	B	599163 EAP Increase	0	0	0	0	212	212	0	212
		Subtotal:	6,953,429	8,416,259	4,043,726	1,227,685	496,027	10,139,971	0	10,139,971
32510	F	F_1991 Salary - General Fund	2,850,722	3,519,382	1,618,855	288,301	217,159	4,024,842	0	4,024,842
32510	F	F_1992 Salary - Federal Funds	4,100,680	4,896,877	2,424,871	936,771	278,867	6,112,515	0	6,112,515
32510	F	F_1993 Salary - Other Funds	2,027	0	0	2,613	1	2,614	0	2,614
		Subtotal:	6,953,429	8,416,259	4,043,726	1,227,685	496,027	10,139,971	0	10,139,971
32530	B	521000 Travel	99,212	165,396	55,405	54,863	0	220,259	0	220,259
32530	B	531000 Supplies - IT Software	28,561	23,952	12,954	1,332	0	25,284	0	25,284
32530	B	532000 Supply/Material-Professional	22,420	23,233	6,345	(13,029)	0	10,204	0	10,204
32530	B	536000 Office Supplies	32,649	37,106	17,742	(7,550)	0	29,556	0	29,556
32530	B	541000 Postage	6,725	752	545	148	0	900	0	900
32530	B	542000 Printing	81,561	55,176	33,448	39,788	0	94,964	0	94,964
32530	B	553000 Office Equip & Furniture-Under	30,631	7,500	4,338	(4,000)	0	3,500	0	3,500
32530	B	571000 Insurance	30	0	0	0	0	0	0	0
32530	B	582000 Rentals/Leases - Bldg/Land	50,761	63,366	30,289	(5,811)	0	57,555	0	57,555
32530	B	591000 Repairs	3,600	2,524	1,735	(498)	0	2,026	0	2,026
32530	B	601000 IT - Data Processing	39,046	45,000	22,822	10,500	0	55,500	0	55,500
32530	B	602000 IT-Communications	2,433	2,673	1,842	(393)	0	2,280	0	2,280
32530	B	603000 IT Contractual Services and Re	526	65,312	61,598	57,968	0	123,280	0	123,280
32530	B	611000 Professional Development	33,215	33,705	21,225	(1,670)	0	32,035	0	32,035

SB 2012 - Attachment THREE
- March 9, 2011 - Maggie Anderson

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-03 MEDICAL SERVICES											
32530	B	621000 Operating Fees and Services		21,524,887	23,288,009	9,407,338	10,291,490	0	33,579,499	0	33,579,499
			Subtotal:	21,956,257	23,813,704	9,677,626	10,423,138	0	34,236,842	0	34,236,842
32530	F	F_3991 Operating - General Fund		18,223,286	20,150,936	7,818,645	6,896,375	0	27,047,311	0	27,047,311
32530	F	F_3992 Operating - Federal Funds		3,010,760	2,870,768	1,655,465	3,116,072	0	5,986,840	0	5,986,840
32530	F	F_3993 Operating - Other Funds		722,211	792,000	203,516	410,691	0	1,202,691	0	1,202,691
			Subtotal:	21,956,257	23,813,704	9,677,626	10,423,138	0	34,236,842	0	34,236,842
32573	B	712000 Grants, Benefits & Claims		401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
			Subtotal:	401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
32573	F	F_7391 MA Grants - General Fund		99,940,901	124,849,375	51,709,543	84,056,117	0	208,905,492	567,367	209,472,859
32573	F	F_7392 MA Grants - Federal Funds		280,581,690	357,244,028	194,068,516	63,899,645	0	421,143,673	1,266,990	422,410,663
32573	F	F_7393 MA Grants - Other Funds		11,573,419	15,929,894	10,945,804	(2,224,694)	0	13,705,200	0	13,705,200
32573	F	F_7394 MA Grants - Retained Funds		9,764,838	17,371,688	0	2,589,026	0	19,960,714	0	19,960,714
			Subtotal:	401,860,848	515,394,985	256,723,863	148,320,094	0	663,715,079	1,834,357	665,549,436
			Subdivision Budget Total:	430,770,534	547,624,948	270,445,215	159,970,917	496,027	708,091,892	1,834,357	709,926,249
300-03 MEDICAL SERVICES			General Funds:	121,014,909	148,519,693	61,147,043	91,240,793	217,159	239,977,645	567,367	240,545,012
			Federal Funds:	287,693,130	365,011,673	198,148,852	67,952,488	278,867	433,243,028	1,266,990	434,510,018
			Other Funds:	12,297,657	16,721,894	11,149,320	(1,811,390)	1	14,910,505	0	14,910,505
			SWAP Funds:	9,764,838	17,371,688	0	2,589,026	0	19,960,714	0	19,960,714
			County Funds:	0	0	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	430,770,534	547,624,948	270,445,215	159,970,917	496,027	708,091,892	1,834,357	709,926,249

Medical Services 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Northbrook LLP			13,608	13,608		27,216
Health Tracks - Minot			2,448	2,448		4,896
Health Tracks - Grand Forks			5,610	5,610		11,220
Health Tracks - Fargo			5,875	5,875		11,750
Health Tracks - Dickinson			678	679		1,357
Booth Rental - MFP			572	544		1,116
			$ 28,791	**$ 28,764**	**$ -**	**$ 57,555**

Medical Services 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
ND Healthcare Review	238,468	565,404		803,872
First Data Bank	42,939	128,819		171,758
Dakota Medical Foundation	168,285	481,715		650,000
Chad Jones	56,245	56,245		112,490
Graphic Arts Production	18,412	18,412		36,824
Acumen Fiscal Agent	1,365	1,366		2,731
Myers & Stauffer LC	125,000	125,000		250,000
Health Management Systems	31,500	31,500		63,000
DDM Ascend Management	514,363	810,891		1,325,254
Health Info Design	123,417	370,249		493,666
Child & Adolescent Psych	2,600	7,800		10,400
PA for MRI's and PET Scans	25,000	75,000		100,000
CHIP EQR Contract	71,197	203,803		275,000
Actuary Services	30,000	30,000		60,000
Upper Payment Limit Contract	37,500	37,500		75,000
Comply w/ Healthcare Reform Legislation Contract	50,000	50,000		100,000
Public Notices	10,000	10,000		20,000
Advertising Services	2,030	470		2,500
Research Fees	1,218	282		1,500
IRS - DIFSLA Project	714	715		1,429
Drug Clawback	25,152,575		1,154,904	26,307,479
Misc.	60	60		120
Years of Services Awards	1,280	2,400		3,680
Licensures	772	1,373		2,145
Freight & Express	2,438	4,558		6,996
Subtotal Regular Medical Services	$ 26,707,378	$ 3,013,562	$1,154,904	$30,875,844

Description	General Fund	Federal Funds	Other Funds	Total
Options - Interst Resource Center	18,478	48,205		66,683
Independence Inc.	12,640	27,160		39,800
Freedom Resource Center	16,011	35,689		51,700
Dakota Center for Independent Living	13,431	30,792		44,223
US Care Management	5,174	19,026		24,200
DLN Consulting Inc.	12,939	31,200		44,139
Nursing Home Diversion Grant		300,000		300,000
Nurse Quality Assurance Positions	-	57,052		57,052
Transition Coordination Positions	-	888,401		888,401
CIL Outreach	-	172,800		172,800
Housing Supports	-	-	50,400	50,400
Housing Positions	-	839,257		839,257
HCBS Marketing	-	125,000		125,000
Subtotal MFP	$ 78,673	$ 2,574,582	$ 50,400	$ 2,703,655
Operating Fees and Services Total	$ 26,786,051	$ 5,588,144	$1,205,304	$33,579,499

-Attachment Four
- SB 2012
-Mar 9, 2011
- Maggie Anderson

ND Department of Human Services
Childrens Health Insurance Program
2011-2013 Biennium

	Executive Budget 160% @ 274.03	Updated Premium 160% @ 272.67	Difference
General	8,661,586	8,618,597	(42,989)
Federal	19,328,935	19,233,007	(95,928)
Total	27,990,521	27,851,604	(138,917)

	To the House 175% @ 274.03	Updated Premium 175% @ 272.67	Difference
General	9,228,953	9,183,148	(45,805)
Federal	20,595,925	20,493,709	(102,216)
Total	29,824,878	29,676,857	(148,021)

ND Departr [illegible]man Services
Childrens He[illegible] Insurance Program
Various Scenarios with updated BCBS Premium ($272.67)
2011-2013 Biennium

CHIP Budget @ 160% Net Compared to 200% Net
It is estimated 200% will add 937 children

Poverty for a family of 4 @ 160% $35,280 @ 200% **$44,100**	Current CHIP Budget @ 160%	CHIP Budget @ 200% with Current BCBS Premiums	Increase in Caseload & Cost
Monthly Average Caseload	4,256	4,848	592
Ending Caseload	4,486	5,423	937
General	8,618,597	9,853,535	1,234,938
Federal	19,233,007	21,990,756	2,757,749
Includes 1 FTE Total	27,851,604	31,844,291	3,992,687

CHIP Budget @ 160% Net Compared to 195% Net
It is estimated 195% will add 910 children

Poverty for a family of 4 @ 160% $35,280 @ 195% **$42,998**	Current CHIP Budget @ 160%	CHIP Budget @ 195% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,830	574
Ending Caseload	4,486	5,396	910
General	8,618,597	9,802,727	1,184,130
Federal	19,233,007	21,877,295	2,644,288
Includes .5 FTE Total	27,851,604	31,680,022	3,828,418

CHIP Budget @ 160% Net Compared to 190% Net
It is estimated 190% will add 811 children

Poverty for a family of 4 @ 160% $35,280 @ 190% **$41,895**	Current CHIP Budget @ 160%	CHIP Budget @ 190% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,769	513
Ending Caseload	4,486	5,297	811
General	8,618,597	9,679,004	1,060,407
Federal	19,233,007	21,601,011	2,368,004
Includes .5 FTE Total	27,851,604	31,280,015	3,428,411

CHIP Budget @ 160% Net Compared to 185% Net
It is estimated 185% will add 673 children

Poverty for a family of 4 @ 160% $35,280 @ 185% **$40,793**	Current CHIP Budget @ 160%	CHIP Budget @ 185% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,685	429
Ending Caseload	4,486	5,159	673
General	8,618,597	9,509,740	891,143
Federal	19,233,007	21,223,026	1,990,019
Includes .5 FTE Total	27,851,604	30,732,766	2,881,162

CHIP Budget @ 160% Net Compared to 180% Net
It is estimated 180% will add 582 children

Poverty for a family of 4 @ 160% $35,280 @ 180% **$39,690**	Current CHIP Budget @ 160%	CHIP Budget @ 180% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,626	370
Ending Caseload	4,486	5,068	582
General	8,618,597	9,368,014	749,417
Federal	19,233,007	20,906,536	1,673,529
Total	27,851,604	30,274,550	2,422,946

CHIP Budget @ 160% Net Compared to 175% Net
It is estimated 175% will add 445 children

Poverty for a family of 4 @ 160% $35,280 @ 175% **$38,588**	Current CHIP Budget @ 160%	CHIP Budget @ 175% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,535	279
Ending Caseload	4,486	4,931	445
General	8,618,597	9,183,148	564,551
Federal	19,233,007	20,493,709	1,260,702
Total	27,851,604	29,676,857	1,825,253

CHIP Budget @ 160% Net Compared to 170% Net
It is estimated 170% will add 342 children

Poverty for a family of 4 @ 160% $35,280 @ 170% **$37,485**	Current CHIP Budget @ 160%	CHIP Budget @ 170% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,472	216
Ending Caseload	4,486	4,828	342
General	8,618,597	9,055,293	436,696
Federal	19,233,007	20,208,196	975,189
Total	27,851,604	29,263,489	1,411,885

CHIP Budget @ 160% Net Compared to 165% Net
It is estimated 165% will add 188 children

Poverty for a family of 4 @ 160% $35,280 @ 165% **$36,383**	Current CHIP Budget @ 160%	CHIP Budget @ 165% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,374	118
Ending Caseload	4,486	4,674	188
General	8,618,597	8,857,608	239,011
Federal	19,233,007	19,766,743	533,736
Total	27,851,604	28,624,351	772,747

- Attachment FIVE
- Maggie Anderson
- SB 2012
- March 9, 2011

Department of Human Services
Medical Services
Rebasing provided for the 09-11 Biennium

Service	Total	General	Federal/Other
Inpatient Hospital @100% of cost	22,013,114	8,140,450	13,872,664
Physician @75% of cost	39,750,000	14,699,550	25,050,450
Chiropractor @75% of cost	312,000	115,377	196,623
Ambulance @ Medicare rates	2,011,114	743,710	1,267,404
Dentists @75% of billed charges	2,445,138	904,167	1,540,971
	66,531,366	24,603,254	41,928,112

- SB 2012
- Attachment 5 IX
- Maggie Anderson
- March 9, 2011

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2011-2013 Executive Budget

	Budget	% of Budget
Traditional Medical Services		
Selected Services		
Inpatient Hospital	165,557,492	25.06%
Outpatient Hospital	75,868,920	11.48%
Physician Services	109,435,068	16.56%
Drugs (net of rebates)	50,513,555	7.65%
Healthy Steps (CHIP)	27,990,521	4.24%
Premiums	29,183,783	4.42%
Dental	24,029,520	3.64%
Psychiatric Residential Treatment Facilities	22,881,622	3.46%
Durable Medical Equipment	8,147,456	1.23%
Psychological Services	6,783,048	1.03%
Ambulance	5,487,816	0.83%
Indian Health Services (100% Federal Funds)	29,480,212	4.46%
Electronic Health Records (100% Fed Funds)	64,895,312	9.82%
Total of Selected Services	**620,254,325**	**93.88%**
Remaining Services	**40,448,552**	**6.12%**
Total 2011-2013 Executive Budget	**660,702,877**	**100.00%**

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Inpatient Hospital

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1,131	$ 2,869.88	4,858	$ 668.14	$ 3,245,838
September-09	1,412	5,673.22	6,804	1,177.33	8,010,581
October-09	1,108	4,652.16	5,051	1,020.51	5,154,597
November-09	1,263	3,901.75	5,615	877.63	4,927,904
December-09	1,262	5,220.18	6,098	1,080.33	6,587,865
January-10	934	4,669.36	4,251	1,025.92	4,361,181
February-10	1,270	5,911.65	5,252	1,429.51	7,507,795
March-10	1,510	5,571.61	6,665	1,262.29	8,413,134
April-10	1,222	4,287.69	5,540	945.77	5,239,555
May-10	1,249	5,441.15	5,988	1,134.94	6,795,993
June-10	1,359	5,901.90	6,117	1,311.21	8,020,684
July-10	1,032	5,152.22	4,447	1,195.66	5,317,092
August-10	1,173	4,978.29	5,662	1,031.36	5,839,534
September-10	1,395	5,902.85	5,825	1,413.64	8,234,478
October-10	1,105	4,399.44	4,662	1,042.77	4,861,384
November-10	1,072	3,923.59	4,432	949.03	4,206,088
Monthly Averages	1,219	$4,960.95	5,454	$ 1,108.37	$ 6,045,231

Avg Aug 09-June 10	5,669	$1,108.23	
6% Inflation (7-1-10)		$60.23	$
3/3 Inflation for 11-13		$48.36	
Monthly Averages Executive Budget 11-13	**5,669**	**$1,216.82**	

Inpatient Hospital contains a variety of reimbursement methodologies and rates DRG-PPS; Critical Access; Out of state, etc. We also tend to see a higher number of low cost services and lower number of high cost services, therefore the cost of inflation is calculated at a detail level, as using the combined average above would overstate the inflationary increase.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Outpatient Hospital

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	7,098	$ 305.98	123,608	$ 17.57	$ 2,171,879
September-09	10,144	337.54	251,172	13.63	3,423,976
October-09	7,069	341.44	97,691	24.71	2,413,673
November-09	8,954	248.67	181,158	12.29	2,226,622
December-09	9,464	309.51	252,614	11.60	2,929,219
January-10	8,206	327.54	186,209	14.43	2,687,794
February-10	8,849	313.79	190,365	14.59	2,776,730
March-10	10,373	347.27	257,555	13.99	3,602,208
April-10	8,977	332.06	195,107	15.28	2,980,899
May-10	8,570	296.09	121,431	20.90	2,537,534
June-10	10,385	304.69	190,767	16.59	3,164,191
July-10	8,947	297.68	143,459	18.57	2,663,375
August-10	8,914	286.68	162,659	15.71	2,555,461
September-10	10,024	276.42	183,769	15.08	2,770,814
October-10	9,102	267.75	164,576	14.81	2,437,058
November-10	8,916	265.78	167,401	14.16	2,369,681
Monthly Averages	9,000	303.57	179,346	15.23	2,731,945

Avg Aug 09-June 10	187,412	$15.69
6% Inflation (7-1-10)		$0.65
3/3 Inflation for 11-13		$0.53
Monthly Averages Executive Budget 11-13	**187,412**	**$16.87**

Outpatient Hospital contains a variety of reimbursement methodologies and rates Cost to Charge; Critical Access; Out of state, etc. We also tend to see a higher number of low cost services and lower number of high cost services, therefore the cost of inflation is calculated at a detail level, as using the combined average above would overstate the inflationary increase.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Physician

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	20,686	$ 155.98	193,386	$ 16.68	$ 3,226,552
September-09	24,549	171.97	240,634	17.54	4,221,625
October-09	19,811	174.59	187,659	18.43	3,458,763
November-09	25,633	164.93	204,636	20.66	4,227,548
December-09	25,002	160.70	206,447	19.46	4,017,751
January-10	22,743	165.72	200,745	18.77	3,768,978
February-10	24,794	181.17	230,299	19.50	4,491,971
March-10	27,583	189.81	291,755	17.94	5,235,467
April-10	24,019	178.46	239,951	17.86	4,286,513
May-10	23,968	172.62	221,209	18.70	4,137,344
June-10	25,775	198.33	273,779	18.67	5,111,951
July-10	21,110	187.29	214,882	18.40	3,953,609
August-10	21,956	182.19	222,557	17.97	4,000,194
September-10	25,673	199.97	257,073	19.97	5,133,832
October-10	23,096	176.20	216,586	18.79	4,069,502
November-10	23,912	165.46	202,987	19.49	3,956,399
Monthly Averages	23,769	176.96	225,287	18.67	4,206,125

Avg Aug 09-Apri 10	232,254	$17.72
6% Inflation (7-1-10)		$1.04
3/3 Inflation for 11-13		$0.87
Monthly Averages Executive Budget 11-13	**232,254**	**$19.63**

Physician contains a variety of reimbursement methodologies and rates In-state; Out of state; Nurse Practitioners; Primary Care Case Management, etc. We also tend to see a higher number of low cost services and lower number of high cost services, therefore the cost of inflation is calculated at a detail level, as using the combined average above would overstate the inflationary increase.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Drugs (Net of Rebates)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	15,457	$ 132.01	43,284	$ 44.20	$2,040,549
September-09	19,477	151.53	63,486	40.80	2,951,265
October-09	19,221	(65.81)	53,859	(47.77)	(1,264,995)
November-09	18,113	68.33	52,842	(2.48)	1,237,696
December-09	19,409	139.30	60,251	41.94	2,703,579
January-10	17,304	105.45	49,454	27.73	1,824,648
February-10	18,923	31.70	54,894	(25.44)	599,811
March-10	21,593	125.52	68,968	29.27	2,710,433
April-10	18,804	81.29	54,168	12.59	1,528,602
May-10	18,758	38.51	53,842	(22.77)	722,453
June-10	19,202	158.04	61,441	47.89	3,034,639
July-10	16,703	137.73	48,358	45.67	2,300,535
August-10	17,140	148.33	49,691	51.16	2,542,438
September-10	20,531	15.19	67,803	2.48	311,797
October-10	18,742	105.02	52,854	37.24	1,968,269
November-10	18,805	144.32	54,508	48.77	2,713,849
Monthly Averages	18,636	$93.65	55,606	$31.39	$1,745,348

	# of Prescriptions	
Used May 2010 eligible's of 62,257; 30% of eligible's receive drugs, and on average, recipients receiving drugs have 2.82 prescriptions per month. Prescriptions were adjusted for 4 and 5 week periods by using 32% in a 5 week period	53,840	
Used a 78% generic and 22% brand name ratio which produced an average prescription cost of		$36.32
4% inflation on brand name and 2% for Generic drugs (7/1/10)		$1.08
Used 4% and 2% in both years of 11-13		$1.69
Monthly Averages Executive Budget 11-13		**$39.09**

Inflation is not 3/3 for drugs, as this service is impacted by the actual cost of prescriptions. Used 4/4 inflation for brand and 2/2 for generic drugs. The average cost of a brand name drug is $166.23 and the average cost of a generic drug is $21.84.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Healthy Steps (CHIP)

Month	Actual Number of Premiums	Actual Cost Per Unit	Actual Expenditures
August-09	3,267	$ 228.89	$ 747,774
September-09	3,207	228.89	734,044
October-09	3,239	230.30	745,942
November-09	3,207	231.75	743,235
December-09	3,288	229.14	753,416
January-10	3,330	229.55	764,385
February-10	3,393	227.15	770,724
March-10	3,431	228.29	783,259
April-10	3,439	228.69	786,453
May-10	3,446	230.13	793,026
June-10	3,565	228.49	814,565
July-10	3,609	228.75	825,543
August-10	3,620	228.67	827,793
September-10	3,680	228.68	841,550
October-10	3,678	227.81	837,870
November-10	3,696	228.67	845,156
Monthly Averages	3,443	228.96	788,421
Started with May 2010	3,446	274.03	**Note 1**
June 2010 - July 2011, Growth of 40 per month	560		
11-13 Biennium, Growth of 20 per month	250		
Monthly Averages Executive Budget 11-13	**4,256**	**$274.03**	

Note 1 - $274.03 is the rate proposed by BC/BS for the 11/13 beinnium.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Premiums

Month	Actual Number of Premiums	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	-		8,466	$ 97.98	$ 829,486
September-09	-		8,404	98.38	826,781
October-09	-		8,341	98.31	819,979
November-09	-		8,550	97.89	836,956
December-09	-		8,441	112.00	945,384
January-10	-		8,595	110.30	948,010
February-10	-		8,638	111.84	966,110
March-10	-		8,652	111.95	968,594
April-10	-		8,740	112.15	980,208
May-10	-		8,871	112.22	995,525
June-10	-		8,875	111.85	992,724
July-10	-		8,800	111.98	985,467
August-10	-		8,824	112.19	989,945
September-10	-		8,824	111.71	985,763
October-10	-		8,799	112.77	992,231
November-10	-		9,056	111.64	1,010,976
Monthly Averages			8,680	108.54	942,134

Avg recipients April 10-July 10	8,824		
AIDS and Group health premiums rates were based average cost from Aug 09 to April 10; all other premiums used the CY2010 Federal rate of $110.50.		$111.96	
Recipient increase for remaining 12 month of 09-11 4 per month for QMB and SLMB; 2 per month QI's and SSA	144		
Recipient growth for 11-13 4 per month for QMB and SLMB; 2 per month QI's and SSA	150		
Cost projection based on Updated Federal rate of $115.40		$5.04	
Inflation for CY 2012 and 7 months of CY13		$16.36	11.56% increase
Monthly Averages Executive Budget 11-13	**9,118**	**$133.36**	

Premiums paid for QMBs, SLMBs, QI1 and SSA are set by the Federal Government. Premiums for AIDS is 100% General Fund and the Group Health Insurance is a cost-effective programs under Medicaid. Premiums do not receive the standard inflationary adjustment.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Dental Services

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	3,241	$ 225.10	12,889	$ 56.60	$ 729,556
September-09	4,941	247.24	20,882	58.50	1,221,635
October-09	3,787	247.40	15,503	60.43	936,896
November-09	3,719	238.95	14,559	61.04	888,656
December-09	4,103	246.79	15,938	63.53	1,012,571
January-10	3,282	226.08	12,196	60.84	741,992
February-10	3,486	230.38	13,383	60.01	803,103
March-10	4,128	221.85	16,348	56.02	915,777
April-10	3,986	220.54	14,849	59.20	879,082
May-10	4,698	251.75	18,785	62.96	1,182,707
June-10	4,238	252.34	16,900	63.28	1,069,417
July-10	3,694	264.18	15,092	64.66	975,876
August-10	3,892	244.92	15,245	62.53	953,225
September-10	4,386	260.64	17,677	64.67	1,143,167
October-10	4,010	253.30	15,707	64.67	1,015,718
November-10	3,477	255.34	13,664	64.97	887,811
Monthly Averages	3,942	243.50	15,601	61.52	959,824

Avg Aug 09-Apri 10	15,183	$59.51
6% Inflation (7-1-10)		$3.57
3/3 Inflation for 11-13		$2.86
Monthly Averages Executive Budget 11-13	**15,183**	**$65.94**

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Psychiatric Residential Treatment Facilities (PRTF)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	81	$ 10,577.63	2,716	$ 315.46	$ 856,788
September-09	93	10,742.34	3,163	315.85	999,038
October-09	72	13,055.29	2,452	383.35	939,981
November-09	60	11,819.33	1,842	384.99	709,160
December-09	79	10,440.43	2,481	332.44	824,794
January-10	68	11,295.53	2,050	374.68	768,096
February-10	82	9,038.23	2,532	292.71	741,135
March-10	88	13,071.19	3,443	334.09	1,150,265
April-10	79	9,081.65	2,189	327.75	717,450
May-10	82	9,910.23	2,408	337.47	812,639
June-10	89	12,077.69	3,346	321.25	1,074,914
July-10	75	9,846.55	2,443	302.29	738,491
August-10	70	11,491.60	2,268	354.68	804,412
September-10	73	11,323.04	2,362	349.95	826,582
October-10	39	9,939.46	1,209	320.63	387,639
November-10	77	12,388.05	2,497	382.01	953,880
Monthly Averages	75	11,023.42	2,463	337.69	831,579

Units based on Avg March 10 to June 10	2,559	
Rate was based on the 11 month Aug 09 to June 10		$337.86
Rate cost increase in CY 2011 of 5%		$16.90
Cost increases of 5/5 for CY 2012 & 2013		$17.88
Monthly Averages Executive Budget 11-13	**2,559**	**$372.64**

PRTF do not receive inflationary increases. Used a 5% cost increase to approximate the historical weighted cost increases of In-state and Out of state PRTFs.

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Durable Medical Equipment

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1,533	$ 169.23	140,242	$ 1.85	$ 259,433
September-09	1,893	183.19	184,949	1.87	346,774
October-09	1,537	198.02	144,549	2.11	304,356
November-09	1,612	157.11	153,146	1.65	253,256
December-09	1,881	168.43	181,353	1.75	316,816
January-10	1,652	166.81	153,325	1.80	275,572
February-10	1,807	167.37	171,210	1.77	302,442
March-10	2,202	172.91	217,532	1.75	380,745
April-10	1,685	204.70	153,635	2.25	344,921
May-10	2,055	168.80	173,473	2.00	346,890
June-10	2,413	178.49	246,702	1.75	430,694
July-10	1,881	178.70	181,239	1.85	336,140
August-10	1,783	221.98	177,036	2.24	395,790
September-10	2,022	208.33	211,455	1.99	421,242
October-10	1,986	191.72	165,487	2.30	380,764
November-10	1,814	167.13	162,514	1.87	303,171
Monthly Averages	1,860	181.44	176,115	1.92	337,438

Avg Aug 09-Apri 10	170,877	$1.79
6% Inflation (7-1-10)		$0.11
3/3 Inflation for 11-13		$0.09
Monthly Averages Executive Budget 11-13	**170,877**	**$1.99**

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Psychological Service

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1,260	$ 161.78	2,443	$ 83.44	$ 203,844
September-09	1,306	197.70	2,858	90.34	258,194
October-09	984	209.22	2,033	101.26	205,868
November-09	1,217	183.20	2,526	88.26	222,952
December-09	1,218	179.77	2,347	93.29	218,960
January-10	1,187	187.85	2,361	94.44	222,975
February-10	1,299	197.31	2,676	95.78	256,304
March-10	1,479	232.26	3,555	96.63	343,515
April-10	1,374	207.50	3,034	93.97	285,101
May-10	1,536	215.38	3,465	95.48	330,822
June-10	1,556	213.35	3,607	92.03	331,968
July-10	1,198	188.97	2,449	92.44	226,391
August-10	1,319	221.33	3,032	96.29	291,938
September-10	1,394	193.85	2,829	95.52	270,225
October-10	1,304	213.18	2,929	94.91	277,992
November-10	1,312	192.21	2,641	95.49	252,185
Monthly Averages	1,309	200.51	2,799	93.76	262,452

Avg Aug 09-Apri 10	2,718	$93.83
6% Inflation (7-1-10)		$5.63
3/3 Inflation for 11-13		$4.52
Monthly Averages Executive Budget 11-13	**2,718**	**$103.98**

North Dakota Dept of Human Services
Traditional Medical Services
Detail of Selected Services
2009-2011 Actual

Ambulance

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	484	$ 352.10	15,525	$ 10.98	$ 170,418
September-09	624	455.17	23,999	11.83	284,027
October-09	461	438.50	15,041	13.44	202,150
November-09	442	457.26	14,631	13.81	202,109
December-09	382	470.12	12,061	14.89	179,584
January-10	517	383.24	14,153	14.00	198,137
February-10	420	423.98	12,022	14.81	178,070
March-10	533	400.21	17,004	12.54	213,312
April-10	473	478.23	14,957	15.12	226,201
May-10	494	412.73	13,609	14.98	203,887
June-10	656	488.17	21,737	14.73	320,242
July-10	575	531.59	17,782	17.19	305,663
August-10	484	568.31	17,105	16.08	275,060
September-10	556	405.24	14,125	15.95	225,314
October-10	510	388.02	12,728	15.55	197,889
November-10	357	560.27	12,368	16.17	200,015
Monthly Averages	498	449.56	15,553	14.39	223,880

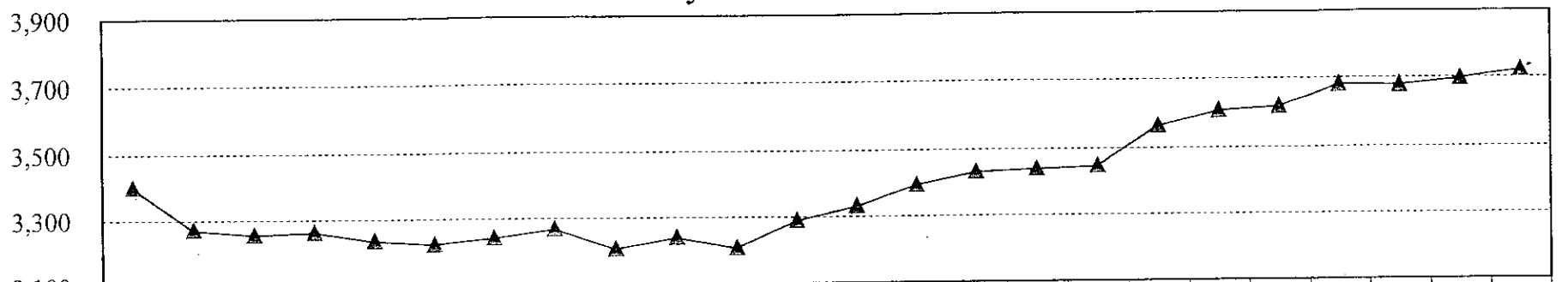
Avg Aug 09-Apri 10	15,513	$13.30
6% Inflation (7-1-10)		$0.80
3/3 Inflation for 11-13		$0.64
Monthly Averages Executive Budget 11-13	**15,513**	**$14.74**

North Dakota Department of Human Services

Attachment D

Healthy Steps Premiums Paid by Month

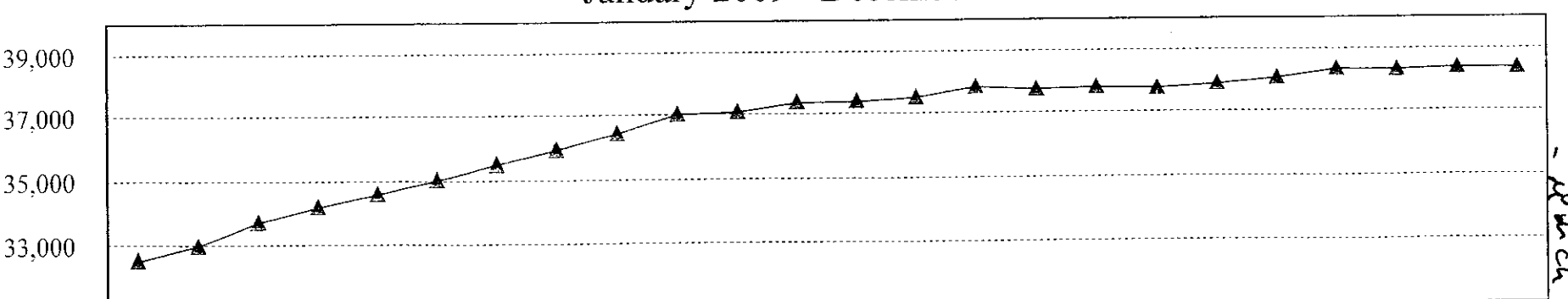
January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
3,399	3,270	3,255	3,262	3,235	3,224	3,242	3,267	3,207	3,239	3,207	3,288	3,330	3,393	3,431	3,439	3,446	3,565	3,609	3,620	3,680	3,678	3,696	3,721

Children Enrolled in Medicaid by Month

January 2009 - December 2010



Jan '09	Feb '09	Mar '09	Apr '09	May '09	Jun '09	Jul '09	Aug '09	Sep '09	Oct '09	Nov '09	Dec '09	Jan '10	Feb '10	Mar '10	Apr '10	May '10	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Nov '10	Dec '10
32,504	32,964	33,694	34,168	34,577	35,012	35,480	35,916	36,399	37,002	37,058	37,358	37,385	37,499	37,824	37,739	37,797	37,761	37,876	38,056	38,337	38,313	38,375	38,375

2/24/11-cj-1113legis\hs enroll & elig H

- SB 2012
- Attachment SEVEN
- Maggie Anderson, ND Medicaid 9, 2011

- Debra McDermott
- Attachment TWO
- SB 2012
- March 9, 2011

North Dakota Department of Human Services
Inflationary Increases Compared to Consumer Price Index (CPI) ^
SB 2012

Fiscal Year Beginning	Inflationary Increases Granted by Legislature	**Overall CPI**	CPI for Specific Categories						
			Food	Transportation	Fuels & Utilities	*CPI Medical Categories*			
						Medical Commodities	Professional Services	Medical Care Services	Hospital & Related Services
July 1, 2010	6.0%	**1.2%**	0.9%	5.6%	3.1%	3.2%	2.8%	3.2%	6.3%
July 1, 2009	6% @	**-2.1%**	0.9%	-14.1%	-10.9%	3.2%	2.6%	3.2%	6.5%
July 1, 2008	5.0%	**5.6%**	6.0%	13.4%	16.0%	1.6%	3.6%	4.1%	6.8%
July 1, 2007	4.0%	**2.4%**	4.2%	-0.7%	3.8%	1.1%	3.9%	5.4%	6.4%
July 1, 2006	2.65%	**4.1%**	2.2%	8.4%	10.2%	3.9%	2.5%	4.0%	6.4%
July 1, 2005	2.65%	**3.2%**	2.1%	6.3%	8.1%	2.4%	3.8%	4.8%	5.2%
July 1, 2004	No Inflation ~	**3.0%**	4.0%	4.6%	4.5%	2.4%	4.0%		6.2%
July 1, 2003	No Inflation ~	**2.1%**	2.1%	2.0%	8.6%	2.4%	2.7%		7.4%
July 1, 2002	No Inflation * ~	**1.5%**	1.4%	-0.5%	-5.2%	3.6%	3.3%		8.8%
July 1, 2001	2.2%	**2.7%**							
July 1, 2000	2.0%	**3.5%**		*Information not obtained at this time*					
July 1, 1999	2.0%	**2.1%**							
July 1, 1998	2.2%	**1.7%**							
July 1, 1997	2.2%	**2.2%**							

^ Consumer Price Index for all Urban Consumers (CPI-U) information was obtained from the US Bureau of Labor Statistics

@ Hospitals, Physicians, Dentists, Ambulance & Chiropractors were rebased therefore they did not receive inflation.

~ Nursing Facilities did receive an inflationary increase since it was required by NDCC. That section was amended by the 2005 Legislative Assembly.

*** Although a 2.2% increase was appropriated, sufficient funding did not exist to provide the increase.**

extra/color

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation
Various Requested Inflation Scenarios

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 2.5% / 2.5%				Decrease from a 3% / 3% to a 2.5% / 2.5%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	13,837,724	5,810,444	8,027,280	(0)	(2,839,458)	(1,193,672)	(1,645,786)	(0)
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	14,070,144	6,193,037	7,877,107	-	(2,908,251)	(1,281,981)	(1,626,270)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	9,451,636	4,210,360	5,236,210	5,066	(1,472,952)	(655,908)	(816,010)	(1,034)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	3,066,709	1,840,508	1,201,203	24,998	(619,972)	(372,094)	(242,824)	(5,054)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	3,179,288	1,731,041	932,048	516,199	(642,263)	(336,708)	(201,779)	(103,776)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	785,912	663,289	85,319	37,304	(158,605)	(133,838)	(17,225)	(7,542)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	1,034,407	911,616	111,279	11,512	(206,869)	(182,312)	(22,255)	(2,302)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**45,425,820**	**21,360,295**	**23,470,446**	**595,079**	**(8,848,370)**	**(4,156,513)**	**(4,572,149)**	**(119,708)**

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 2% / 2%				Decrease from a 3% / 3% to a 2% / 2%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	11,061,771	4,645,190	6,416,581	-	(5,615,411)	(2,358,926)	(3,256,485)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	11,235,542	4,943,671	6,291,871	-	(5,742,853)	(2,531,347)	(3,211,506)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	7,603,745	3,387,220	4,212,472	4,053	(3,320,843)	(1,479,048)	(1,839,748)	(2,047)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	2,448,979	1,469,833	959,174	19,972	(1,237,702)	(742,769)	(484,853)	(10,080)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	2,539,132	1,377,356	749,320	412,456	(1,282,419)	(690,393)	(384,507)	(207,519)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	627,779	529,844	68,150	29,785	(316,738)	(267,283)	(34,394)	(15,061)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	827,528	729,294	89,026	9,208	(413,748)	(364,634)	(44,508)	(4,606)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**36,344,476**	**17,082,408**	**18,786,594**	**475,474**	**(17,929,714)**	**(8,434,400)**	**(9,256,001)**	**(239,313)**

North Dakota Department of Human Services
2011-2013 Executive Budget Recommendation
Various Requested Inflation Scenarios

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 1.5% / 1.5%				Decrease from a 3% / 3% to a 1.5% / 1.5%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	8,229,951	3,454,850	4,775,101	(0)	(8,447,231)	(3,549,266)	(4,897,965)	(0)
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	8,397,571	3,700,715	4,696,856	-	(8,580,824)	(3,774,303)	(4,806,521)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	5,768,325	2,569,644	3,195,645	3,036	(5,156,263)	(2,296,624)	(2,856,575)	(3,064)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	1,832,943	1,100,057	717,945	14,941	(1,853,738)	(1,112,545)	(726,082)	(15,111)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	1,901,334	1,051,792	542,228	307,314	(1,920,217)	(1,015,957)	(591,599)	(312,661)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	470,120	396,790	51,037	22,293	(474,397)	(400,337)	(51,507)	(22,553)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	620,667	546,992	66,763	6,912	(620,609)	(546,936)	(66,771)	(6,902)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**27,220,911**	**12,820,840**	**14,045,575**	**354,496**	**(27,053,279)**	**(12,695,968)**	**(13,997,020)**	**(360,291)**

	Executive Budget Provider Inflation 3% / 3%				Provider Inflation 1% / 1%				Decrease from a 3% / 3% to a 1% / 1%			
Provider Groups	Total	General	Federal	Other	Total	General	Federal	Other	Total	General	Federal	Other
Inflation for Medicaid grant providers	16,677,182	7,004,116	9,673,066	-	5,550,153	2,331,418	3,218,735	-	(11,127,029)	(4,672,698)	(6,454,331)	-
Inflation for DD grant providers	16,978,395	7,475,018	9,503,377	-	5,614,565	2,474,178	3,140,387	-	(11,363,830)	(5,000,840)	(6,362,990)	-
Inflation for Nursing Homes with 1/1/09 Rebasing (limits at 20/20/10)	10,924,588	4,866,268	6,052,220	6,100	3,962,139	1,765,097	2,195,019	2,023	(6,962,449)	(3,101,171)	(3,857,201)	(4,077)
Inflation for Other LTC providers	3,686,681	2,212,602	1,444,027	30,052	1,219,596	732,064	477,581	9,951	(2,467,085)	(1,480,538)	(966,446)	(20,101)
Inflation for Children and Family Service grant providers	3,821,551	2,067,749	1,133,827	619,975	1,265,445	686,120	373,815	205,510	(2,556,106)	(1,381,629)	(760,012)	(414,465)
Inflation for Mental Health/Substance Abuse, Aging, Disability Services contracted providers and Family Preservation Services	944,517	797,127	102,544	44,846	312,943	264,132	33,987	14,824	(631,574)	(532,995)	(68,557)	(30,022)
Inflation for the Human Service Center contracted providers	1,241,276	1,093,928	133,534	13,814	413,764	364,647	44,513	4,604	(827,512)	(729,281)	(89,021)	(9,210)
Total Inflation	**54,274,190**	**25,516,808**	**28,042,595**	**714,787**	**18,338,605**	**8,617,656**	**9,484,037**	**236,912**	**(35,935,585)**	**(16,899,152)**	**(18,558,558)**	**(477,875)**

- Attachment Four
- SB 2012
- Mar 9, 2011
- Maggie Anderson

ND Department of Human Services
Childrens Health Insurance Program
2011-2013 Biennium

	Executive Budget 160% @ 274.03	Updated Premium 160% @ 272.67	Difference
General	8,661,586	8,618,597	(42,989)
Federal	19,328,935	19,233,007	(95,928)
Total	27,990,521	27,851,604	(138,917)

	To the House 175% @ 274.03	Updated Premium 175% @ 272.67	Difference
General	9,228,953	9,183,148	(45,805)
Federal	20,595,925	20,493,709	(102,216)
Total	29,824,878	29,676,857	(148,021)

ND Departr an Services
Childrens He. nsurance Program
Various Scenarios with updated BCBS Premium ($272.67)
2011-2013 Biennium

CHIP Budget @ 160% Net Compared to 200% Net
It is estimated 200% will add 937 children

Poverty for a family of 4 @ 160% $35,280 @ 200% **$44,100**		Current CHIP Budget @ 160%	CHIP Budget @ 200% with Current BCBS Premiums	Increase in Caseload & Cost
Monthly Average Caseload		4,256	4,848	592
Ending Caseload		4,486	5,423	937
	General	8,618,597	9,853,535	1,234,938
	Federal	19,233,007	21,990,756	2,757,749
Includes 1 FTE	Total	27,851,604	31,844,291	3,992,687

CHIP Budget @ 160% Net Compared to 190% Net
It is estimated 190% will add 811 children

Poverty for a family of 4 @ 160% $35,280 @ 190% **$41,895**		Current CHIP Budget @ 160%	CHIP Budget @ 190% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload		4,256	4,769	513
Ending Caseload		4,486	5,297	811
	General	8,618,597	9,679,004	1,060,407
	Federal	19,233,007	21,601,011	2,368,004
Includes .5 FTE	Total	27,851,604	31,280,015	3,428,411

CHIP Budget @ 160% Net Compared to 180% Net
It is estimated 180% will add 582 children

Poverty for a family of 4 @ 160% $35,280 @ 180% **$39,690**	Current CHIP Budget @ 160%	CHIP Budget @ 180% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,626	370
Ending Caseload	4,486	5,068	582
General	8,618,597	9,368,014	749,417
Federal	19,233,007	20,906,536	1,673,529
Total	27,851,604	30,274,550	2,422,946

CHIP Budget @ 160% Net Compared to 170% Net
It is estimated 170% will add 342 children

Poverty for a family of 4 @ 160% $35,280 @ 170% **$37,485**	Current CHIP Budget @ 160%	CHIP Budget @ 170% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,472	216
Ending Caseload	4,486	4,828	342
General	8,618,597	9,055,293	436,696
Federal	19,233,007	20,208,196	975,189
Total	27,851,604	29,263,489	1,411,885

CHIP Budget @ 160% Net Compared to 195% Net
It is estimated 195% will add 910 children

Poverty for a family of 4 @ 160% $35,280 @ 195% **$42,998**	Current CHIP Budget @ 160%	CHIP Budget @ 195% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,830	574
Ending Caseload	4,486	5,396	910
General	8,618,597	9,802,727	1,184,130
Federal	19,233,007	21,877,295	2,644,288
Includes .5 FTE Total	27,851,604	31,680,022	3,828,418

CHIP Budget @ 160% Net Compared to 185% Net
It is estimated 185% will add 673 children

Poverty for a family of 4 @ 160% $35,280 @ 185% **$40,793**	Current CHIP Budget @ 160%	CHIP Budget @ 185% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,685	429
Ending Caseload	4,486	5,159	673
General	8,618,597	9,509,740	891,143
Federal	19,233,007	21,223,026	1,990,019
Includes .5 FTE Total	27,851,604	30,732,766	2,881,162

CHIP Budget @ 160% Net Compared to 175% Net
It is estimated 175% will add 445 children

Poverty for a family of 4 @ 160% $35,280 @ 175% **$38,588**	Current CHIP Budget @ 160%	CHIP Budget @ 175% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,535	279
Ending Caseload	4,486	4,931	445
General	8,618,597	9,183,148	564,551
Federal	19,233,007	20,493,709	1,260,702
Total	27,851,604	29,676,857	1,825,253

CHIP Budget @ 160% Net Compared to 165% Net
It is estimated 165% will add 188 children

Poverty for a family of 4 @ 160% $35,280 @ 165% **$36,383**	Current CHIP Budget @ 160%	CHIP Budget @ 165% with Current BCBS Premiums	Increase in Caseload and Cost
Monthly Average Caseload	4,256	4,374	118
Ending Caseload	4,486	4,674	188
General	8,618,597	8,857,608	239,011
Federal	19,233,007	19,766,743	533,736
Total	27,851,604	28,624,351	772,747

- Attachment ONE
- SB 2012
- March 10, 2011
- Maggie Anderson

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2011-2013 Executive Budget

	Budget	% of Budget
Long Term Care Continuum		
All Services		
Nursing Homes*	459,123,033	83.05%
Basic Care	25,972,395	4.70%
Personal Care Community	29,149,905	5.27%
SPED	13,782,988	2.49%
HCBS Waiver	10,268,386	1.86%
PACE	9,370,980	1.70%
TCM - Aged & Disabled	1,564,749	0.28%
Children's Medically Fragile Waiver	318,780	0.06%
Ex-SPED	976,724	0.18%
Tech Dependent Waiver	500,136	0.09%
Children's Hospice Waiver	1,770,430	0.32%
Total of LTC Services	**552,798,506**	**100.00%**
Total 2011-2013 Executive Budget	**$552,798,506**	

* Budget amount does not include the expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium.

North Dakota Dept of Human Services
Medical Services
Detail of Selected Services
2009-2011 Actual

Nursing Homes

Month	Actual Units of Service (Bed Days)	Actual Cost Per Unit	Actual Expenditures
August-09	102,508	$153.73	$15,758,336
September-09	105,018	154.88	16,265,539
October-09	100,339	156.52	15,705,226
November-09	101,453	152.87	15,509,067
December-09	99,995	155.16	15,515,199
January-10	103,600	155.67	16,127,850
February-10	101,619	165.07	16,774,441
March-10	97,264	162.69	15,824,301
April-10	96,029	165.17	15,861,506
May-10	99,644	163.98	16,339,790
June-10	104,933	167.23	17,547,493
July-10	95,800	166.76	15,975,856
August-10	100,178	165.56	16,585,596
September-10	108,053	165.94	17,930,750
October-10	97,976	165.47	16,211,989
November-10	91,448	162.84	14,891,799
Monthly Averages	100,366	$ 161.22	$16,176,546

In-State Nursing facility rates are established annually from a cost report.

Swing Bed Rates are based on the average Medicaid Nursing Facility Rates from the previous year.

The Average Cost per unit for Out of State Nursing Facility Services is the average amount paid.

The rates above do not include the 6% inflation effective January 1, 2011

Rebasing January 1, 2013 ($1.04 per day)

3/3 Inflation ($4.34 per day)

Increased In-State nursing facility beds by 129 to correspond with the known bed increases of 09-11. 71 nursing home beds at St. Gabriel's in Bismarck, which became operational in the June of 2010; 48 beds for Good Samaritan in Bismarck; 64 beds for Sheyenne Crossing in West Fargo; and 78 beds for Bethany on 42nd in Fargo for a total of 261. Assuming 90% occupancy and 55% Medicaid we estimated 129 beds.

	Units	
In-state NF	97,832	
Dakota Alpha	449	
Geropsych	975	
Swing Bed	1,310	
Hospice	2,650	
Out of State NF	1,888	
Total	105,104	**$187.09**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Basic Care (Room & Board & Personal Care Services)

Month	Actual Units of Service (Bed Days)	Actual Cost Per Unit	Actual Expenditures
August-09	29,671	$27.16	$805,869
September-09	30,684	27.09	831,272
October-09	29,132	26.92	784,187
November-09	29,547	27.23	804,449
December-09	29,207	26.83	783,703
January-10	31,057	26.62	826,736
February-10	33,595	27.79	933,762
March-10	29,599	29.78	881,318
April-10	33,171	28.09	931,615
May-10	29,522	30.34	895,596
June-10	34,243	26.89	920,630
July-10	30,847	27.94	861,821
August-10	32,112	29.28	940,226
September-10	34,738	29.85	1,036,833
October-10	34,447	28.67	987,641
November-10	34,519	28.91	998,000
Monthly Averages	31,631	$28.10	$888,979

Units -Avg March 10 - April 10	31,385	
Rate -Avg Aug 09 - April 10		$27.50
Growth May 10 thru July 11 Approximately 20 beds	1,266	
No Growth projected in 11-13		
5% increase for historical costs 09-11 6% Inflation (7-1-10)		$1.38
5% increase for historical costs 11-13 3/3 Inflation for 11-13		$1.00
Monthly Averages **Executive Budget 11-13**	**32,651**	**$29.88**

Facility specific rates are established annually from a cost report.

Basic Care includes room and board AND personal care services.

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Personal Care Community

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	602	$1,542.87	220,773	$4.21	$928,806
September-09	594	1,567.19	216,406	4.30	930,909
October-09	612	1,462.45	215,609	4.15	895,017
November-09	613	1,503.55	217,203	4.24	921,675
December-09	628	1,521.67	224,941	4.25	955,609
January-10	639	1,464.62	219,161	4.27	935,891
February-10	614	1,439.20	209,562	4.22	883,671
March-10	627	1,436.65	212,583	4.24	900,781
April-10	617	1,596.72	229,631	4.29	985,176
May-10	626	1,491.27	221,461	4.22	933,533
June-10	623	1,605.92	236,116	4.24	1,000,489
July-10	606	1,516.55	217,038	4.23	919,027
August-10	631	1,595.74	224,499	4.49	1,006,909
September-10	634	1,573.68	223,725	4.46	997,712
October-10	633	1,560.39	215,078	4.59	987,726
November-10	626	1,684.62	238,694	4.42	1,054,573
Monthly Averages	620	$1,535.26	221,405	$4.30	$952,344

Avg Aug 09-April 10	616	$1,503.34	
Growth May 10 thru July 11 (2 per month)	30		
Growth 11-13 biennium (2 per month)	25		
Personal Care Tier 3		$129.63	**Note 1**
6% Inflation (7-1-10)		$97.98	
3/3 Inflation for 11-13		$89.14	
Monthly Averages Executive Budget 11-13	**671**	**$1,820.10**	

Note 1: $129.63 represents the cost of Tier 3 which provides for 10hrs of personal care per day. This change was effective January 1, 2010.

Although Tier 3 Recipients were eligible to come on in January 2010 we did not see any substantial cost increases until June. Average cost from Aug to May was $1,502.12. The average cost from June to Nov is $87.66 higher at $1,589.78.

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

SPED (Service Payments for Elderly and Disabled)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1,299	$396.75	62,624	$8.23	$515,377
September-09	1,314	399.66	62,046	8.46	525,152
October-09	1,294	366.40	59,389	7.98	474,118
November-09	1,260	375.23	57,827	8.18	472,790
December-09	1,348	370.13	60,268	8.28	498,937
January-10	1,281	376.15	54,229	8.89	481,854
February-10	1,280	356.00	45,210	10.08	455,678
March-10	1,329	359.92	58,810	8.13	478,337
April-10	1,252	362.36	53,631	8.46	453,676
May-10	1,329	378.72	61,798	8.14	503,324
June-10	1,310	381.06	61,986	8.05	499,192
July-10	1,286	358.06	54,610	8.43	460,459
August-10	1,332	384.98	58,833	8.72	512,800
September-10	1,342	407.99	64,066	8.55	547,527
October-10	1,352	394.24	61,301	8.69	533,008
November-10	1,295	384.45	56,376	8.83	497,867
Monthly Averages	1,306	$378.42	58,313	$8.51	$494,381

Avg Aug 09 - April 10	1,295	$373.67	
Growth May 10 thru July 11 (2 per month)	30		
Growth 11-13 biennium (2 per month)	25		
Non-Medical Transp.		$9.32	**Note 1**
Removal of Point Split		$0.83	
6% Inflation (7-1-10)		$23.03	
3/3 Inflation for 11-13		$18.55	
Monthly Averages Executive Budget 11-13	**1,350**	**$425.40**	

Note 1 - This amount represents the cost of adding Non-Medical transportation for such things as going to the grocery store, post office or other places necessary to keep an individual in their community. This change was effective January 1, 2010.

Note 2 - The amount represents the cost of removing the point split for Adult Family Foster Care services within the SPED program. This change was effective January 1, 2010.

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

HCBS Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	269	$1,137.74	12,783	$23.94	$306,052
September-09	262	1,193.53	11,469	27.27	312,706
October-09	273	1,231.21	12,134	27.70	336,120
November-09	274	1,168.13	12,147	26.35	320,067
December-09	294	1,056.26	14,060	22.09	310,541
January-10	285	1,087.26	12,755	24.29	309,870
February-10	298	1,132.51	11,988	28.15	337,488
March-10	293	1,048.75	11,800	26.04	307,285
April-10	294	1,180.57	12,992	26.72	347,089
May-10	298	1,173.17	13,247	26.39	349,605
June-10	301	1,166.29	13,564	25.88	351,054
July-10	298	1,164.53	12,260	28.31	347,030
August-10	308	1,182.18	13,850	26.29	364,110
September-10	309	1,136.40	12,248	28.67	351,147
October-10	306	1,145.52	11,787	29.74	350,530
November-10	299	1,175.32	12,665	27.75	351,422
Monthly Averages	291	$1,148.28	12,609	$26.60	$334,507

Used 270 A&D and 27 TBI	297		
Avg Aug 09 - April 10		$1,136.92	
Growth May 10 thru July 11 (2 per month)	30		
Growth 11-13 biennium (2 per month)	25		
Home Delivered Meals		$6.00	**See Note 1**
Removal of Point Split		-$9.52	
6% Inflation (7-1-10)		$44.95	
3/3 Inflation for 11-13		$37.12	
Monthly Averages Executive Budget 11-13	**352**	**$1,215.47**	

Note 1 - Added Home Delivered Meals to the waiver. Effective January 1, 2010

Note 2 - Due to the cost of the point split for Adult Family Foster Care services being smaller (409.33 per individual per month) than the average cost of this service, it results in a decrease to the average cost per person. Effective January 1, 2010

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

PACE (Program of All Inclusive Care for the Elderly)

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Expenditures
August-09	32	$4,427.56	$141,682
September-09	35	3,725.06	130,377
October-09	37	3,728.11	137,940
November-09	38	3,619.42	137,538
December-09	38	3,714.79	141,162
January-10	41	3,705.07	151,908
February-10	43	4,418.98	190,016
March-10	44	3,717.77	163,582
April-10	42	3,732.98	156,785
May-10	45	3,732.80	167,976
June-10	45	4,240.67	190,830
July-10	52	4,384.81	228,010
August-10	51	4,213.78	214,903
September-10	52	4,205.40	218,681
October-10	51	4,200.86	214,244
November-10	53	4,123.13	218,526
Monthly Averages	44	$4,011.67	$175,260

Used April 2010 actual	42	
Rate is set Actuarially		$4,286.00
Growth May 10 thru July 11 (2 per month)	30	
Growth 11-13 biennium (1 per month)	13	
Estimated actuarial rate increase of 5% (7-1-11)		$214.30
Estimated actuarial rate increase of 5% (7-1-12)		$225.02
Monthly Averages Executive Budget 11-13		**$4,725.32**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Targeted Case Management for Aged & Disabled

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	432	$115.13	451	$110.27	$49,734
September-09	509	116.33	559	105.92	59,212
October-09	399	119.11	406	117.05	47,524
November-09	413	127.97	467	113.17	52,850
December-09	423	117.26	451	109.98	49,603
January-10	390	122.11	415	114.76	47,624
February-10	454	126.75	524	109.82	57,546
March-10	533	120.98	613	105.19	64,480
April-10	453	120.92	496	110.43	54,775
May-10	587	117.40	628	109.73	68,913
June-10	479	117.65	511	110.28	56,353
July-10	446	118.24	466	113.17	52,735
August-10	489	127.54	516	120.86	62,365
September-10	561	134.61	627	120.44	75,517
October-10	506	126.53	520	123.13	64,025
November-10	462	124.94	505	114.30	57,722
Monthly Averages	471	$122.21	510	$113.03	$57,561

Avg Aug 09 - April 10	445	$120.66
Growth May 10 thru July 11 (2 per month)	30	
Growth 11-13 biennium (1 per month)	13	
6% Inflation (7-1-10)		$7.24
3/3 Inflation for 11-13		$5.84
Monthly Averages Executive Budget 11-13		**$133.74**

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Children's Medically Fragile Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1	$ 648.00	2	$ 324.00	$ 648
September-09	2	1,675.50	7	478.71	3,351
October-09	4	709.75	7	405.57	2,839
November-09	2	1,136.00	4	568.00	2,272
December-09	2	2,201.50	9	489.22	4,403
January-10	2	948.50	3	632.33	1,897
February-10	3	389.33	4	292.00	1,168
March-10	0		0		-
April-10	0		0		-
May-10	0		0		-
June-10	4	2,503.25	15	667.53	10,013
July-10	0		0		-
August-10	3	706.67	8	265.00	2,120
September-10	1	352.00	2	176.00	352
October-10	0		0		-
November-10	4	804.50	10	321.80	3,218
Monthly Averages	2	$1,152.89	4	$420.01	$2,018
Avg Aug 09 - June 10	2	$1,329.55			
Growth July 10 thru July 11 (2 per year)	4				
Growth 11-13 biennium (2 per year)	3				
6% Inflation (7-1-10)		$79.77			
3/3 Inflation for 11-13		$64.06			
Monthly Averages Executive Budget 11-13	**9**	**$1,473.38**			

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Ex-SPED

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	108	$238.63	3,752	$6.87	$25,772
September-09	110	271.20	3,761	7.93	29,832
October-09	108	247.38	3,393	7.87	26,717
November-09	108	258.57	3,588	7.78	27,926
December-09	114	252.90	3,859	7.47	28,831
January-10	121	243.97	3,861	7.65	29,520
February-10	118	235.47	3,390	8.20	27,786
March-10	124	238.79	3,783	7.83	29,610
April-10	112	262.10	3,618	8.11	29,355
May-10	125	278.59	4,679	7.44	34,824
June-10	121	222.26	4,107	6.55	26,894
July-10	119	241.82	3,901	7.38	28,777
August-10	117	233.69	3,836	7.13	27,342
September-10	121	236.68	3,941	7.27	28,638
October-10	123	216.57	3,771	7.06	26,638
November-10	119	216.25	3,794	6.78	25,734
Monthly Averages	117	$243.15	3,815	$7.46	$28,387

Avg Aug 09 - April 10	114	$249.61	
Growth May 10 thru July 11 (1 per month)	15		
Growth 11-13 biennium (1 per month)	13		
Non-Medical Transp.		$9.08	**Note 1**
Point Split		$0.68	
6% Inflation (7-1-10)		$15.56	
3/3 Inflation for 11-13		$12.68	
Monthly Averages Executive Budget 11-13	**142**	**$287.61**	

Note 1 - This amount represents the cost of adding Non-Medical transportation for such things as going to the grocery store, post office or other places necessary to keep an individual in their community. This change was effective January 1, 2010.

Note 2 - The amount represents the cost of removing the point split for Adult Family Foster Care services within the Ex-SPED program. This change was effective January 1, 2010.

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Technology Dependent Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1	$9,330.00	2,381	$3.92	$9,330
September-09	1	11,415.00	2,912	3.92	11,415
October-09	1	9,245.00	2,309	4.00	9,245
November-09	1	9,322.00	2,354	3.96	9,322
December-09	1	8,922.00	2,276	3.92	8,922
January-10	1	9,251.00	2,360	3.92	9,251
February-10	1	9,503.00	2,357	4.03	9,503
March-10	1	8,334.00	2,101	3.97	8,334
April-10	1	9,298.00	2,372	3.92	9,298
May-10	1	8,821.00	2,225	3.96	8,821
June-10	1	9,377.00	2,367	3.96	9,377
July-10	1	10,051.00	2,564	3.92	10,051
August-10	1	10,105.00	2,374	4.26	10,105
September-10	1	13,441.00	3,368	3.99	13,441
October-10	1	9,451.00	2,272	4.16	9,451
November-10	1	15,101.00	3,688	4.09	15,101
Monthly Averages	1	$10,060.44	2,518	$3.99	$10,060
Avg Aug 09 - April 10	1	$9,402.22			
Growth May 10 thru July 11	1				
6% Inflation (7-1-10)		$564.13			
3/3 Inflation for 11-13		$452.97			
Monthly Averages Executive Budget 11-13		**$10,419.32**			

North Dakota Dept of Human Services
Long Term Care Continuum
Detail of Selected Services
2009-2011 Actual

Children's Hospice Waiver

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	0		0		$ -
September-09	0		0		-
October-09	0		0		-
November-09	0		0		-
December-09	0		0		-
January-10	0		0		-
February-10	0		0		-
March-10	0		0		-
April-10	0		0		-
May-10	0		0		-
June-10	0		0		-
July-10	0		0		-
August-10	0		0		-
September-10	0		0		-
October-10	0		0		-
November-10	0		0		-
Monthly Averages	0		0		$0

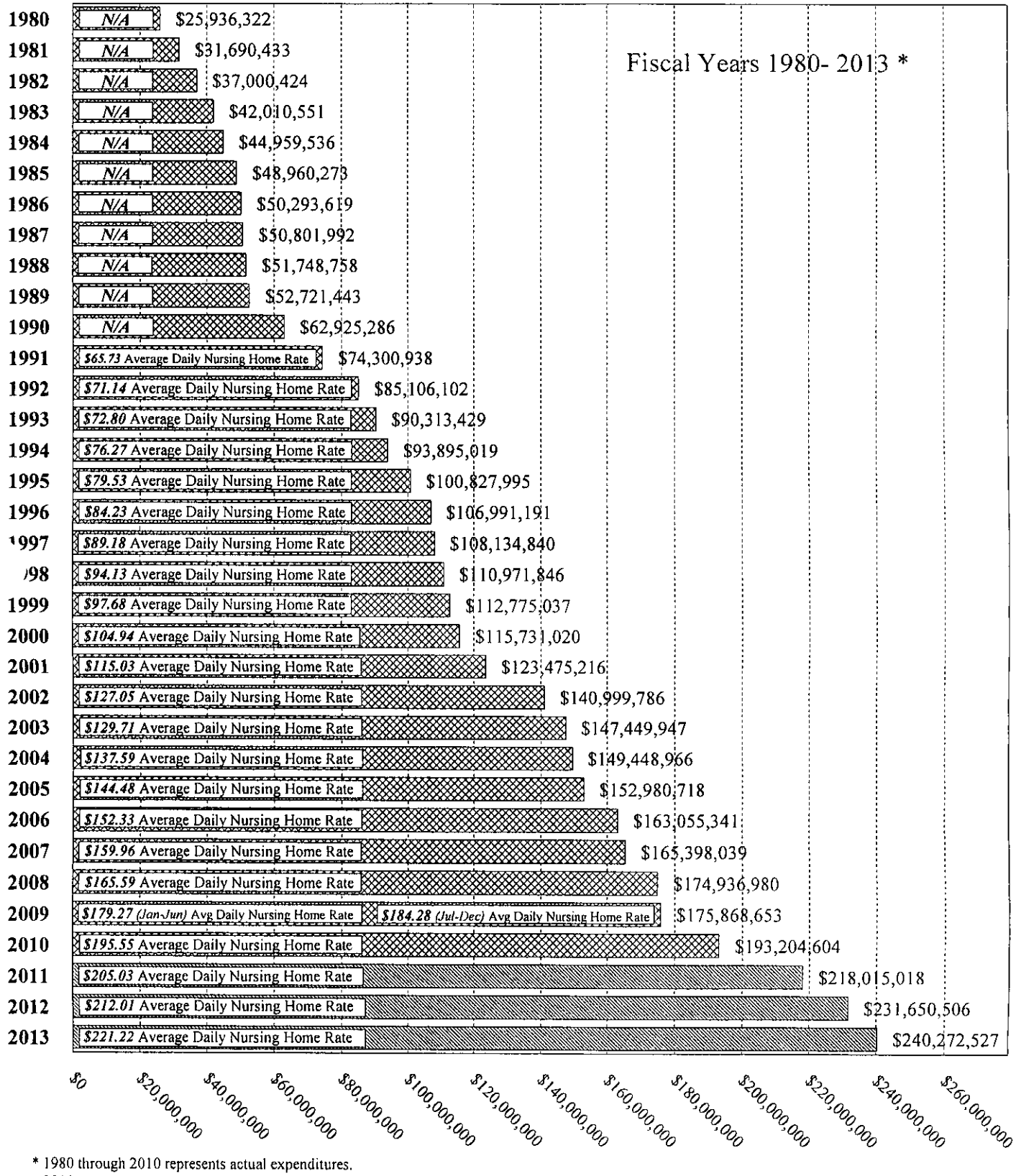
Used Waiver Request Rate		$2,352.03
Anticipated recipients	30	
Growth 11-13 biennium	0	
3/3 Inflation for 11-13		$143.24
Monthly Averages Executive Budget 11-13		**$2,495.27**

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-10 LONG TERM CARE										
S101		FULL-TIME EQUIVALENTS (FTEs)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
32573	B	712000 Grants, Benefits & Claims	647,327,278	849,700,328	380,901,287	100,322,211	0	950,022,539	11,364,049	961,386,588
		Subtotal:	647,327,278	849,700,328	380,901,287	100,322,211	0	950,022,539	11,364,049	961,386,588
32573	F	F_7391 MA Grants - General Fund	233,408,076	283,801,911	146,447,935	138,506,732	0	422,308,643	5,021,489	427,330,132
32573	F	F_7392 MA Grants - Federal Funds	410,498,843	554,326,370	234,162,515	(29,887,534)	0	524,438,836	6,342,560	530,781,396
32573	F	F_7393 MA Grants - Other Funds	0	4,088,412	0	(3,786,864)	0	301,548	0	301,548
32573	F	F_7394 MA Grants - Retained Funds	2,284,362	2,284,362	0	0	0	2,284,362	0	2,284,362
32573	F	F_7395 MA Grants - County Funds	610,400	874,767	290,837	(185,617)	0	689,150	0	689,150
32573	F	F_7396 MA Grants - IGT Funds	525,597	4,324,506	0	(4,324,506)	0	0	0	0
		Subtotal:	647,327,278	849,700,328	380,901,287	100,322,211	0	950,022,539	11,364,049	961,386,588
		Subdivision Budget Total:	647,327,278	849,700,328	380,901,287	100,322,211	0	950,022,539	11,364,049	961,386,588
300-10 LONG TERM CARE		**General Funds:**	233,408,076	283,801,911	146,447,935	138,506,732	0	422,308,643	5,021,489	427,330,132
		Federal Funds:	410,498,843	554,326,370	234,162,515	(29,887,534)	0	524,438,836	6,342,560	530,781,396
		Other Funds:	0	4,088,412	0	(3,786,864)	0	301,548	0	301,548
		SWAP Funds:	2,284,362	2,284,362	0	0	0	2,284,362	0	2,284,362
		County Funds:	610,400	874,767	290,837	(185,617)	0	689,150	0	689,150
		IGT Funds:	525,597	4,324,506	0	(4,324,506)	0	0	0	0
		Subdivision Funding Total:	647,327,278	849,700,328	380,901,287	100,322,211	0	950,022,539	11,364,049	961,386,588

North Dakota Department of Human Services
Nursing Home Facilities
Senate Bill 2012 to House
2011 - 2013 Biennium

Attachment C



* 1980 through 2010 represents actual expenditures.
2011 represents one month actual and eleven months estimated expenditures.
2012 and 2013 represents estimated expenditures included in the Governor's budget.
The average daily nursing home rate is effective January 1 of each year as indicated.
NOTE: Budget amount for 2012 and 2013 reflects the expected carryover of unused general fund appropriation of $12.8m from the 2009-2011 biennium.

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North Dakota Department of Human Services
Changes in Long Term Care from 2009-2011 Appropriation to 2011-2013 Budget To HOUSE

Description	2009-2011 Appropriation	Funding Shift	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Offset for General Fund Carryover **	Total Changes	2011-2013 Budget To Senate	Total Changes	2009-2011 Budget To House
Nursing Homes	425,713,210		18,306,125	16,979,110		10,924,588	(12,800,000)	33,409,823	459,123,033		459,123,033
Basic Care ^	18,113,925		2,995,658	3,726,798		1,136,014		7,858,470	25,972,395		25,972,395
Home & Community Based Services	63,862,579		1,538,520	(248,688)		2,550,667		3,840,499	67,703,078	0	67,703,078
SPED ^^	17,495,327		(1,901,567)	(2,411,820)		601,048		(3,712,339)	13,782,988		13,782,988
Ex-SPED ^^^	726,578		121,856	85,229		43,061		250,146	976,724		976,724
Personal Care Services	25,044,599		2,830,627	(6)		1,274,685		4,105,306	29,149,905		29,149,905
Targeted Case Management	1,957,896		(552,024)	90,558		68,319		(393,147)	1,564,749		1,564,749
Home & Community Based Services Waiver	8,707,606		705,502	404,800		450,478		1,560,780	10,268,386		10,268,386
Children's Medically Fragile Waiver	1,147,844		(771,555)	(71,873)		14,364		(829,064)	318,780		318,780
Technology Dependent Waiver	532,608		65,376	(119,592)		21,744		(32,472)	500,136		500,136
PACE	7,393,711		1,049,983	927,286				1,977,269	9,370,980		9,370,980
Children's Hospice Waiver	856,410		(9,678)	846,730		76,968		914,020	1,770,430		1,770,430
Total	**507,689,714**		**22,840,303**	**20,457,220**	**0**	**14,611,269**	**(12,800,000)**	**45,108,792**	**552,798,506**	**0**	**552,798,506**
General Funds	**172,803,502**	**6,817,423 ***	**7,702,004**	**6,162,907**	**60,084,630**	**7,078,870**	**(12,800,000)**	**75,045,834**	**247,849,336**	**-**	**247,849,336**

Other Areas:

Community of Care Funds $120,000 for both the 09-11 and 11-13 Bienniums- 100% General funds

Personal Care Needs Allowance SSI $148,068 for the 09-11 Biennium and 108,000 for the 11-13 Biennium - 100% General Funds

Assisted Living Rent Subsidy $200,000 for the 09-11 Biennium and $0 for the 11-13 Biennium - IGT Funds

* BND Loan Funds of $2,692,917 and IGT Funds of $4,124,506 were replaced with General Funds.

** Budget amount does not include expected carryover of unused general fund appropriation ($12.8m) from the 2009-2011 biennium. This offset is reflected in Nursing Homes.

^ Room & board costs are funded with general funds and retained funds.

^^ SPED is funded with 95% general funds and 5% county funds.

^^^ Expanded SPED is funded with 100% general funds.

Attachment D

- March 10, 2011
- Attachment TWO
- Maggie Anderson
- SB 2012

North Dakota Department of Human Services
Medical Services Division
Cost to Continue Nursing Facility Property Limits

The nursing facility property limits are adjusted annually on July 1 by the increase, if any, in the consumer price index for all urban consumers, for the 12 month period ending May 31.

2009 HB 1012 increased the nursing facility property limits on July 1, 2009. The appropriation was $877,158, of which $324,526 was from the Health Care Trust Fund for the state match.

Nursing Facility Property Limits		
	Single Occupancy	**Double Occupancy**
July 1, 2009	169,098	112,732
July 1, 2008	138,907	92,604

The estimated cost to continue for the 2011-2013 Biennium is:

	Medicaid	**Private Pay**	**Total**
2011-2013 Impact	986,278	1,219,820	$2,206,098

The estimated useful life for buildings is 25-50 years based on the type of construction.

The cost of construction, depreciable life, interest rate and census units impact the increased property cost per day.

ND Department of Human Services
Medical Services Division
Nursing Facility Beds History

	June 2007	June 2009	December 2010
Licensed Beds	6,297	6,176	6,359
Occupied Beds	5,873	5,708	5,799
Medicaid Beds	3,249	3,003	3,002

There were 3 LTC beds converted to basic care beds during the 2007-2009 biennium.

There have been 23 LTC beds converted to basic care beds so far in the 2009-2011 biennium.

The listing for Nursing Facilities reflects the low and high rates for the range of 34 case mix classifications.
Rates are only effective as of the date at the top of the page. Please contact the individual facility for current desk rates.

ND Department of Human Services - Division of Medical Services

Nursing Facilities -- Rates effective January 1, 2011

CITY	FACILITY	RATES Low Rate	High Rate
Aneta	Aneta Parkview Health Center-30322	$146.13	$331.27
Arthur	Arthur Good Samaritan Center-30058	$152.50	$358.06
Ashley	Ashley Medical Center SNF-30188	$134.05	$353.83
Beulah	Knife River Care Center-30002	$191.75	$408.81
Bismarck	Baptist Home-30003	$162.71	$406.51
Bismarck	Bismarck Good Samaritan Society - 30494	$190.30	$421.86
Bismarck	Medcenter One St. Vincent's Care Center-30005	$164.48	$407.84
Bismarck	Missouri Slope Lutheran Care Center-30004	$175.81	$431.33
Bismarck	St. Gabriel's Community - 30497	$223.00	$454.56
Bottineau	Bottineau Good Samaritan Center-30118	$162.98	$380.54
Bowman	Southwest Healthcare Services-30403	$169.99	$405.79
Cando	Towner County Living Center-30379	$157.67	$321.83
Carrington	Golden Acres Manor-30008	$145.86	$350.12
Cavalier	Wedgewood Manor-30424	$166.79	$385.69
Cooperstown	Cooperstown Medical Center-30095	$151.75	$370.95
Crosby	Crosby Good Samaritan Center-30122	$142.47	$317.51
Devils Lake	Devils Lake Good Samaritan Center-30115	$149.03	$350.73
Devils Lake	Heartland Care Center-30010	$171.73	$406.21
Dickinson	St. Benedict's Health Center-30237	$150.93	$356.43
Dickinson	St. Luke's Home-30011	$150.70	$361.38
Dunseith	Dunseith Community Nursing Home-30052	$145.54	$331.94
Elgin	Jacobson Memorial Care Center-30077	$149.15	$331.65
Ellendale	Prince of Peace Care Center-30012	$141.99	$305.23
Enderlin	Maryhill Manor-30421	$152.20	$359.00
Fargo	Bethany Homes-30060	$172.27	$411.95
Fargo	Bethany on 42nd Skilled Care - 30492	$217.67	$473.19
Fargo	Elim Home-30051	$157.86	$375.74
Fargo	Manorcare Health Services-30478	$140.34	$332.16
Fargo	Rosewood on Broadway-30420	$174.76	$393.00
Fargo	Villa Maria Healthcare-30419	$176.26	$396.50
Forman	Four Seasons Health Care Center-30406	$123.70	$258.34
Garrison	Benedictine Living Center of Garrison-30247	$146.48	$329.76
Garrison	Garrison Memorial Hospital NF-30134	$172.03	$418.57
Glen Ullin	Marian Manor HealthCare Center-30067	$151.49	$400.37

CITY	FACILITY	RATES Low Rate	High Rate
Grafton	Lutheran Sunset Home-30016	$165.30	$415.62
Grand Forks	Valley Eldercare Center-30017	$175.19	$403.91
Grand Forks	Woodside Village-30201	$178.39	$405.49
Hankinson	St. Gerard's Community NH-30163	$146.89	$344.89
Harvey	St. Aloisius Medical Center-30129	$148.56	$356.64
Hatton	Tri-County Retirement & NH-30018	$176.60	$414.88
Hettinger	Western Horizons Living Center-30477	$180.52	$436.04
Hillsboro	Hillsboro Medical Center NH-30019	$211.77	$467.29
Jamestown	Ave Maria Village -30422	$172.36	$407.98
Jamestown	Eventide at Hi-Acres - 30498	$161.16	$409.86
Killdeer	Hill Top Home of Comfort-30271	$166.60	$396.88
Lakota	Lakota Good Samaritan Center-30097	$142.65	$322.85
LaMoure	St. Rose Care Center-30119	$151.34	$350.64
Langdon	Maple Manor Care Center-30083	$176.75	$350.73
Larimore	Larimore Good Samaritan Center-30113	$152.16	$339.66
Lisbon	North Dakota Veterans Home-30293	$177.64	$433.16
Lisbon	Parkside Lutheran Home-30109	$177.82	$411.10
Mandan	Dacotah Alpha-30225	$363.61	same for all residents
Mandan	Medcenter One Care Center Off Collins-30106	$170.78	$409.04
Mandan	Medcenter One Mandan Living Center-30288	$188.07	$439.43
Mayville	Luther Memorial Home-30024	$155.73	$397.41
McVille	Nelson County Health System Care Ctr-30384	$157.83	$354.63
Minot	Manorcare Health Services-30479	$133.73	$316.01
Minot	Trinity Nursing Home-30028	$168.92	$416.26
Mohall	North Central Good Samaritan Center-30173	$148.30	$343.10
Mott	Mott Good Samaritan Nursing Center-30142	$132.58	$299.96
Napoleon	Napoleon Care Center-30114	$148.07	$344.01
New Rockford	Lutheran Home of the Good Shepherd-30029	$172.13	$402.55
New Salem	Elm Crest Manor-30116	$180.81	$398.99
Northwood	Northwood Deaconess Health Center-30031	$193.34	$448.86
Oakes	Oakes Manor Good Samaritan Center-30124	$125.74	$288.66
Osnabrock	Osnabrock Good Samaritan Center-30117	$136.97	$319.99
Park River	Park River Good Samaritan Center-30154	$145.51	$335.37
Parshall	Rock View Good Samaritan Center-30155	$163.23	$364.29
Richardton	Richardton Health Center CC-30487	$183.37	$438.89
Rolla	Rolette Community Care Center-30466	$191.46	$371.14
Rugby	Heart of American Nursing Facility-30135	$169.99	$401.19
Stanley	Mountrail Bethel Home-30032	$163.65	$394.41
Strasburg	Strasburg Nursing Home-30033	$147.83	$368.17
Tioga	Tioga Medical Center LTC-30176	$159.63	$382.33

CITY	FACILITY	RATES Low Rate	High Rate
Underwood	Prairieview Nursing Home-30053	$152.06	$369.28
Valley City	Sheyenne Care Center-30418	$154.35	$387.25
Valley City	Sheyenne Care Center Geropsych-30423	$216.25	same for all residents
Velva	Souris Valley Care Center-30216	$140.60	$308.48
Wahpeton	St. Catherine's Living Center-30034	$140.54	$287.78
Walhalla	Pembilier Nursing Center-30035	$129.03	$314.79
Watford City	McKenzie County Healthcare-30449	$170.24	$415.74
West Fargo	Sheyenne Crossings Care Center - 30496	$195.19	$426.75
Williston	Bethel Lutheran Home-30038	$158.52	$389.16
Wishek	Wishek Home for the Aged-30039	$158.04	$384.84

- Attachment ONE
- March 11, 2011
- Tina Bay
- SB 2012

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2011-2013 Excecutive Budget

	Budget	% of Budget
DD Community Based Care		
Selected Services		
ISLA	84,253,112	21.22%
ICF/MR Adult	64,970,778	16.37%
Day Supports	62,031,254	15.63%
ICF/MR Physically Handicapped	33,314,525	8.39%
ICF/MR Children	31,206,816	7.86%
Minimally Supervised Living Arrangement	29,821,096	7.51%
Transitional Community Living - Training	21,014,522	5.29%
Family Support Services - In Home Support	16,570,451	4.17%
Infant Development	12,172,112	3.07%
DD Funding Buckets *	8,422,628	2.12%
Total of Selected Services	**363,777,294**	**91.63%**
Remaining Services	**33,218,739**	**8.37%**
Total 2011-2013 Executive Budget	**396,996,033**	**100.00%**

* Enhanced funding for various critical needs provided to children and adults with disabilities.

Explanation of Delayed Provider Billing Adjustments reflected on following pages:

When two billings are processed in the same month for the same person, the system does not count the person twice. Therefore, the persons receiving are understated; actual units of service are accurate.

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

ISLA

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	701	$ 4,165.37	21,783	$ 134.05	$ 2,919,927
September-09	721	$ 4,178.98	22,790	$ 132.21	$ 3,013,041
October-09	721	$ 3,973.00	21,474	$ 133.40	$ 2,864,533
November-09	693	$ 4,088.97	21,307	$ 132.99	$ 2,833,656
December-09	715	$ 4,035.11	22,064	$ 130.76	$ 2,885,106
January-10	714	$ 4,152.18	22,418	$ 132.24	$ 2,964,657
February-10	704	$ 4,093.46	21,686	$ 132.89	$ 2,881,796
March-10	716	$ 3,677.97	20,016	$ 131.57	$ 2,633,427
April-10	720	$ 4,093.95	22,311	$ 132.12	$ 2,947,646
May-10	713	$ 3,927.49	21,204	$ 132.06	$ 2,800,303
June-10	723	$ 4,124.60	22,419	$ 133.02	$ 2,982,086
July-10	723	$ 3,981.11	21,906	$ 131.40	$ 2,878,340
August-10	674	$ 4,334.72	20,939	$ 139.53	$ 2,921,601
September-10	733	$ 4,734.63	24,245	$ 143.14	$ 3,470,487
October-10	729	$ 4,183.92	21,892	$ 139.32	$ 3,050,081
November-10	647	$ 4,348.89	19,764	$ 142.37	$ 2,813,730
Monthly Averages	709	$ 4,041.02	21,782	$ 132.39	$ 2,883,710
Ave., Aug '09 - April '10	712	$ 4,048.66	21,761	$ 132.50	$ 2,882,643
Adjustment for delayed provider billings	1				
Growth May '10 - July '11:					
• high school graduates	22				
• transitions from the Developmental Center	8				
• caseload growth in Grand Forks area	9				
6% Inflation 7/1/10				$ 7.95	
11-13 Average Caseload Growth:					
•22 high school graduates beginning 7/1/2011 & 22 high school graduates beginning 7/1/2012	33				
3%, 3% Inflation for 11/13 Biennium				$ 6.38	
Monthly Average	785			$ 146.83	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

ICF/MR Adult

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	225	$ 8,859	5,660	$ 352.18	$ 1,993,354
September-09	237	$ 8,757	7,683	$ 270.13	$ 2,075,431
October-09	207	$ 9,504	6,293	$ 312.61	$ 1,967,245
November-09	217	$ 9,866	8,076	$ 265.11	$ 2,141,013
December-09	239	$ 12,081	8,677	$ 332.77	$ 2,887,475
January-10	236	$ 10,743	7,256	$ 349.40	$ 2,535,253
February-10	236	$ 10,069	7,390	$ 321.55	$ 2,376,276
March-10	236	$ 8,880	6,672	$ 314.12	$ 2,095,795
April-10	224	$ 10,047	6,914	$ 325.49	$ 2,250,465
May-10	234	$ 7,419	7,434	$ 233.54	$ 1,736,137
June-10	213	$ 10,571	6,582	$ 342.10	$ 2,251,698
July-10	227	$ 9,908	7,432	$ 302.63	$ 2,249,118
August-10	227	$ 9,270	7,081	$ 297.19	$ 2,104,377
September-10	228	$ 9,985	7,181	$ 317.03	$ 2,276,600
October-10	227	$ 9,564	6,862	$ 316.39	$ 2,171,085
November-10	228	$ 10,381	7,113	$ 332.75	$ 2,366,875
Monthly Averages	228	$ 9,744	7,144	$ 311.56	$ 2,217,387
Ave., Aug '09 - April '10	229	$ 9,860.41	7,180	$ 314.49	$ 2,258,034
Adjustment for delayed provider billings	7				
6% Inflation 7/1/10				$ 18.87	
Average Growth May '10 - July '11:					
• *new provider programs - two new four bed ICF's/MR HIT (Opened 12/2010), two new clients from DC (Projected to open in 09/11 Biennium)*	10			$ 10.32	
ICF/MR provider assessment increase				$ 2.47	
3%, 3% Inflation for 11/13 Biennium				$ 15.15	
Monthly Average	246			$ 361.30	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

Day Supports

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	1,037	$ 1,941.48	150,245	$ 13.40	$ 2,013,313
September-09	1,047	$ 1,980.31	145,570	$ 14.24	$ 2,073,384
October-09	1,041	$ 2,119.64	145,565	$ 15.16	$ 2,206,545
November-09	1,009	$ 2,050.83	143,996	$ 14.37	$ 2,069,294
December-09	1,033	$ 2,133.73	134,656	$ 16.37	$ 2,204,145
January-10	1,032	$ 2,182.41	143,287	$ 15.72	$ 2,252,244
February-10	1,030	$ 1,976.68	133,340	$ 15.27	$ 2,035,983
March-10	1,065	$ 1,639.64	136,715	$ 12.77	$ 1,746,220
April-10	1,066	$ 2,328.43	160,263	$ 15.49	$ 2,482,111
May-10	1,041	$ 1,716.24	146,789	$ 12.17	$ 1,786,608
June-10	1,070	$ 2,081.42	142,664	$ 15.61	$ 2,227,117
July-10	1,074	$ 2,444.10	151,174	$ 17.36	$ 2,624,959
August-10	1,004	$ 2,210.30	136,321	$ 16.28	$ 2,219,141
September-10	1,096	$ 2,460.65	168,410	$ 16.01	$ 2,696,874
October-10	1,008	$ 2,479.85	140,012	$ 17.85	$ 2,499,691
November-10	1,042	$ 2,247.14	139,969	$ 16.73	$ 2,341,516
Monthly Averages	1,043	$ 2,124.55	144,936	$ 15.30	$ 2,217,447
Ave., Aug '09 - April '10	1,040	$ 2,038.81	143,737	$ 14.75	$ 2,120,360
Adjustment for delayed provider billings	30				
Growth May '10 - July '11:					
• high school graduates	22				
• transitions from the Developmental Center	8				
• ISLA caseload growth in Grand Forks area	9				
6% inflation 7/1/10				$ 0.88	
11-13 Average Caseload Growth:					
•22 high school graduates beginning 7/1/2011 & 22 high school graduates beginning 7/1/2012	33				
• new eight bed TCLF opening 7/1/2012 in Fargo area	4				
3%, 3% Inflation for 11/13 Biennium				$ 0.71	
Monthly Average	1,146			$ 16.34	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

ICF/MR Physically Handicapped

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	119	$ 10,131.41	3,957	$ 304.68	$ 1,205,638
September-09	116	$ 10,113.52	3,599	$ 325.97	$ 1,173,168
October-09	113	$ 11,285.94	3,413	$ 373.66	$ 1,275,311
November-09	114	$ 11,565.46	4,086	$ 322.68	$ 1,318,463
December-09	104	$ 13,825.64	3,639	$ 395.13	$ 1,437,867
January-10	118	$ 12,691.86	4,198	$ 356.75	$ 1,497,639
February-10	121	$ 11,041.25	3,796	$ 351.95	$ 1,335,991
March-10	117	$ 9,683.37	3,279	$ 345.52	$ 1,132,954
April-10	114	$ 11,131.84	3,617	$ 350.85	$ 1,269,030
May-10	117	$ 10,788.15	3,635	$ 347.24	$ 1,262,213
June-10	112	$ 11,117.98	3,573	$ 348.51	$ 1,245,214
July-10	117	$ 11,106.38	3,784	$ 343.41	$ 1,299,447
August-10	115	$ 11,102.05	3,595	$ 355.14	$ 1,276,736
September-10	118	$ 12,252.14	3,824	$ 378.07	$ 1,445,752
October-10	121	$ 11,470.47	3,729	$ 372.20	$ 1,387,927
November-10	121	$ 11,824.23	3,794	$ 377.10	$ 1,430,732
Monthly Averages	116	$ 11,320.73	3,720	$ 353.05	$ 1,312,130
Ave., Aug '09 - April '10	115	$ 11,252.23	3,732	$ 346.29	$ 1,294,007
Adjustment for delayed provider billings	3				
6% Inflation 7/1/10				$ 20.78	
ICF/MR provider assessment increase				$ 2.47	
3%, 3% Inflation for 11/13 Biennium				$ 16.68	
Monthly Average	118			$ 386.22	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

ICF/MR Children

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	92	$ 12,861.51	2,991	$ 395.61	$ 1,183,259
September-09	92	$ 12,117.13	2,824	$ 394.75	$ 1,114,776
October-09	90	$ 12,756.91	2,734	$ 419.94	$ 1,148,122
November-09	92	$ 12,557.49	2,852	$ 405.08	$ 1,155,289
December-09	92	$ 13,833.12	2,764	$ 460.44	$ 1,272,647
January-10	85	$ 13,330.32	2,718	$ 416.88	$ 1,133,077
February-10	85	$ 13,904.32	2,812	$ 420.29	$ 1,181,867
March-10	89	$ 11,942.72	2,554	$ 416.17	$ 1,062,902
April-10	90	$ 13,378.84	2,875	$ 418.82	$ 1,204,096
May-10	75	$ 12,857.32	2,315	$ 416.54	$ 964,299
June-10	89	$ 12,770.38	2,696	$ 421.57	$ 1,136,564
July-10	88	$ 13,159.48	2,795	$ 414.32	$ 1,158,034
August-10	92	$ 15,724.83	3,418	$ 423.25	$ 1,446,684
September-10	92	$ 13,003.63	2,748	$ 435.35	$ 1,196,334
October-10	92	$ 12,621.61	2,745	$ 423.02	$ 1,161,188
November-10	93	$ 13,939.14	3,079	$ 421.03	$ 1,296,340
Monthly Averages	89	$ 13,172.42	2,808	$ 418.94	$ 1,175,967
Ave., Aug '09 - April '10	90	$ 12,908.69	2,792	$ 415.97	$ 1,161,782
Adjustment for delayed provider billings	2				
Adjustment for rate changes (delayed rate sheet/mass adj necessary)				$ 0.53	
6% Inflation 7/1/10				$ 24.99	
ICF/MR provider assessment increase				$ 2.47	
3%, 3% Inflation for 11/13 Biennium				$ 20.07	
Monthly Average	92			$ 464.03	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

Minimally Supervised Living Arrangement

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	187	$ 4,375.97	5,661	$ 144.55	$ 818,307
September-09	187	$ 4,805.47	6,143	$ 146.28	$ 898,622
October-09	186	$ 5,772.27	5,918	$ 181.42	$ 1,073,643
November-09	174	$ 5,174.20	5,502	$ 163.63	$ 900,311
December-09	201	$ 6,254.57	6,931	$ 181.38	$ 1,257,168
January-10	202	$ 5,541.25	6,253	$ 179.01	$ 1,119,332
February-10	202	$ 5,408.99	6,320	$ 172.88	$ 1,092,615
March-10	202	$ 4,832.11	5,669	$ 172.18	$ 976,087
April-10	202	$ 5,342.25	6,239	$ 172.97	$ 1,079,134
May-10	201	$ 5,103.81	5,971	$ 171.81	$ 1,025,866
June-10	201	$ 5,387.17	6,256	$ 173.09	$ 1,082,821
July-10	203	$ 5,182.90	6,133	$ 171.55	$ 1,052,129
August-10	205	$ 5,693.57	6,581	$ 177.36	$ 1,167,182
September-10	206	$ 5,582.64	6,275	$ 183.27	$ 1,150,024
October-10	203	$ 5,472.07	6,075	$ 182.85	$ 1,110,830
November-10	202	$ 5,945.51	6,243	$ 192.37	$ 1,200,994
Monthly Averages	198	$ 5,367.17	6,136	$ 172.91	$ 1,062,817
Ave., Aug '09 - April '10	194	$ 31.29	6,071	$ 168.66	$ 1,023,913
Adjustment for delayed provider billings and new provider programs	17			$ 2.56	
Growth Average May '10 - July '11: • *transitions from the Developmental Center (relicense a HIT facility to an MSLA)*	4				
6% Inflation 7/1/10				$ 10.27	
3%, 3% Inflation for 11/13 Biennium				$ 8.25	
Monthly Average	215			$ 189.74	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

Transitional Community Living - Training

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	160	$ 4,185.18	4,995	$ 134.06	$ 669,629
September-09	160	$ 4,315.71	4,990	$ 138.38	$ 690,513
October-09	160	$ 5,387.96	4,945	$ 174.33	$ 862,073
November-09	154	$ 4,662.97	4,775	$ 150.39	$ 718,098
December-09	162	$ 4,955.22	5,095	$ 157.56	$ 802,746
January-10	158	$ 5,782.22	4,923	$ 185.58	$ 913,590
February-10	163	$ 4,968.06	5,156	$ 157.06	$ 809,793
March-10	163	$ 4,406.82	4,572	$ 157.11	$ 718,312
April-10	163	$ 4,961.29	5,044	$ 160.33	$ 808,691
May-10	164	$ 5,062.41	4,944	$ 167.93	$ 830,235
June-10	164	$ 5,071.92	5,217	$ 159.44	$ 831,795
July-10	164	$ 4,814.97	4,904	$ 161.02	$ 789,655
August-10	162	$ 5,089.58	5,026	$ 164.05	$ 824,512
September-10	161	$ 5,106.48	4,989	$ 164.79	$ 822,143
October-10	161	$ 5,043.14	4,862	$ 167.00	$ 811,946
November-10	162	$ 5,465.09	5,030	$ 176.01	$ 885,344
Monthly Averages	161	$ 4,954.94	4,967	$ 160.94	$ 799,317
Ave., Aug '09 - April '10	160	$ 4,856.56	4,944	$ 157.23	$ 777,049
Adjustment for delayed provider billings	1				
6% Inflation 7/1/10				$ 9.43	
11-13 Average Caseload Growth:					
• *new eight bed TCLF opening 7/1/2012 in Fargo area*	4				
3%, 3% Inflation for 11/13 Biennium				$ 7.57	
Monthly Average	165			$ 174.23	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

Family Support Services - In-Home Support

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	473	$ 1,429.28	24,963	$ 27.08	$ 676,049
September-09	490	$ 1,279.26	23,084	$ 27.15	$ 626,839
October-09	505	$ 1,091.42	20,218	$ 27.26	$ 551,167
November-09	499	$ 1,040.29	19,134	$ 27.13	$ 519,104
December-09	502	$ 1,107.05	20,427	$ 27.21	$ 555,739
January-10	510	$ 1,060.16	19,814	$ 27.29	$ 540,682
February-10	512	$ 1,072.09	20,198	$ 27.18	$ 548,911
March-10	528	$ 1,092.50	21,248	$ 27.15	$ 576,839
April-10	531	$ 1,138.73	22,254	$ 27.17	$ 604,667
May-10	541	$ 1,117.28	22,206	$ 27.22	$ 604,448
June-10	557	$ 1,274.75	26,131	$ 27.17	$ 710,038
July-10	541	$ 1,457.22	29,066	$ 27.12	$ 788,358
August-10	528	$ 1,682.90	31,062	$ 28.61	$ 888,570
September-10	569	$ 1,582.49	31,361	$ 28.71	$ 900,439
October-10	539	$ 1,275.52	23,950	$ 28.71	$ 687,503
November-10	509	$ 1,377.16	24,376	$ 28.76	$ 700,975
Monthly Averages	521	$ 1,254.88	23,718	$ 27.56	$ 655,021
Ave., Aug '09 - April '10	506	$ 1,141.85	21,260	$ 27.19	$ 577,777
Growth May '10 - July '11:	31				
6% Inflation 7/1/10				$ 1.63	
11-13 Average Caseload Growth (Approx. 2 per month)	24				
3%, 3% Inflation for 11/13 Biennium				$ 1.31	
Monthly Average	561			$ 30.13	

North Dakota Dept of Human Services
Developmental Disabilities Community Based Care
Detail of Selected Services
2009-2011 Actual

Infant Development

Month	Actual Persons Receiving	Actual Cost Per Person	Actual Units of Service	Actual Cost Per Unit	Actual Expenditures
August-09	726	$ 459.92	16,327	$ 20.45	$ 333,902
September-09	828	$ 510.08	19,503	$ 21.66	$ 422,345
October-09	802	$ 510.32	17,389	$ 23.54	$ 409,278
November-09	673	$ 491.08	14,941	$ 22.12	$ 330,500
December-09	837	$ 554.16	20,951	$ 22.14	$ 463,830
January-10	837	$ 502.40	18,847	$ 22.31	$ 420,512
February-10	679	$ 593.69	16,568	$ 24.33	$ 403,113
March-10	835	$ 542.79	20,384	$ 22.23	$ 453,233
April-10	817	$ 502.52	18,663	$ 22.00	$ 410,559
May-10	643	$ 500.65	14,358	$ 22.42	$ 321,916
June-10	853	$ 566.36	21,535	$ 22.43	$ 483,103
July-10	822	$ 743.39	17,618	$ 34.68	$ 611,066
August-10	565	$ 507.46	2,012	$ 142.50	$ 286,715
September-10	749	$ 684.95	3,304	$ 155.27	$ 513,024
October-10	711	$ 566.06	2,546	$ 158.08	$ 402,466
November-10	672	$ 600.55	2,480	$ 162.73	$ 403,569
Monthly Averages	753	$ 552.27	14,214	$ 56.18	$ 416,821
Ave., Aug '09 - April '10	782	$ 518.23	18,175	$ 22.30	$ 405,252
Growth May '10 - July '11 (5 per month):	75				
6% Inflation 7/1/10				$ 1.34	
Conversion to a fee-for-service rate setting methodology effective 7/1/10:					
• Conversion from a daily rate to a rate per service				$ 119.03	
• Anticipated additional assessments performed (not each assessment results in an eligible client)	59				
11-13 Average Caseload Growth (5 per month)	63				
3%, 3% Inflation for 11/13 Biennium				$ 6.48	
Monthly Average	979			$ 149.15	

Note: Infant Development Payment process changed from a retrospective rate setting process to a fee-for-service process as of 7/1/2010. We arrived at the new fees by working with Infant Development Providers to determine the number of pay points, the specific products that could be clearly defined, the average amount of time needed to complete each of the four pay points and the average number of occurrences per year for each pay point. That information along with the total funds available (cost neutrality) and number of recipients was used to determine the fee for each pay point.

-Carol Olson
-Attachment TWO
-SB 2012

north dakota department of human services

Glossary of Human Services Terms and Acronyms

January 2011 - March 11, 2011

960 - Refers to the State Form Number 960 (SFN 960) for the reporting of suspected child abuse or neglect.

AASK - Adults Adopting Special Kids is a collaboration involving the department's Children and Family Services Division, Catholic Charities North Dakota, and PATH ND. They work together to promote and facilitate the adoption of children with special needs from the foster care system.

Abuse - Any willful act or omission by a caregiver or other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation of a vulnerable adult.

Abused Child - An individual under the age of 18 years who is suffering from abuse as defined in Subdivision A of Subsection 1 of Section 14-09-22 caused by a person responsible for the child's welfare, and "sexually abused child" means an individual under the age of 18 years who is subjected by a person responsible for the child's welfare to any act in violation of sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or Chapter 12.1-27.2 (sex offenses listed in the criminal code). (14-09-22 "Inflicts, or allows to be inflicted, upon the child, bodily injury, substantial bodily injury, or serious bodily injury as defined by section 12.1-01-04 or mental injury") (12.1-01-04 "Bodily injury" means any impairment of physical condition, including physical pain. "Serious bodily injury" means bodily injury that creates a substantial risk of death or which causes serious permanent disfigurement, unconsciousness, extreme pain, permanent loss or impairment of the function of any bodily member or organ, a bone fracture, or impediment of air flow or blood flow to the brain or lungs. "Substantial bodily injury" means a substantial temporary disfigurement, loss, or impairment of the function of any bodily member or organ.)

Access Services - Services such as transportation, escort/shopping assistance, outreach, and information and assistance, which help people to identify, obtain, and use existing services.

ACJ - Alliance for Children's Justice is a statewide multi-disciplinary coalition of professionals and parents dedicated to quality child protection services in North Dakota.

ACS - Affiliated Computer Services Inc. is the company North Dakota has contracted with for its Medicaid Management Information System replacement project and its Pharmacy Point of Sale system project.

Acute Care Unit - A service unit in the department's Human Service Centers that provides general outpatient mental health services.

ADA - Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. § 12101 et seq.]

ADL - Activities of Daily Living refers to daily self-care personal activities that include bathing, dressing and undressing, eating or feeding, toileting, continence, transferring in and out of a bed, or chair, or on and off the toilet; and mobility inside the home.

Administrative Assessment - Process of documenting reports of suspected child abuse or neglect that do not meet the criteria for a Child Protection Services Assessment.

Administrative Referral - Process of documenting the referral of reports of suspected child abuse or neglect that fall outside the jurisdiction of the county where the report is received.

Adoption Assistance - A form of monetary assistance to families adopting children from foster care who have special needs. This assistance can take the form of a monthly payment, Medicaid as a backup to a family's private health insurance, or reimbursement of nonrecurring expenses related to adoption.

Adoption Search/Disclosure - The process whereby an adopted individual, a birth parent, or birth sibling of an adopted individual, or an adult child of a deceased adopted individual can request and receive identifying information related to the adoption.

Adoption Subsidy - See Adoption Assistance.

Adult Day Care - A program of non-residential activities provided at least three (3) hours per day on a regularly scheduled basis one or more days per week and encompassing both health and social services needed to ensure the optimal functioning of the individual.

Adult Education Transition Services (AETS) - Refers to services provided to students 18-21 years of age who are eligible for Developmental Disabilities Program Management Services and can benefit from residential and/or day services provided in the developmental disabilities system while they are still in school. This is a joint initiative between the Department of Public Instruction and the Department of Human Services. Individuals must meet eligibility requirements. Education agencies and Medicaid provide funding.

Adult Family (Foster) Care - Provision of 24-hour room, board, supervision, and extra care to adults who are unable to function independently or who may benefit from a family home environment. Care is provided in a licensed home.

ADRC - Aging and Disability Resource Center is a community-level resource that people can turn to for information and for assistance locating available long-term care supports and services. It is intended to help connect older adults and adults with physical disabilities (of all incomes) and their families with needed services and supports. The DHS Aging Services Division received a demonstration grant to pilot an ADRC in the 10-county Bismarck region, and plans to expand ADRC services statewide by 2013 using existing resources at the regional human service centers.

Aging Services - Refers to the Aging Services Division of the N.D. Department of Human Services, which administers programs and services for older persons and vulnerable adults as the designated State and Area Agency on Aging under the Older Americans Act.

American Recovery and Reinvestment Act (ARRA) – Is legislation passed by Congress and signed into law in 2009 that is also referred to as "stimulus" funding. As OMB states on the ARRA Website, a majority of the ARRA funding for North Dakota was "committed to education, transportation and human and community services."

Approved Relative - An unlicensed child care provider who is eligible to participate in the Child Care Assistance Program. By federal law, an approved relative must be related to the child by marriage, blood relationship, or court order such as a grandparent, great-grandparent, aunt, uncle, or a sibling age 18 or older who does not live with the child. These providers can care for up to 5 children including their own children under the age of 12. All adults living in the home are checked against the ND Office of Attorney General's sex offender list.

ARRA – See American Recovery and Reinvestment Act

Arrearages - Past-due, unpaid child support owed by the noncustodial parent. Also may be referred to as "arrears."

ASAM - American Society of Addiction Medicine, Patient Placement Criteria, Second Edition-Revised. These are the clinical guidelines used for matching clients to the appropriate level of care for the treatment of substance-related disorders.

ASFA - The Adoption and Safe Families Act of 1997 [Pub. L. 105-89; 111 Stat. 2115; 42 U.S.C. § 1305 et seq.] is federal legislation to shorten the length of time in foster care and to ensure safety and permanency for children.

Assisted Living - An environment that helps people maintain as much independence as possible by providing apartment-like units and individualized support services, which accommodate individual needs and abilities. Assisted living facilities are required to be licensed in the North Dakota.

Assistive Technology (AT) Device - Any item or piece of equipment used to maintain or improve the functional capabilities of individuals with disabilities.

Assistive Technology (AT) Service - Any service that directly assists an individual with a disability in selecting, acquiring or using an assistive technology device. AT services may include: evaluation, purchasing, designing, leasing, training for individuals, family members, and professionals; and coordinating therapies. It also includes services that expand access to electronic and information technology for people with disabilities.

Attendant Care Service (ACS) - Hands-on care, of both a supportive and medical nature, specific to a client who is ventilator-dependent for a minimum of 20 hours per day and includes nursing activities that have been delegated by the Nurse Manager to the ACS provider. ACS is an all-inclusive service that provides direct care to ventilator-dependent individuals to meet their care needs.

Attendant Care Service Provider - Is a Qualified Service Provider (QSP) who is an unlicensed assistive person enrolled and in good standing with the North Dakota Board of Nursing. The attendant care service is provided under the direction of a licensed nurse who is enrolled with the Department of Human Services as a QSP to provide Nurse Management.

Background Check - (See also *Criminal Background Check*) Refers to the check that is currently done on child care provider applicants (licensed and self-certified) to see if a person's name appears on the ND Child Abuse and Neglect Index showing a finding of "services required" for child abuse or neglect and to see if the person is on the ND Office of Attorney General's List of Convicted Sex Offenders and Offenders Against Children.

Basic Care Assistance Program - Supplements room and board payments made by individuals of limited means living in basic care facilities. The Basic Care Assistance Program is funded with state general funds.

Basic Care Facility - A licensed residential facility that provides room and board and services to individuals who need health, social, or personal care services, but do not require extensive medical services.

Benchmark – A specific measurement as it relates to progress toward meeting a standard or goal.

BEST - Basic Employment and Skills Training program provides motivation and job seeking skills to Supplemental Nutrition Assistance Program recipients who are required to register for work. The department contracts with Job Service North Dakota to provide the service in Burleigh County and Cass County.

Best Practice - Practices that incorporate the best objective information currently available from recognized experts regarding effectiveness and acceptability.

BLHSC - Badlands Human Service Center is located in Dickinson. (*See HSC definition.*)

CA/N - Child Abuse and Neglect

Care Coordinator - Describes the comprehensive case manager in a child and family case involving severe emotional disturbance.

CARF - Commission for Accreditation for Rehabilitation Facilities

Case Management - A service where needs are assessed, services are arranged, coordinated, and monitored; and client preferences are advocated for within the context of a clinical treatment plan.

CCAP - Child Care Assistance Program provides partial payment for child care services provided to children from qualifying low-income families.

CCDBG - Child Care Development Block Grant

CCWIPS - The Comprehensive Child Welfare, Information, and Payment System is a computerized case management and payment system for foster care and adoption services.

CFS - Refers to the Children and Family Services Division of the Department of Human Services. CFS has administrative responsibility for the policies and procedures relating to children and families. The division is responsible for program supervision and technical assistance for the delivery of public child welfare services.

CFSR - Child and Family Services Review is a federal child welfare review conducted in all states. North Dakota uses this same process to conduct child welfare reviews in each region of the state annually.

Child and Family Team - Related to children's mental health services and child welfare services, the Child and Family Team consists of the child, family and persons most pertinent in the life of the child and family, as determined by the family (in most instances). The team meets to identify family strengths, needs, risks, and resources to reduce and/or eliminate the risk of removal from the home, reunification, emotional and educational needs, child abuse and neglect and ensure the safety, permanency and well-being of children and families.

Child Care Provider - A person, group of persons, or agency that is responsible for the education and supervision of the child/children in their care in exchange for money, goods, or services.

Child Care Provider Licensing - County social service offices conduct child care licensing studies, investigate complaints, and issue correction orders. The Department of Human Services' regional child welfare administrators review applications and studies, and issue licenses, denials, revocations, and suspensions. The Department's "State Office," which includes the Children and Family Services Division and the Legal Unit, develops and reviews regulations, policies, and procedures; conducts licensing training; reviews notices before issuance; and provides technical assistance.

Child Care Resource and Referral (CCR&R) – In North Dakota, two CCR&R agencies assist families searching for licensed child care and educate families about what to look for in providers. They also collect and maintain a database of providers, compile supply and demand information, provide and coordinate provider training, provide technical assistance to help providers become licensed and to improve quality, support child care programs in other ways, and work with communities to address child care issues. Established in 1992 by the North Dakota Legislature, the CCR&R programs in the state are supported by public funding (mainly from the ND Department of Human Services) and private funding.

Child Fatality Review Panel - A multi-professional group that meets to review the deaths of all minors in the state and identifies trends or patterns in the deaths of minors.

CHIP - Children's Health Insurance Program. See Healthy Steps and State Children's Health Insurance entries.

Chore Service - These tasks enable a client to remain in the home. Tasks include heavy housework and periodic cleaning, professional extermination, snow removal, and the task must be the responsibility of the client and not the responsibility of the landlord. Emergency Response Systems (ERS), such as electronic devices enabling the client to secure help in an emergency by activating the "help" button, are also available under this service.

CIL - Center for Independent Living. The four CILs in North Dakota provide services to individuals with disabilities so they can live and work more independently in their homes and communities.

Client Assistance Program (CAP) - Designed to inform and advise all Vocational Rehabilitation clients and applicants about the benefits available under the Federal Rehabilitation Act of 1973, and to assist clients in securing those services.

CMHS Block Grant - Community Mental Health Service Block Grant

Congregate Care - Refers to a specialized group residential facility that provides programming for elderly individuals with mental retardation to help them maintain their current level of functioning. The health and medical conditions of the individuals served are stable and do not require continued nursing or medical care.

Continuum of Care - A functional philosophy that seeks to ensure clients receive the right service in the right place at the right time.

Co-occurring Disorders (COD) - Individual has one or more substance-related disorders along with one or more mental disorders.

Corporate Guardianship - A service purchased on behalf of individuals eligible for developmental disabilities case management services when a district court has determined the individual requires a guardian and no one else is available to serve as guardian.

The Council for Quality and Leadership - Often referred to as "The Council" or "CQL," this entity accredits providers of services for mentally retarded/developmentally disabled people.

CP - For child support purposes, the Custodial Parent is the person (generally a parent) who has primary care, custody, and control of a child or, if a court has made a custody determination, the person who has legal custody of a child.

CPS - Child Protection Services protect the health and welfare of children by encouraging the reporting of children known to be or suspected of being abused or neglected; provide services for the protection and treatment of abused and neglected children to protect them from further harm.

CPS Assessment - A fact finding process designed to provide information that enables a determination to be made whether services are required for the protection and treatment of a child. These assessments are completed by County Social Service Board social workers.

CPS Assessment Decision - The result of a CPS assessment, which reflects whether services are required for the protection and treatment of an abused or neglected child.

Criminal Background Check - Fingerprints are taken and sent to the North Dakota Bureau of Criminal Investigation (BCI) and the Federal Bureau of Investigation (FBI) to determine if there is any criminal history record information regarding the person. This type of background check is being proposed for child care providers and is currently in place in North Dakota for foster care and non-relative adoptions, as well as North Dakota's CareCheck Registry – the existing voluntary criminal background check process for child care providers. (See *Background Check entry.*)

CRU - Crisis Residential Units provide generally short-term stabilization and support to individuals diagnosed with mental illness and/or chemical dependence who are experiencing crisis as a result of exacerbation of symptoms.

CSAP - Center for Substance Abuse Prevention is the sole federal organization with responsibility for improving accessibility and quality of substance abuse prevention services.

CSAT - Center for Substance Abuse Treatment is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), that works to expand the availability of effective treatment and recovery services for alcohol and drug problems.

CSCC - Children Services Coordinating Committee

CSHCN - Children with Special Health Care Needs. As defined at the federal level, this population of children has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions requiring health and related services of a type or amount beyond that required by children generally.

CSHS - Children's Special Health Services (formerly Crippled Children's Services) is part of the Department of Health; it provides services directly or through contracts to children with special health care needs and their families.

Custodial Parent – See *Parent Who Has Primary Residential Responsibility*.

Day Supports - This is a single day program, which encompasses services previously known as Developmental Day Activity, Developmental Work Activity, Prevocational Work Activity and Adult Day Care. Day supports may include assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills; provision of social, recreational, and therapeutic activities to maintain physical, recreational, personal care, and community integration skills; development of non-job task oriented prevocational skills such as compliance, attendance, task completion, problem solving and safety; and supervision for health and safety. Services are provided in settings appropriate to an individual's needs.

DC - Refers to the Developmental Center. Located in Grafton, N.D., it provides residential and other services to individuals with developmental disabilities.

DD - Refers to the Developmental Disabilities service system, which provides case management, day supports, residential services, and family support services to individuals with mental retardation or developmental disabilities of all ages, and early intervention services to infants and toddlers who are at risk for, or experiencing developmental delays.

DD Program Management - A function where a professional program manager assesses client need, authorizes payment for services, and assures that appropriate quality services are provided.

DDS - Disability Determination Services makes eligibility decisions for Social Security Disability Insurance and Supplemental Security Income so that eligible individuals can receive disability benefits. This is part of the ND Department of Human Services.

Debit Card - A card that may be used to electronically withdraw account deposits at an Automated Teller Machine (ATM) or a bank teller window, or to use at a point-of-sale (POS) machine to purchase goods, or services, or to obtain cash. Debit cards are used by the Department of Human Services to pay cash assistance under TANF programs and to distribute child support payments to custodial parents. Custodial parents receiving child support payments may also choose "direct deposit" as an alternative.

Determination - The result of an assessment of suspected institutional child abuse or neglect.

Developmental Disability - Refers to a severe chronic condition that constitutes a lifelong mental or physical impairment, which became apparent during childhood and has hampered an individual's ability to participate in mainstream society, either socially or vocationally.

Direct Deposit - For child support purposes, it is a process involving the electronic funds transfer of support payments from the State Disbursement Unit (SDU) into a custodial parent's bank account. This is done only upon the request of the custodial parent. Custodial parents may also choose to receive payments via a debit card.

Disease Management - A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant (for example, Medicaid recipients). Disease management: (1) supports the physician or practitioner/patient relationship and plan of care, (2) emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and empowerment strategies, and (3) evaluates clinical, quality of life and economic outcomes on an on-going basis with a goal of improving participants overall health.

Diversion Assistance - An alternative to Temporary Assistance for Needy Families (TANF) assistance, Diversion Assistance is available for no more than four months in a year, and is intended to allow individuals to avoid some of the complications of TANF in an effort to quickly achieve self-sufficiency.

DJS - Division of Juvenile Services is a division of the North Dakota Department of Corrections and Rehabilitation. DJS is responsible for the custody of delinquent and unruly children placed in its care by the courts.

DRA - Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. § 1108, et seq.]

Dual Diagnosed - Diagnosed with two disorders such as those individuals diagnosed with mental illness and chemical dependence or individuals diagnosed with mental illness and developmental disabilities.

Dual Eligibles - Individuals who qualify for both Medicaid (state and federally-funded health coverage for low-income persons) and Medicare (federal health coverage program for persons age 65 and older and other qualifying individuals with disabilities).

DUR Board - Drug Utilization Review Board is a volunteer board whose makeup and duties appear in Code of Federal Regulations and subsequently in state statute. Comprised of pharmacists and physicians, the Board was established to advise the Medicaid program on prior authorization and other pharmacy cost control and utilization matters.

EAP - Economic Assistance Policy is a division of the department that administers policy for and includes the following programs: Child Care Assistance Program, Basic Care Assistance Program, Energy Assistance (also referred to as Low Income Home Energy Assistance, or LIHEAP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), including Diversion Assistance and Job Opportunities and Basic Skills (JOBS). EAP is also responsible for Medicaid Estate Recovery, Quality Control, and System Support and Development.

Early Head Start - A federally funded program that serves income eligible infants, toddlers and expectant parents. Early Head Start provides services that include prenatal development/healthy pregnancy, child development, health, nutrition, parent education/family development and parent leadership opportunities. Early Head Start reserves 10 percent of its enrollment for children with special needs.

Early Intervention Services - Refers to a statewide program for infants and toddlers who range from newborn to three years of age who have a developmental delay, disability, or a condition that could result in substantial limitations if intervention is not provided. Intervention services are designed to help address the physical and developmental needs of children, and to augment the capacity of their families to meet their special needs.

Early Learning Guidelines - These voluntary guidelines are intended as a resource for parents, child care providers, pre-kindergarten and Head Start teachers, and others. They outline the skills, knowledge, and dispositions young children need prior to entering first grade.

EFT - Electronic Funds Transfer is a process by which money is transmitted electronically from one bank to another.

English Language Learners (ELL) - People who are learning the English. Another related term commonly used is English as a Second Language (ESL).

Environmental Modification - Physical adaptions to the home necessary to ensure the health, welfare, and safety of a client or that enable a client to function with greater independence in his/her home.

Expanded SPED Program - Expanded Service Payments to the Elderly and Disabled Program is a companion program to the Basic Care Assistance Program. It pays for services that can be provided in the home and community so that people can avoid having to move to a basic care facility. The Expanded SPED Program is funded with state general funds.

Extended Personal Care - Includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse licensed to practice in the state will provide training to a QSP approved by the Department to provide the required care and will provide at a minimum, a review of the client's needs every six months to determine if additional training is required. Activities of daily living (ADL) and instrumental activities of daily living (IADL) are not a part of this service.

Extended Services - This refers to long term supports provided by a job coach for individuals with disabilities employed in the community.

FACSES - The Fully Automated Child Support Enforcement System is the statewide automated system that supports the processing of child support cases in North Dakota and supports the State Disbursement Unit (SDU) in processing child support payments.

Family Caregiver Support Program - Federally funded under the Older Americans Act, this Aging Services program offers help to caregivers who are caring for an adult age 60 or older, or who are themselves age 55 or older and are caring for grandchildren or relatives who are age 18 or younger or for an adult child with a disability who is between 19 and 59 years of age. Services include information and referral, assistance from a trained caregiver coordinator to help caregivers assess needs and access support services, individual and family counseling, support groups, training, and respite care for caregivers.

Family Group Decision Making - Relating to the provision of child welfare services, this is defined as a strengths-based collaborative, coordinated decision making process using family, agency and support service resources to ensure the safety, permanency and well-being of children and families.

Family Home Care - The provision of room, board, supervisory care, and personal care service to an eligible elderly or disabled individual by the spouse or by one the following relatives, or the current or former spouse of one of the following relatives of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew. The family home care provider does not need to be present in the home on a 24-hour basis if the welfare and safety of the client is maintained.

Family Personal Care -This helps individuals remain with their family members and provides extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

Family Subsidy - A program that may reimburse a family for excess expenses related to their child's disability. This offers support to enable families to keep their children in their homes when lack of financial support would make it very difficult for families to care for their children at home. A child may be eligible for this program through age 21.

Family Support Services - Refers to services, which are provided for eligible individuals with developmental disabilities to enable them to remain in appropriate home environments. Services are based on the primary caregiver's need for support in meeting the health, safety, developmental and personal care needs of their family member. Personal care needs include activities of daily living such as eating, bathing, dressing, and personal hygiene. When the eligible client is a minor, out-of-home support may also be provided in a licensed family home. This Family Care Option may be appropriate for children who cannot remain in their family home on a full-time basis. It is available only if the child is not considered deprived within the definition of NDCC 27-20-02 (5), and is not considered boarding care according to the definition of the North Dakota Department of Public Instruction.

FFY - Federal Fiscal Year runs from October 1 to September 30.

Fidelity - This is the degree of adherence to essential elements in the implementation of evidence-based clinical practice. Program with high fidelity are expected to have greater effectiveness in achieving desired client outcomes.

FIDM - The Financial Institution Data Match process is operated by the Child Support Enforcement program in coordination with financial institutions and pursuant to federal and state laws. The process provides for a data match system in which account records are matched with child support cases.

FLEP - Family Life Education Program. The department of human services is required by law (NDCC 50-06-06.10) to enter into an agreement with the North Dakota State University extension service for the design of a program to educate and support individuals at all points within the family life cycle. The program must provide support for families and youth with research-based information relating to personal, family, and community concerns and must contain a research component aimed at evaluation of planned methods or programs for prevention of family and social problems. The program must address: 1) child and youth development; 2) parent education with an emphasis on parents as educators; 3) human development; 4) interpersonal relationships; 5) family interaction and family systems;

6) family economics; 7) intergenerational issues; 8) impact of societal changes on the family; 9) coping skills; and 10) community networks and supports for families.

FMAP - Federal Medical Assistance Percentage is the federal matching rate for the Medicaid program. FMAP changes annually on October 1.

Food Stamps - See Supplemental Nutrition Assistance Program or SNAP.

Front End System/FRAME - An added component to the Department's current child welfare computer system that makes intake and data entry more efficient and user-friendly and supports enhanced case management services.

GA - General Assistance is a county program designed to cover emergency needs of low-income individuals or families. The covered needs may include rent, fuel and utilities, medical, and burial expenses.

Good Start, Grow Smart - The federal initiative that encouraged states to develop early learning guidelines, professional development systems, and quality rating systems and required Head Start programs to demonstrate progress in children's learning.

Governor's Prevention Advisory Council (GPAC) on Drugs and Alcohol - Formed by an executive order from the Governor's office, the council is charged with oversight and monitoring of substance abuse prevention activities across state agencies in North Dakota. The Department holds two of the eight council membership positions.

Guardian Ad Litem - A court-appointed child advocate mandated by North Dakota law for all abused and neglected children involved in a Juvenile Court proceeding.

HCBS - Home and Community Based Services refers to the array of services that are essential and appropriate to sustain individuals in their homes and communities, and to delay or prevent institutional care.

Head Start - This is a federally funded program for families with pre-school aged children who meet income eligibility guidelines. Head Start is family-focused and provides early literacy and education, child development, child health services (dental, physical, social-emotional, nutrition) and parent education and support services.

Head Start-State Collaboration Office (HS-SCO) - This office is designed to create a visible presence at the state level to assist in the development of significant, multi-agency and public-private partnerships between Head Start and the state. The following are the federally-identified purposes of the HS-SCO: Build early childhood systems and access to comprehensive services and support for all children of families with low-incomes; Create partnership agreements and initiatives between Head Start and appropriate state programs/agencies and encourage Head Start's capacity to be a partner in State initiatives on behalf of children and their families; and Facilitate the involvement of Head Start in State policies, plans, processes and decisions affecting the Head Start target population and other families with low-incomes.

Health Care Trust Fund - This trust fund was established by the 1999 North Dakota Legislature as a source of funding for grants and loans to pay for legislatively approved projects.

Health Tracks - See North Dakota Health Tracks.

Healthy Steps - Is North Dakota's Children's Health Insurance Program that offers comprehensive health coverage for children 18 years of age and younger. To qualify, a child's family must have a net income that is greater than the Medicaid eligibility level, but not exceeding 160% of the federal poverty level. (Deductions for child care, child support, and taxes are allowed when determining eligible income.) Healthy Steps is a state "Children's Health Insurance Program" (CHIP).

HIPAA - Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 42 U.S.C. § 1301 et seq.] that among other things standardizes the format of certain health care information that is transmitted electronically and regulates the release of health care information. HIPAA impacts entities (and their computer systems) that handle individual health care information.

Home Delivered Meal - Provides a well-balanced meal to any qualifying individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the recipient.

Homemaker Service - Includes tasks such as housekeeping, laundry, and shopping, this service allows an individual to maintain or develop the independence needed to remain in the home.

HSC – Human Service Centers are part of the Department and provide help to individuals and families with concerns including family and relationship issues, mental illness, addiction, disabilities, and other needs. Centers are located in Bismarck (WCHSC), Devils Lake (LRHSC), Dickinson (Badlands HSC or BLHSC), Fargo (SEHSC), Grand Forks (NEHSC), Jamestown (SCHSC), Minot (NCHSC), and Williston (NWHSC).

IADL - Instrumental Activities of Daily Living means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include meal preparation, shopping, managing money, doing housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

ICAMA - Interstate Compact on Adoption and Medical Assistance

ICFMR - Intermediate Care Facility for the Mentally Retarded is a residential facility operated pursuant to federal regulations and serving people with developmental disabilities and related conditions. The programming provided is for individuals with extensive needs. Each client must receive a continuous active treatment program, which includes an aggressive and consistent program of training, health services, and related services so that the client acquires the ability to function with as much self-determination and independence as possible.

ICPC - Interstate Compact on the Placement of Children relates to the placement of foster children across state lines.

ICWA - Indian Child Welfare Act of 1978 [Pub. L. 95-608; 92 Stat. 3069; 25 USCA § 1901 et seq.] recognizes the importance of allowing tribal courts to assume full responsibility for the placement of Indian children in foster care and adoptive homes. Under ICWA, Indian tribes may intervene in such State court proceedings concerning Indian children, and Indian Tribal courts have exclusive jurisdiction over some such proceedings.

IDDT - Integrated Dual Disorder Treatment is an evidence-based practice that improves the quality of life of people with co-occurring mental and substance use disorders by promoting consumer and family involvement in service delivery, stable housing as a necessary condition of recovery, and employment as an expectation for many. The IDDT model integrates mental health and substance abuse services utilizing treatment that combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their families and other support system members. The implementation of IDDT promotes system change, organizational change, and clinical change.

Individualized Supported Living Arrangement (ISLA) - This residential service is provided to people with developmental disabilities and/or mental retardation in their own homes or apartments. The level of support provided is individualized to the person's need for training and assistance with personal care, laundry, money management, etc. Individuals who receive ISLA typically need a higher level of support than people in a Supported Living Arrangement (SLA).

Infant Development - Home-based, family focused services that provide supports to families of eligible infants and toddlers at high risk for, or with developmental delays or disabilities. An Individual Family Service Plan is developed that identifies services and learning opportunities that support the family in meeting the needs of their child, enhance their child's development, and increase the child's and family's participation in everyday routines and activities within the home and community. An eligible child may receive Infant Development services until he or she is three years of age.

Institutional Child Abuse or Neglect - Situations of known or suspected child abuse or neglect where the institution responsible for the child's welfare is a residential child care facility, a treatment or care center for the mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

Integrated Treatment - The skills and techniques used by treatment providers to comprehensively address both mental health and substance abuse issues in people with co-occurring disorders.

Intensive In-Home Services - Services provided under contract with a private agency to families who have at least one child about to be placed in foster care. The program's purpose is to preserve the family, prevent foster care, and assist with family re-unification of children who are placed in foster care.

Intergovernmental Transfer (IGT) – This is a complex funding process that was used by North Dakota and about 20 other states to access extra federal Medicaid dollars. The Health Care Financing Administration approved the IGT as part of North Dakota's Medicaid State Plan Amendment. Funds generated by the IGT were deposited into the Health Care Trust Fund. In a compromise worked out in Congress, this source of extra federal Medicaid funding has been phased out. The final North Dakota payment was in July 2004.

IPAT - Refers to the Interagency Program for Assistive Technology. IPAT's mission is to increase access to assistive technology devices and services for individuals with disabilities regardless of their type of disability, age, or income level in order to positively impact work, independent living, learning, community involvement and recreation.

IV-D - Refers to Title IV-D of the Social Security Act [Pub. L. 93-647; 42 U.S.C. title IV-D]. A Child Support Enforcement program that provides services to locate parents, to establish paternity, to establish child support and medical support obligations, to enforce child support and medical support obligations, and to review and adjust obligations. Services are provided to families receiving public assistance [through Temporary Assistance for Needy Families (TANF) or Medicaid], in cases in which a child has been placed in foster care or upon application for services from either parent.

IPE - Is an Individualized Plan for Employment. It describes the nature and scope of rehabilitation, employment and training services provided to an individual with a disability to help that individual reach his or her employment goal. A Vocational Rehabilitation counselor and the client write the client's IPE.

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

JOBS - Job Opportunities and Basic Skills program provides vocational training and employment for eligible individuals through TANF for the purpose of entering or reentering the job market. The Department of Human Services Program contracts with Job Service North Dakota, Career Options, Spirit Lake Employment and Training, and Turtle Mountain Tribal Employment and Training to provide JOBS program services.

Kinship Care - A Temporary Assistance for Needy Families (TANF) program that allows relatives, with supportive services, to provide care and protection to children who are under the care, custody, and control of County Social Services and who would otherwise be in foster care.

Licensed Child Care Providers – Are required to maintain at least minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios. See the definitions of the licensed child care provider categories: licensed family child care, licensed group child care, licensed child center, licensed preschools, licensed school-age programs, and multiple license facility. (Unlicensed child care provider categories include: self-declared providers, formerly called "self-certified," approved relative providers, and registered providers.)

Licensed Family Child Care - Care for 7 or fewer children in the provider's own home.

Licensed Group Child Care - Care for 8 to 18 children in the home or other type of facility.

Licensed Child Care Center - Care for 19 or more children in public or private buildings, churches or schools; children are often grouped by age.

Licensed Preschools - Part-time educational and socialization experiences for children age 2 years to kindergarten

Licensed School-Age Programs - The care of 19 or more school-age children before and/or after school; some programs provide care during school holidays and summer vacations.

LIHEAP - Low Income Home Energy Assistance Program that is also referred to as the energy assistance program. It provides heating assistance grants and services for qualifying low-income households. Benefits equal each household's estimated cost of heat minus a percentage of the household's income and are usually paid directly to heating fuel suppliers.

Local Child Protection Team - A multidisciplinary team of staff members from public and private community agencies who assist child protection service agencies to make decisions and recommendations for families involved in Child Protection System (CPS) assessments.

Long Term Care Facility - (As defined by North Dakota law) A skilled nursing facility/nursing home, basic care facility, assisted living facility, or swing bed hospital unit. Common usage generally equates it to a nursing facility.

Long Term Care Ombudsman - A person who identifies, investigates, and resolves complaints made by or on behalf of residents of long term care facilities and tenants of assisted living facilities. The ombudsman also works in other ways to protect the health, safety, welfare, and rights of residents.

LRHSC - Lake Region Human Service Center is located in Devils Lake. (*See HSC entry.*)

MA - Medical Assistance, commonly referred to as "Medicaid," provides medical assistance to certain specified groups of needy low-income individuals as defined by federal law.

Managed Care - A system of health care that combines delivery and payment and influences utilization of services by employing management techniques (i.e., case management, referral for specialty services, etc.) designed to promote the delivery of cost-effective health care.

Matrix – Is an evidence-based treatment for those who are addicted to methamphetamine. It is specifically designed to accommodate the damage done to the brain by methamphetamine use.

MDS - Minimum Data Set is an assessment used to determine a nursing facility resident's classification for rate setting purposes.

Medicaid - See MA above.

Medicaid Systems Project - Also referred to as "The Project," it is the technology project dealing with the replacement of North Dakota's Medicaid Management Information System (MMIS), Pharmacy Point of Sale (POS) system, and the Medicaid Decision Support System.

Medicaid Waiver for Home and Community Based Services - A program authorized by federal law that funds in-home and community based services to individuals who meet Medicaid eligibility standards and require the level of care provided in a nursing facility. This waiver combines the previously separate waivers for aged and disabled and traumatic brain injury populations. The waiver's goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. The waiver provides service options for a continuum of home and community based services in the least restrictive environment.

Medicaid Waiver for Mentally Retarded and Developmentally Disabled - A program authorized by federal law that funds in-home and community based services for individuals with mental retardation and/or developmental disabilities who meet Medicaid eligibility standards and require the level of care provided in an Intermediate Care Facility for Mentally Retarded (ICFMR).

Medicare Part D - The federal Medicare Prescription Drug Program that provides Medicare beneficiaries with access to prescription drug coverage from a host of private plans.

Medicare Savings Programs - Medicaid coverage that pays all or part of the Medicare premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries, Specified Low income Medicare Beneficiaries and Qualifying Individuals.

Mental Retardation - Is a condition diagnosed by age 18 and characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life such as communication, self-care, and getting along in social situations and school activities. Mental retardation is sometimes referred to as a cognitive or intellectual disability.

MFP – Money Follows the Person is a federal Real Choice Systems Change Rebalancing grant that supports the transition of qualifying Medicaid-eligible individuals from institutional settings to home and community-based long term services.

MHSAS - Mental Health & Substance Abuse Services is a division of the Department of Human Services.
MHSIP - Mental Health Statistical Improvement Project is the statistical and outcome measurement system for the Department's community based mental health system of care at the regional human service centers.

MMIS - Medicaid Management Information System is the computer system that processes all Medicaid claims. Developed in 1978, it is also used to monitor utilization and to provide information needed to manage the Medicaid program. (*See Medicaid Systems Project.*)

MSLA - Minimally Supervised Living Arrangement is a community waiver group home or community complex setting, which provides training in community integration, social, leisure, and daily living skills.
Multiple License Facility – Entity that has more than one type of child care license such as a Center and Preschool license.

NCHSC - North Central Human Service Center is located in Minot. (See HSC entry.)

NDSH - North Dakota State Hospital

Neglect - The failure of a caregiver to provide essential services necessary to maintain the physical and mental health of another person in the caregiver's care.

Neglected Child - Uses the definition in juvenile law for a "deprived child." Refers to: A child who is without proper parental care, control, subsistence or education necessary for the child's physical, mental or emotional health or morals. A child who has been placed for care or adoption in violation of law. A child who has been abandoned. A child who is without proper care (as described above) because of the physical, mental, emotional, or other illness or disability of the parent. A child who is in need of treatment and whose caregiver has refused to participate in treatment, which is court-ordered. A child who was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance. A child who is present in an environment subjecting the child to exposure to a controlled substance, chemical substance or drug paraphernalia.

NEHSC - Northeast Human Service Center is located in Grand Forks. (*See HSC definition.*)

New Hire Reporting - Under this reporting process mandated by federal and state law, employers must submit new hire information within 20 days of hiring to the State Directory of New Hires, a component of the Child Support Enforcement Division.

NF LOC Determination - Nursing Facility Level of Care Determination is an assessment based on established criteria of an individual's medical needs. A determination must be completed before an individual can receive Medicaid funded nursing facility services or home and community-based services through the Medicaid Waiver for Home and Community Based Services.

Non-Custodial Parent - *See Parent Who Does Not Have Primary Residential Responsibility.*

Non-Medical Transportation - Transportation the enables individuals to access essential community services such as grocery stores, pharmacies, banking, post office, laundromat, utility company, social services, and the social security office, in order to maintain themselves in their home. *Non-Medical Transportation Driver with Vehicle* refers to situations when the driver with the vehicle is considered as solely transporting the client to and from his/her home and points of destination. *Non-Medical Transportation Escort* is solely accompanying the client for the purpose of assisting in boarding and exiting, as well as during transport, in order that the client may complete the activity for which (non-medical) transportation is authorized.

North Dakota Health Tracks - Also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), this program provides preventive health care to Medicaid eligible individuals up to age 21. Services include physical exams and screenings, immunizations, and referrals.

No Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has not been abused or neglected.

No Services Required, Services Recommended - A CPS assessment decision that reflects the belief that a child has not been abused or neglected, but the family may be in need of preventative services.

NSDUH - National Survey on Drug Use and Health is a survey of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Office of Applied Studies.

Nurse Management - This is an aspect of Attendant Care Services. Nurse Management is the provision of nursing assessment, care planning, training of skilled nursing tasks to an Attendant Care Services (ACS) provider, and monitoring of delegated tasks, for clients who are ventilator-dependent and receiving Attendant Care Services.

Nursing Facility Level of Care Determination - See NF LOC Determination.

NWHSC - Northwest Human Service Center is located in Williston. (*See HSC definition.*)

Obligee - The person to whom a child support obligation is owed, generally the Parent Who Has Primary Residential Responsibility (formerly referred to as custodial parent). It may also be an entity to which a child support obligation is owed.

Obligor - The person who is obliged to pay child support. *(See also Parent Who Does Not Have Primary Residential Responsibility.)*

Older Americans Act (OAA) - The Older Americans Act of 1965 [Pub. L. 89-73; 79 Stat. 219; 42 U.S.C. § 3001 et seq.] provides federal funding for services to older persons, especially those who are low income, socially needy, frail, or minority persons. Among the services offered are nutrition services, support services, Long Term Care Ombudsman program, and information and referral.

Olmstead Commission - Established by an executive order of the Governor, the commission monitors services and conducts planning in order to comply with the United States Supreme Court's Olmstead decision related to providing appropriate community-based services for individuals with disabilities, consistent with needs and available resources of the state.

Olmstead Decision - A 1999 U.S. Supreme Court decision, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176 (1999), in which the Court held that it is a form of discrimination under the Americans With Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals if: 1) the state's treatment professionals have determined that community placement is appropriate; 2) the individual does not oppose the transfer to a community setting; and 3) the placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities.

Outreach - Actions and communication initiated by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits.

PACE - Program of All-inclusive Care for the Elderly involves Northland Healthcare Alliance and Medicaid and began operation in August 2008. It is a managed care program providing patient-centered, coordinated care to frail elderly individuals who are eligible for Medicare and Medicaid and live in the community. The goal is to meet individual health needs through a care team so participants can remain living independently in the community.

PAR - Progress Assessment Review is a written instrument used as the basis of the eligibility process within Developmental Disabilities. The instrument includes an assessment of needs, which helps determine level of care and authorization of services.

Parent Aides - Individuals who, through training and support, work with parents who are at risk of abusing or neglecting their children. County social service boards employ the aides.

Parent Who Does Not Have Primary Residential Responsibility – (*formerly referred to as Non-Custodial Parent*) For child support purposes, this is the parent who does not have primary care, custody, and control of the child(ren) or, if a court has made a custody determination, the parent who does not have legal custody of the child(ren).

Parent Who Has Primary Residential Responsibility - The parent to whom a child support obligation is owed. (Formerly referred to as *Custodial Parent.*)

Part C - Is a section within the federal law of the Individuals with Disabilities Education Act (IDEA) [Pub. L. 94-142; 84 Stat. 175; 20 U.S.C. § 1400 et seq.] that entitles a child under the age of three years and their family to certain supports, services, and rights, which in North Dakota are known as Early Intervention Services for Infants and Toddlers. Part C provides federal financial assistance to states to develop and implement a collaborative statewide system of services for these children and their families.

Participant Directed Service - Sometimes called Self-Directed Supports, this option gives the individual the most control over his or her services and supports and also the most responsibility.

Partnerships Program - Integrated comprehensive services for children with serious emotional disorders.

PASRR - Pre-Admission Screening and Resident Review is a federal requirement that every person who seeks admission to a nursing facility be screened by the state for evidence of mental retardation or mental illness. If either exists, the screening is intended to determine if nursing facility care is necessary, and if so, to determine if specialized services are needed.

Peer Support Services - These consumer centered services have a rehabilitation and recovery focus and are designed to promote skills for coping with and managing symptoms while facilitating the use of natural resources and the enhancement of community living skills. Support services are provided by a person who has progressed in his or her own mental health or substance abuse recovery and is working to assist other people with those issues. Because of their life experience, peers have expertise that professional training cannot replicate.

Peer Support Specialist - An occupational title for a person who has progressed in his or her own recovery from a mental disorder and is working to assist other people with a mental disorder. Their life experiences give these individuals expertise that cannot be replicated by professional training.

PEPP - Parental Employment Pilot Project. Renamed "PRIDE" (Parental Responsibility Initiative for the Development of Employment) in late 2006. (See PRIDE definition below.)

PERM - Payment Error Rate Measurement is an examination of selected Medicaid and Healthy Steps (SCHIP) provider claims to determine if a service is required and the beneficiary is eligible.

Personal Care Service - A service that provides assistance with bathing, dressing, toileting, continence, transferring, mobility in the home, eating, and personal hygiene, passive range of motion exercises and simple bandage changes. When specified within the plan of care, this service may also include cueing or prompting, housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the individual, rather than the individual's family.

Pharmacy Point of Sale - This is a computerized point of sale (POS) system that allows pharmacists to enter claims on a real time basis into the payment system. Within seconds, providers receive confirmation that a claim has been processed for payment or denied. If a claim is denied, providers receive immediate information about the reason. The system also prevents payment of duplicate claims, audits claims to ensure the health of Medicaid recipients is maintained by preventing inappropriate drug dispensing, reduces administrative costs and streamlines identification of recipient liability for pharmacy providers.

Portability - An individual can move from one area of the state to another or from one service to another and his/ her individual budget and waiver eligibility can remain the same.

Preschool - Programs that typically serve children age three through entrance into kindergarten.

Prevention Activities - Activities with goals of eliminating or reducing the factors that cause or predispose individuals to increased risk, disease, problems, or disabilities.

PRIDE - Parental Responsibility Initiative for the Development of Employment provides employment-related services to noncustodial parents who are behind in their child support obligations. It is administered through the Child Support Enforcement Division with TANF funding assistance. The goal is to help the parents obtain work in order to increase their incomes so that they can support their children. This may result in better family relationships and improved visitation. The Department has implemented it in Dickinson and Grand Forks. It was formerly referred to as PEPP (Parental Employment Pilot Project).

Prime Time Care - A prevention program designed to provide temporary child care to families at risk of neglecting or abusing their children.

Program Management for Developmental Disabilities - *See DD Program Management.*

Psychiatric Residential Treatment Facility (PRTF) - (*Formerly called Residential Treatment Center or RTC*) A facility or a distinct part of a facility that provides children and adolescents with a 24-hour therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family.

QI - Qualifying Individuals are individuals for whom Medicaid pays their Medicare Part B premium. Income must be between 120 percent and 135 percent of poverty level. They cannot be covered by other Medicaid to receive benefits. *See Medicare Savings Programs.*

QMB - Qualified Medicare Beneficiaries are persons for whom Medicaid pays the Medicare premiums, deductibles, and co-insurance. Income cannot exceed 100% of the poverty level. See Medicare Savings Programs.

Qualified Service Provider (QSP) - An agency or independent contractor that agrees to meet standards for services and operations established by the Department of Human Services to provide home and community based long term care services.

Quality Rating and Improvement System - A method to assess (initially and ongoing), improve, and communicate the level of quality in early childhood care and education settings.

RCCF - Residential Child Care Facility (foster care facility)

RCSEU - There are eight Regional Child Support Enforcement Units in North Dakota. These regional offices provide child support enforcement services.

Recipient Liability (*also called **Client Share***) - This is the amount an individual who is eligible for Medicaid under the "Medically Needy" coverage group must contribute toward his or her monthly medical expenses before Medicaid pays for services.

Registered Providers - Child care providers who are eligible to participate in the Child Care Assistance Program and who are generally registered by Tribal entities. These child care providers may be licensed by Tribal entities and subject to their licensing criteria, but are not licensed by the state.

Refugee Cash Assistance - A benefit program available for the first eight months that qualifying refugees are living in the United States.

Rehabilitation Services - Medical, psychological, social, and vocational services, including physical items, which are necessary to assist persons with disabilities to engage in gainful activity.

Rehabilitation Services Administration - The federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

Report of Suspected Child Abuse or Neglect - Information received by child protection services concerning the suspected maltreatment of a child.

Reserved Waiver Capacity - The state may reserve a portion of the participant capacity for specified purposes such as community transition of institutionalized persons or for individuals who may experience a crisis.

Residential Care - Services provided in a facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security.

Respite Care - Temporary relief to a primary caregiver for a specified period of time. The caregiver is relieved of the stress and demands associated with continuous daily care.

Right Track - This Developmental Disabilities program works to identify infants or toddlers who may be at-risk for developmental delays. The program provides developmental screenings in environments natural and familiar to the child, refers families to appropriate supports and shares child development information with them. For this program, at-risk infants and toddlers are defined as children younger than three years of age who have environmental or biological risk factors for developmental delays or parental concern regarding development.

RIS - Regional Intervention Services provide community based intervention for individuals with serious mental health and/or substance abuse needs to determine appropriate level of care. RIS units at the department's human service centers conduct the admission screening for State Hospital admissions.

RMA - Refugee Medical Assistance provides up to eight months of Medical Assistance for qualifying newly arriving refugees. The program is 100 percent federally funded.

ROAP - The Regional Office Automation Project is a technology system that provides a comprehensive and integrated electronic medical records system to manage and support the business functions and requirements of the department's eight regional Human Service Centers and the Central Office.

RSA - Rehabilitation Services Administration is the federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

RTC - Term is no longer used. *See Psychiatric Residential Treatment Facility (PRTF) entry.*

Safety, Strengths, Risk Assessment - Refers to State Form Number (SFN 455) that is used to document the Child Protection Services (CPS) assessment.

SAMHSA - Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services (DHHS) that focuses on programs and providing funding to improve the lives of people with or at risk for mental and substance abuse disorders.

SAPT - Substance Abuse Prevention and Treatment block grant

SCHIP - See Healthy Steps Children's Health Insurance Program definition.

SCHSC - South Central Human Service Center is located in Jamestown. (*See HSC definition.*)

SDU - The State Disbursement Unit is the unit within the department's Child Support Enforcement Division that receives, records, and distributes all child support payments in North Dakota.

SED - Serious Emotional Disorder (or Disturbance)

SEHSC - Southeast Human Service Center is located in Fargo. (*See HSC definition.*)

Self-Certified/Self-Declared Child Care Providers - Care for 5 or fewer children or 3 infants in the provider's home. These providers are not licensed or monitored; they are eligible to participate in the Child Care Assistance Program.

Senior Community Services Employment Program - Funded under the Older Americans Act, this program provides career counseling, training, and community service work experience to help low-income persons age 55 and older to secure meaningful employment.

Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has been abused or neglected and requires contact with the juvenile court.

SFY - State Fiscal Year is the period of time in the state budget cycle from July 1 to June 30.

Single Plan of Care (SPOC) – This is the computerized treatment/service plan that supports the Wraparound Process in the provision of mental health services to children.

SLA - Supported Living Arrangement is a residential service that provides support to people living in their own homes or apartments. Supportive services include help with budgeting, shopping, laundry, etc. and are provided on an intermittent basis, usually less than 20 hours per month. There is a fixed staff to client ratio. People receiving this service generally need less support than people receiving Individualized Supported Living Arrangement services.

Sliding fee scale – A system of cost sharing based on income and number of persons in the household.

SLMB - Specified Low-Income Medicare Beneficiaries are persons for whom Medicaid pays the Medicare Part B premium. Income must be between 100 percent and 120 percent of poverty level. See Medicare Savings Programs.

Slots - The maximum number of individuals who can be enrolled in the waiver at any one point in time. The number of waiver slots is tied to the amount of funding the state legislature has made available for waiver services. One 'slot' usually equals the average amount of money the state expects to spend for an individual for a full year of services.

SMI - Seriously mentally ill

SNAP - See Supplemental Nutrition Assistance Program (Formerly called the Food Stamp program.)

SPARCS- Structured Psychotherapy for Adolescents Responding to Chronic Stress is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. These include difficulties with regulation and impulsivity, self-perception, relationships, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as world views that make it difficult for them to see a future for themselves. Program goals include helping teens cope more effectively, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning.

Special needs - Refers to the needs of children who have, or are at risk of developing, a developmental, emotional, behavioral, learning or physical condition that requires attention, services, and/or program modifications beyond what is generally needed by other children.

Special Needs Adoption - The classification of adoption for children who have a physical, emotional, and/or psychological disability (or are at risk for such a disability), are older than age seven, part of a sibling group, or are children whose race/ethnicity may be a barrier to placement.

Specialized Equipment and Supplies - Includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Specialized Placement - Refers to a residence for people who are diagnosed as both mentally retarded and mentally ill and whose individualized programs address residential, psychosocial and psychiatric development prior to entry into less restrictive settings.

SPED - Service Payments for Elderly and Disabled is authorized by state law to provide a number of home and community based services to functionally impaired older individuals and people with physical disabilities who require assistance to continue to live in a home-like setting.

SSA - Social Security Administration

SSBG - Social Service Block Grant

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Income

State Child Protection Team - A multidisciplinary team of staff members from public and private agencies (determined by law) that makes the determination whether child abuse or neglect is indicated in cases of suspected institutional child abuse or neglect.

State Interagency Coordinating Council (ICC) - Is a council appointed by the Governor. Federal law under Part C of the Individuals with Disabilities Education Act (IDEA) requires the ICC to advise and assist the designated lead agency (ND Department of Human Services) in the performance of responsibilities set forth under Part C regarding early intervention services and to advise the Department of Public Instruction (DPI) regarding the transition of toddlers with disabilities to preschool and other appropriate services. The council is comprised of parents of infants and toddlers with disabilities and representatives of providers of early intervention services, the state legislature, the Department of Human Services, preschools, the State Insurance Department, Head Start, child care providers, and other members at large.

Subject - In child welfare terminology, the person who is suspected of abuse or neglect of a child or the person who has abused or neglected a child.

Supplemental Nutrition Assistance Program (SNAP) - Formerly called the Food Stamp program, this federally-funded USDA program is intended to raise levels of nutrition among low-income households by supplementing their food purchasing power with monthly benefits distributed through an electronic benefit card.

Supported Employment - Competitive work, in an integrated work environment, with ongoing support services for individuals with the most severe disabilities.

Swing Bed - A licensed hospital bed in a rural hospital that is used to provide nursing facility level of care services to an individual who is not in need of acute care services.

TANF - Temporary Assistance for Needy Families is a federal block grant program established under Title IV-A of the Social Security Act. It serves many needs, such as meeting some of the costs of Foster Care and Child Care Assistance programs. TANF also provides temporary cash assistance to needy families primarily to facilitate the return to or preparation for work.

TBI - Traumatic Brain Injury

TCC - Transitional Child Care provides partial payment of child care to families who lose TANF assistance eligibility.

TCLF - Transitional Community Living Facility is a community waiver group home that provides training for individuals in community integration, social, leisure, and daily living skills in a group living environment. It is preliminary to entry into a lesser restrictive setting.

TECS - Technical Eligibility Computer System is the computer system currently used by county social service boards to manage Supplemental Nutrition Assistance Program cases and some Medicaid cases.

TPL - Third Party Liability describes potential resources that may be available to offset claims against the Medicaid program. They include health insurance, accident insurance, court settlements, and decrees stemming from accidents of various kinds.

Transitional Living Service - Services that train people to live with greater independence in their own homes. This includes training, supervision, or assistance to the individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

Transition Services - Services provided to assist students with disabilities as they move from school to adult services and/or employment.

Transitional Medicaid Benefits - Provides up to 12 months of Medicaid coverage for families who lose eligibility under the Family Coverage group due to earnings.

Tribal NEW - Tribal Native Employment Works program is the tribal equivalent of the Job Opportunities and Basic Skills (JOBS) program. The job placement and education program is available to American Indian TANF recipients.

Tribal TANF - Tribal governments have the option of direct administration of TANF programs. No Tribe in North Dakota has yet exercised this option.

Uniform Interstate Family Support Act (UIFSA) - is a model Act, enacted at the state level, to provide mechanisms for establishing and enforcing child support obligations in interstate cases (cases in which a noncustodial parent lives in a different state than the custodial parent and child).

UPA - Either the Uniform Parentage Act or Unreimbursed Public Assistance. The **Uniform Parentage Act** refers to laws, based on model legislation drafted by the National Conference of Commissioners on Uniform State Laws (NCCUSL), enacted at the state level to provide mechanisms for establishing paternity. **Unreimbursed Public Assistance** refers to money paid in the form of public assistance (for example, Temporary Assistance for Needy Families expenditures), which has not been recovered by retaining assigned child support.

URM - Unaccompanied Refugee Minor is a child between the ages of birth and 18 who enters the United States with refugee immigration status and the parents are deceased or their whereabouts unknown, and the child is without a family connection. URM youth enter a foster care program specifically administered for their care through a voluntary agency with coordination of the Department. URM foster care meets state licensing requirements.

VIPR - The Very Intelligent Payment Recognition system is a computerized check processing system used by the Child Support Enforcement Division to process child support payments quickly and accurately. It interfaces with the Fully Automated Child Support Enforcement System (FACSES) computer system.

Vision - The computer system currently used by county social services to administer Temporary Assistance for Need Families (TANF) benefits and some Medicaid cases.

Vocational Development - A program of vocational preparation prior to competitive or extended employment.

VR - Vocational Rehabilitation provides training and employment services to individuals with disabilities so they can become and/or remain employed. Services are designed to assist business owners and employers in developing short and long term strategies regarding disability-related issues including staffing, education, tapping into financial incentives associated with hiring an individual who has a permanent injury, illness, or impairment; or ensuring accessibility to goods or services.

Vulnerable Adult Protective Services - Refers to remedial social, legal, health, mental health, and referral services provided for prevention, correction, or discontinuation of abuse or neglect which are necessary and appropriate under the circumstances to protect an abused or neglected vulnerable adult. Services also ensure that the least restrictive alternatives are provided, prevent further abuse or neglect, and promote self care and independent living. (Reference: North Dakota Century Code Chapter 50-25)

WCHSC - West Central Human Service Center is located in Bismarck. (*See HSC definition.*)

Wraparound - This is a strength-based philosophy of care that includes a definable process involving the child and family that results in a unique set of community services and supports individualized for that child and family. Wraparound is a process. It is not a program. It does not create new programs or services, but is the method of meeting the needs of families through the coordination and identification of natural supports and formal supports which constitute the Child and Family Team. This process is team driven, focuses on least restrictive methods of care, and uses the family's strengths, preferences, and choices whenever possible. It is a continuum of intensity, which is driven by family needs, complexity, and level of risk.

YRBS - Youth Risk Behavioral Survey is conducted by the North Dakota Department of Health and the North Dakota Department of Public Instruction and monitors health-risk behaviors among youth and young adults including behaviors that contribute to injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, and physical activity.

DD Providere Wage Increase
2011-2013 Biennium

- Tina Bay
- March 11, 2011

- Attachment THREE
- SB 2012

Start Date: July 1, 2011

Description	Recipients	11-13 Biennial Cost	General Fund	Federal Funds	Other
Individual effects of wage increases					
.25 wage increase		$5,682,032	$2,510,748	$3,171,284	$0
.50 wage increase		$11,364,049	$5,021,489	$6,342,560	$0
.75 wage increase		$17,046,083	$7,532,238	$9,513,845	$0

Notes:

Based on current providers with inflationary increases @ 3% / 3% .

Wage increase was calculated prior to the inflationary increases being applied.

The per hour wage increase does include the cost of additional FICA and Medicare taxes at 7.65%

Change in salaries would be effective July 1, 2011

This proposed increase is calculated independently of other proposals and of the 2011-2013 Executive Budget request.

North Dakota Department of Human Services
2011-2013 Biennium
DD Hourly Wage Comparisons

DD Standard Hourly Wage Allowances	Effective 7/1/2010	$0.50 Hourly Wage Increase Effective 7/1/2011	3% Inflation Effective 7/1/2011	3% Inflation Effective 7/1/2012
	Wage Allowance	**Wage Allowance**	**Wage Allowance**	**Wage Allowance**
Group Homes				
1st Approved FTE (residential manager)	**$17.24**	**$17.74**	**$18.27**	**$18.82**
2nd Approved FTE	**$15.73**	**$16.23**	**$16.72**	**$17.22**
Remaining Approved FTE	**$13.72**	**$14.22**	**$14.65**	**$15.09**
Standby	**$11.81**	**$12.31**	**$12.68**	**$13.06**
Day Services				
Day Supports Approved FTE	**$14.38**	**$14.88**	**$15.33**	**$15.79**

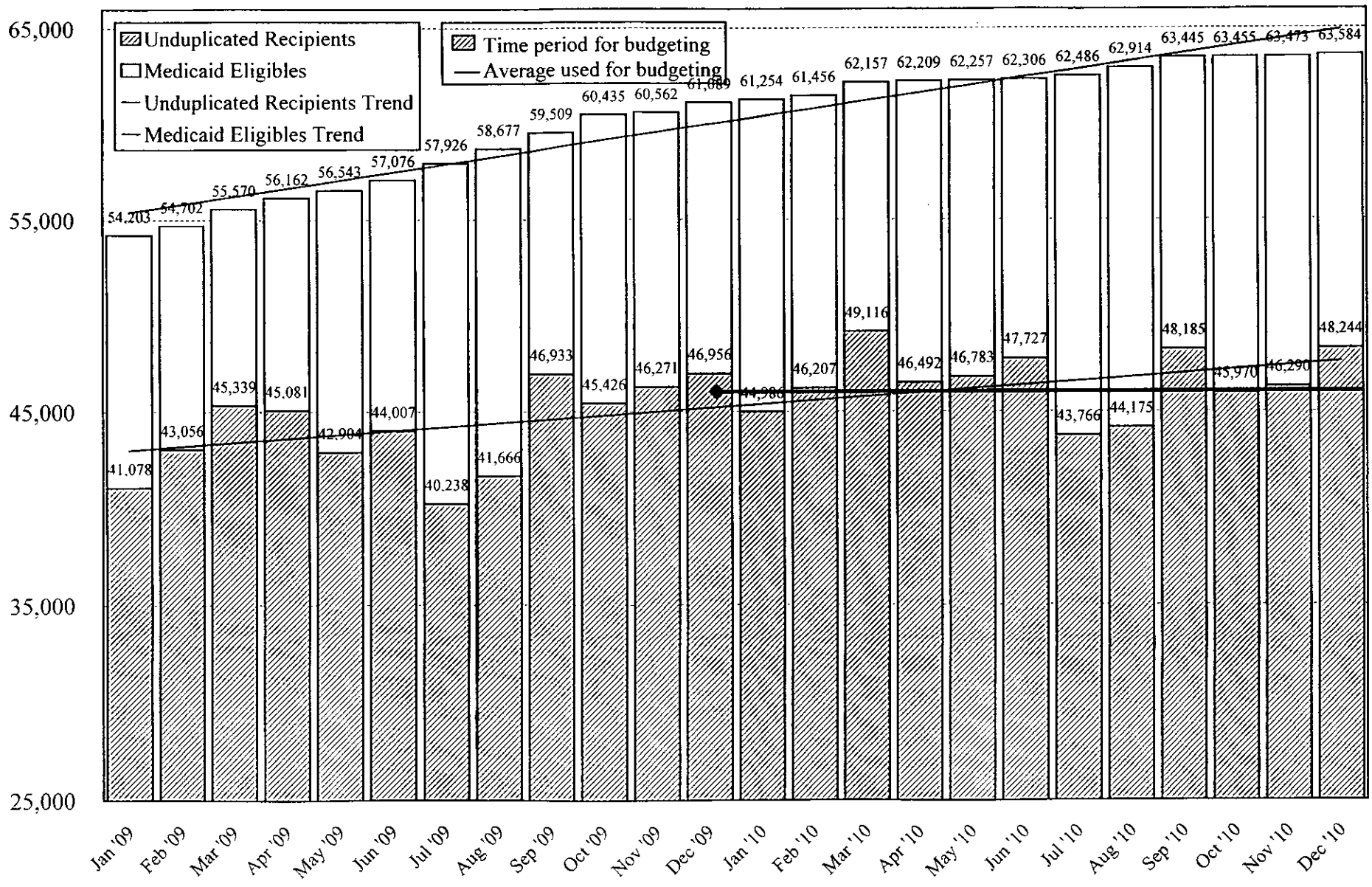
History of Fringe Benefit Percentages:

July 1, 1988 thru June 30, 1999 - **25%** of salaries

July 1, 1999 thru June 30, 2003 - **30%** of salaries

July 1, 2003 to current - **33%** of salaries

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients
January 2009 - December 2010



3/10/11-cj-hgw\medical\eligdupbudget h

- March 11, 2011 Attachment Four
- SB 2012
- Debra McDermott

-Attachment FIVE
-March 11, 2011
-Debra McDermott
-SB 2012

North Dakota Department of Human Services
Major Categories of Service
2009-2011 Biennium
Budget vs Projected Need

Traditional Medicaid Grants

Service	2009 - 2011 Appropriation	Total Projected Expenditures	Projected Expenditures (Over) Under Budget	Legislative Caseload Reduction
Inpatient Hospital	136,073,409	154,534,483	(18,461,074)	(7,542,867)
Outpatient Hospital	62,313,737	69,230,257	(6,916,520)	(1,965,883)
Physician Services	99,606,658	103,246,849	(3,640,191)	(2,512,618)
Drugs Net (Includes Rebates)	50,911,883	44,907,415	6,004,468	
Premiums	24,089,464	25,528,138	(1,438,674)	(387,617)
Psychiatric Residential Treatment Facilities	25,112,375	21,175,027	3,937,348	(866,720)
Dental Services	17,026,199	23,423,318	(6,397,119)	(40,197)
Healthy Steps	21,632,536	19,814,375	1,818,161	
Durable Medical Equipment	6,682,391	8,105,091	(1,422,700)	(160,492)
Psychological Service	3,795,618	6,513,994	(2,718,376)	
Ambulance	5,649,154	5,583,451	65,703	
Other	60,104,150	57,139,989	2,964,161	
Totals	512,997,574	539,202,387	(26,204,813)	(13,476,394)

The 2009 - 2011 Appropriation reflected above does not include Emergency Commission action for the Extended ARRA.

North Dakota Department of Human Services
Major Categories of Service
2009 - 2011 Biennium
Budget vs Projected Need

Long Term Care Grants				
Service	2009 - 2011 Appropriation	Total Projected Expenditures	Projected Expenditures (Over) Under Budget	Legislative Caseload Reduction
Nursing Homes (& Hospice)*	425,713,210	411,219,622	14,493,588	(7,861,230)
Basic Care	18,113,925	21,194,695	(3,080,770)	
SPED	17,495,327	12,216,767	5,278,560	
Expanded SPED	726,578	748,194	(21,616)	
HCBS Waiver	8,707,606	8,433,045	274,561	
Targeted Case Management	1,957,896	1,373,237	584,659	
Personal Care Option	25,044,599	24,185,111	859,488	
Technology Dependent Waiver	532,608	342,237	190,371	
Medically Fragile Waiver	1,147,844	121,754	1,026,090	
Children's Hospice Waiver	856,410	846,720	9,690	
PACE	7,393,711	5,028,615	2,365,096	
Total Long Term Care (Excluding DD)	507,689,714	485,709,997	21,979,717	(7,861,230)
Developmental Disability Grants	341,542,546	348,561,681	(7,019,135)	(3,475,787)
Total Long Term Care Grants	849,232,260	834,271,678	14,960,582	(11,337,017)

* The nursing home expenditures are less than budgeted due to nursing home construction projects being completed at a later date than anticipated, and nursing home occupancy rates being less than budgeted.

** The Long Term Care legislative reduction was applied to nursing homes, as no specific service was identified with the exception of SPED which was not to be reduced.

The 2009 - 2011 Appropriation reflected above does not include Emergency Commission action for the Extended ARRA.

- Attachment SIX
- Andrea Pena
- SB 2012
- March 11, 2011

NORTH DAKOTA
STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Organizational Chart



DEPARTMENT OF [redacted]MAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-42 DD COUNCIL											
S101		FULL-TIME EQUIVALENTS (FTEs)		1.000	1.000	0.000	0.000	0.000	1.000	0.000	1.000
32510	B	511000	Salaries - Permanent	124,277	111,268	51,750	3,252	0	114,520	0	114,520
32510	B	516000	Fringe Benefits	36,978	39,105	18,981	125	0	39,230	0	39,230
32510	B	599110	Salary Increase	0	0	0	0	4,926	4,926	0	4,926
32510	B	599160	Benefit Increase	0	0	0	0	833	833	0	833
32510	B	599161	Health Increase	0	0	0	0	1,456	1,456	0	1,456
32510	B	599162	Retirement Increase	0	0	0	0	1,127	1,127	0	1,127
32510	B	599163	EAP Increase	0	0	0	0	3	3	0	3
			Subtotal:	161,255	150,373	70,731	3,377	8,345	162,095	0	162,095
32510	F	F_1992	Salary - Federal Funds	161,255	150,373	70,731	3,377	8,345	162,095	0	162,095
			Subtotal:	161,255	150,373	70,731	3,377	8,345	162,095	0	162,095
32530	B	521000	Travel	22,168	24,627	14,164	(1,545)	0	23,082	0	23,082
32530	B	531000	Supplies - IT Software	45	0	0	45	0	45	0	45
32530	B	532000	Supply/Material-Professional	75	200	158	(125)	0	75	0	75
32530	B	535000	Miscellaneous Supplies	2,157	4,000	1,927	(343)	0	3,657	0	3,657
32530	B	536000	Office Supplies	616	1,800	322	0	0	1,800	0	1,800
32530	B	541000	Postage	0	150	0	0	0	150	0	150
32530	B	542000	Printing	2,124	4,000	2,214	4,000	0	8,000	0	8,000
32530	B	551000	IT Equip under $5,000	203	0	0	0	0	0	0	0
32530	B	553000	Office Equip & Furniture-Under	1,000	0	0	0	0	0	0	0
32530	B	582000	Rentals/Leases - Bldg/Land	4,586	600	450	0	0	600	0	600
32530	B	601000	IT - Data Processing	43	0	0	0	0	0	0	0
32530	B	602000	IT-Communications	1	0	0	0	0	0	0	0
32530	B	603000	IT Contractual Services and Re	20	0	0	2,400	0	2,400	0	2,400
32530	B	611000	Professional Development	12,579	9,624	6,757	500	0	10,124	0	10,124
32530	B	621000	Operating Fees and Services	7,453	7,830	7,715	74,889	0	82,719	0	82,719
			Subtotal:	53,070	52,831	33,707	79,821	0	132,652	0	132,652
32530	F	F_3992	Operating - Federal Funds	53,070	52,831	33,707	79,821	0	132,652	0	132,652

DEPARTMENT OF [redacted]MAN SERVICES

Summary by Subdivision and Bgt_Acct with Funding Sources

2011 - 2013

Class FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-42 DD COUNCIL										
		Subtotal:	53,070	52,831	33,707	79,821	0	132,652	0	132,652
32560 B	712000 Grants, Benefits & Claims		709,574	812,514	380,393	(191,372)	0	621,142	0	621,142
		Subtotal:	709,574	812,514	380,393	(191,372)	0	621,142	0	621,142
32560 F	F_6992 Grants - Federal Funds		709,574	812,514	380,393	(191,372)	0	621,142	0	621,142
		Subtotal:	709,574	812,514	380,393	(191,372)	0	621,142	0	621,142
		Subdivision Budget Total:	923,899	1,015,718	484,831	(108,174)	8,345	915,889	0	915,889
		General Funds:	0	0	0	0	0	0	0	0
300-42 DD COUNCIL		**Federal Funds:**	923,899	1,015,718	484,831	(108,174)	8,345	915,889	0	915,889
		Other Funds:	0	0	0	0	0	0	0	0
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	923,899	1,015,718	484,831	(108,174)	8,345	915,889	0	915,889

DD Council - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Misc. booth/conference room rental				600		600
			$ -	$ 600	$ -	$ 600

DD Council - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Additional staff on contract		80,000		80,000
Cross Cutting conference speaker		2,500		2,500
Misc awards and expenditures		150		150
Research Fees		69		69
	$ -	**$ 82,719**	**$ -**	**$ 82,719**

DD Council - 2011-13 Biennium Budget

Budget Account Code 712000 - Grants

Description	Fund	Funds	Funds	Total
Education/Early Intervention		88,864		88,864
Employment		114,650		114,650
Community Supports		89,595		89,595
Quality Assurance		328,033		328,033
	$ -	**$ 621,142**	**$ -**	**$ 621,142**

- Attachment SEVEN
- SB 2012

11.8152.02003
Title.

Prepared by the Legislative Council staff for
Senator Mathern
March 3, 2011 - March 11, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 1, line 2, after the third semicolon insert "to provide for a legislative management study;"

Page 4, after line 28, insert:

"**SECTION 9. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY.** During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation is resulting in North Dakotans experiencing health care savings and improved medical results as well as whether implementation is impacting North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly."

Renumber accordingly

-Attachment FIVE

North Dakota Department of Human Services
Major Categories of Service
2009-2011 Biennium
Budget vs Projected Need

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North Dakota Department of Human Services
Major Categories of Service
2009 - 2011 Biennium
Budget vs Projected Need

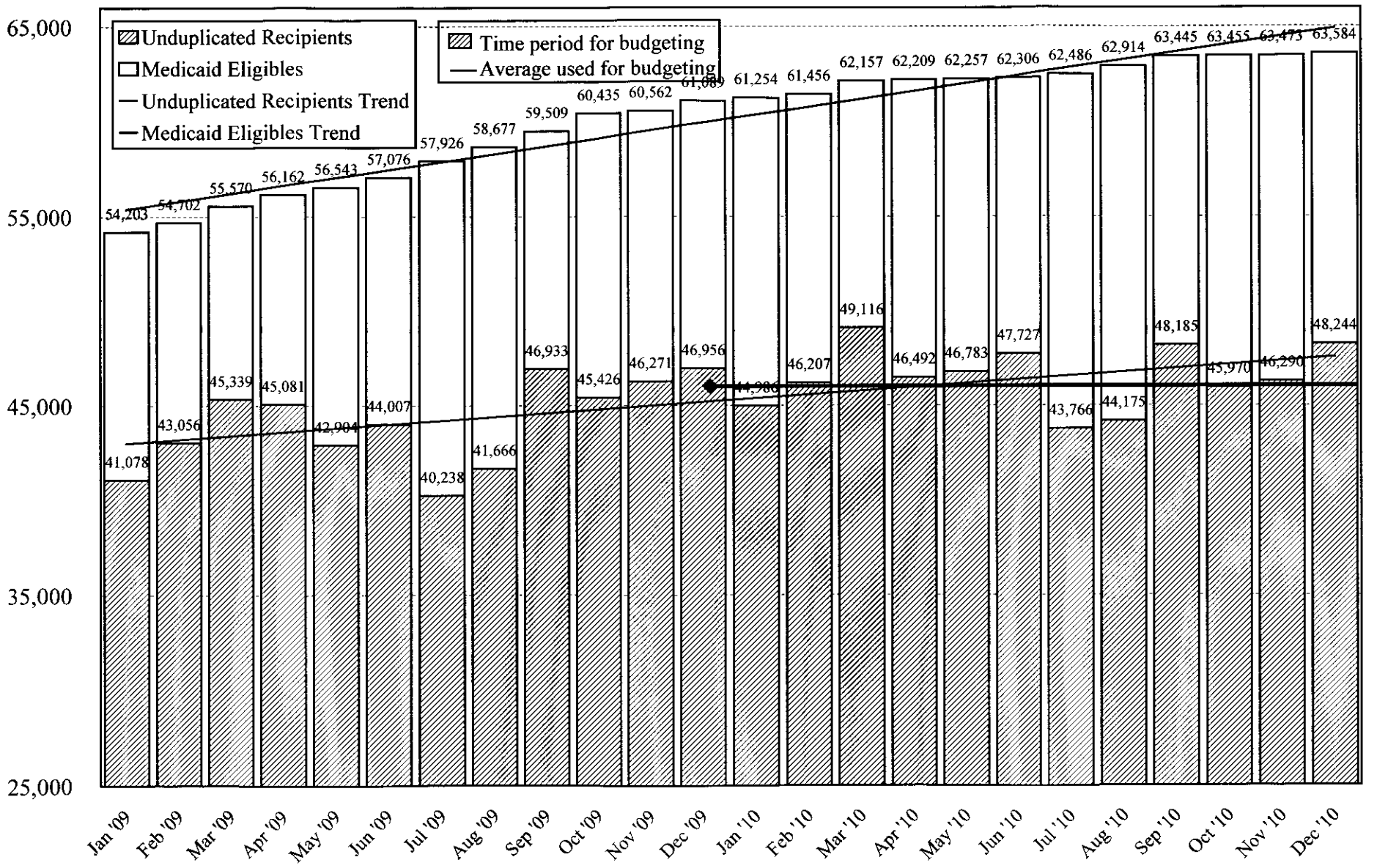
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** The Long Term Care legislative reduction was applied to nursing homes, as no specific service was identified with the exception of SPED which was not to be reduced.

The 2009 - 2011 Appropriation reflected above does not include Emergency Commission action for the Extended ARRA.

Comparison of Net Medicaid Eligibles (Less QMB's Only, SLMB's Only & QI's) and Unduplicated Recipients January 2009 - December 2010



3/10/11-cj-hgw\medical\eligdupbudget h

- Attachment Four

- Attachment Two

north dakota department of human services

Glossary of Human Services Terms and Acronyms

January 2011

960 - Refers to the State Form Number 960 (SFN 960) for the reporting of suspected child abuse or neglect.

AASK - Adults Adopting Special Kids is a collaboration involving the department's Children and Family Services Division, Catholic Charities North Dakota, and PATH ND. They work together to promote and facilitate the adoption of children with special needs from the foster care system.

Abuse - Any willful act or omission by a caregiver or other person, which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation of a vulnerable adult.

Abused Child - An individual under the age of 18 years who is suffering from abuse as defined in Subdivision A of Subsection 1 of Section 14-09-22 caused by a person responsible for the child's welfare, and "sexually abused child" means an individual under the age of 18 years who is subjected by a person responsible for the child's welfare to any act in violation of sections 12.1-20-01 through 12.1-20-07, sections 12.1-20-11 through 12.1-20-12.2, or Chapter 12.1-27.2 (sex offenses listed in the criminal code). (14-09-22 "Inflicts, or allows to be inflicted, upon the child, bodily injury, substantial bodily injury, or serious bodily injury as defined by section 12.1-01-04 or mental injury") (12.1-01-04 "Bodily injury" means any impairment of physical condition, including physical pain. "Serious bodily injury" means bodily injury that creates a substantial risk of death or which causes serious permanent disfigurement, unconsciousness, extreme pain, permanent loss or impairment of the function of any bodily member or organ, a bone fracture, or impediment of air flow or blood flow to the brain or lungs. "Substantial bodily injury" means a substantial temporary disfigurement, loss, or impairment of the function of any bodily member or organ.)

Access Services - Services such as transportation, escort/shopping assistance, outreach, and information and assistance, which help people to identify, obtain, and use existing services.

ACJ - Alliance for Children's Justice is a statewide multi-disciplinary coalition of professionals and parents dedicated to quality child protection services in North Dakota.

ACS - Affiliated Computer Services Inc. is the company North Dakota has contracted with for its Medicaid Management Information System replacement project and its Pharmacy Point of Sale system project.

Acute Care Unit - A service unit in the department's Human Service Centers that provides general outpatient mental health services.

ADA - Americans with Disabilities Act of 1990 [Pub. L. 101-336; 104 Stat. 327; 42 U.S.C. § 12101 et seq.]

ADL - Activities of Daily Living refers to daily self-care personal activities that include bathing, dressing and undressing, eating or feeding, toileting, continence, transferring in and out of a bed, or chair, or on and off the toilet; and mobility inside the home.

Administrative Assessment - Process of documenting reports of suspected child abuse or neglect that do not meet the criteria for a Child Protection Services Assessment.

Administrative Referral - Process of documenting the referral of reports of suspected child abuse or neglect that fall outside the jurisdiction of the county where the report is received.

Adoption Assistance - A form of monetary assistance to families adopting children from foster care who have special needs. This assistance can take the form of a monthly payment, Medicaid as a backup to a family's private health insurance, or reimbursement of nonrecurring expenses related to adoption.

Adoption Search/Disclosure - The process whereby an adopted individual, a birth parent, or birth sibling of an adopted individual, or an adult child of a deceased adopted individual can request and receive identifying information related to the adoption.

Adoption Subsidy - See Adoption Assistance.

Adult Day Care - A program of non-residential activities provided at least three (3) hours per day on a regularly scheduled basis one or more days per week and encompassing both health and social services needed to ensure the optimal functioning of the individual.

Adult Education Transition Services (AETS) - Refers to services provided to students 18-21 years of age who are eligible for Developmental Disabilities Program Management Services and can benefit from residential and/or day services provided in the developmental disabilities system while they are still in school. This is a joint initiative between the Department of Public Instruction and the Department of Human Services. Individuals must meet eligibility requirements. Education agencies and Medicaid provide funding.

Adult Family (Foster) Care - Provision of 24-hour room, board, supervision, and extra care to adults who are unable to function independently or who may benefit from a family home environment. Care is provided in a licensed home.

ADRC - Aging and Disability Resource Center is a community-level resource that people can turn to for information and for assistance locating available long-term care supports and services. It is intended to help connect older adults and adults with physical disabilities (of all incomes) and their families with needed services and supports. The DHS Aging Services Division received a demonstration grant to pilot an ADRC in the 10-county Bismarck region, and plans to expand ADRC services statewide by 2013 using existing resources at the regional human service centers.

Aging Services - Refers to the Aging Services Division of the N.D. Department of Human Services, which administers programs and services for older persons and vulnerable adults as the designated State and Area Agency on Aging under the Older Americans Act.

American Recovery and Reinvestment Act (ARRA) – Is legislation passed by Congress and signed into law in 2009 that is also referred to as "stimulus" funding. As OMB states on the ARRA Website, a majority of the ARRA funding for North Dakota was "committed to education, transportation and human and community services."

Approved Relative - An unlicensed child care provider who is eligible to participate in the Child Care Assistance Program. By federal law, an approved relative must be related to the child by marriage, blood relationship, or court order such as a grandparent, great-grandparent, aunt, uncle, or a sibling age 18 or older who does not live with the child. These providers can care for up to 5 children including their own children under the age of 12. All adults living in the home are checked against the ND Office of Attorney General's sex offender list.

ARRA – See American Recovery and Reinvestment Act

Arrearages - Past-due, unpaid child support owed by the noncustodial parent. Also may be referred to as "arrears."

ASAM - American Society of Addiction Medicine, Patient Placement Criteria, Second Edition-Revised. These are the clinical guidelines used for matching clients to the appropriate level of care for the treatment of substance-related disorders.

ASFA - The Adoption and Safe Families Act of 1997 [Pub. L. 105-89; 111 Stat. 2115; 42 U.S.C. § 1305 et seq.] is federal legislation to shorten the length of time in foster care and to ensure safety and permanency for children.

Assisted Living - An environment that helps people maintain as much independence as possible by providing apartment-like units and individualized support services, which accommodate individual needs and abilities. Assisted living facilities are required to be licensed in the North Dakota.

Assistive Technology (AT) Device - Any item or piece of equipment used to maintain or improve the functional capabilities of individuals with disabilities.

Assistive Technology (AT) Service - Any service that directly assists an individual with a disability in selecting, acquiring or using an assistive technology device. AT services may include: evaluation, purchasing, designing, leasing, training for individuals, family members, and professionals; and coordinating therapies. It also includes services that expand access to electronic and information technology for people with disabilities.

Attendant Care Service (ACS) - Hands-on care, of both a supportive and medical nature, specific to a client who is ventilator-dependent for a minimum of 20 hours per day and includes nursing activities that have been delegated by the Nurse Manager to the ACS provider. ACS is an all-inclusive service that provides direct care to ventilator-dependent individuals to meet their care needs.

Attendant Care Service Provider - Is a Qualified Service Provider (QSP) who is an unlicensed assistive person enrolled and in good standing with the North Dakota Board of Nursing. The attendant care service is provided under the direction of a licensed nurse who is enrolled with the Department of Human Services as a QSP to provide Nurse Management.

Background Check - (See also *Criminal Background Check*) Refers to the check that is currently done on child care provider applicants (licensed and self-certified) to see if a person's name appears on the ND Child Abuse and Neglect Index showing a finding of "services required" for child abuse or neglect and to see if the person is on the ND Office of Attorney General's List of Convicted Sex Offenders and Offenders Against Children.

Basic Care Assistance Program - Supplements room and board payments made by individuals of limited means living in basic care facilities. The Basic Care Assistance Program is funded with state general funds.

Basic Care Facility - A licensed residential facility that provides room and board and services to individuals who need health, social, or personal care services, but do not require extensive medical services.

Benchmark – A specific measurement as it relates to progress toward meeting a standard or goal.

BEST - Basic Employment and Skills Training program provides motivation and job seeking skills to Supplemental Nutrition Assistance Program recipients who are required to register for work. The department contracts with Job Service North Dakota to provide the service in Burleigh County and Cass County.

Best Practice - Practices that incorporate the best objective information currently available from recognized experts regarding effectiveness and acceptability.

BLHSC - Badlands Human Service Center is located in Dickinson. (*See HSC definition.*)

CA/N - Child Abuse and Neglect

Care Coordinator - Describes the comprehensive case manager in a child and family case involving severe emotional disturbance.

CARF - Commission for Accreditation for Rehabilitation Facilities

Case Management - A service where needs are assessed, services are arranged, coordinated, and monitored; and client preferences are advocated for within the context of a clinical treatment plan.

CCAP - Child Care Assistance Program provides partial payment for child care services provided to children from qualifying low-income families.

CCDBG - Child Care Development Block Grant

CCWIPS - The Comprehensive Child Welfare, Information, and Payment System is a computerized case management and payment system for foster care and adoption services.

CFS - Refers to the Children and Family Services Division of the Department of Human Services. CFS has administrative responsibility for the policies and procedures relating to children and families. The division is responsible for program supervision and technical assistance for the delivery of public child welfare services.

CFSR - Child and Family Services Review is a federal child welfare review conducted in all states. North Dakota uses this same process to conduct child welfare reviews in each region of the state annually.

Child and Family Team - Related to children's mental health services and child welfare services, the Child and Family Team consists of the child, family and persons most pertinent in the life of the child and family, as determined by the family (in most instances). The team meets to identify family strengths, needs, risks, and resources to reduce and/or eliminate the risk of removal from the home, reunification, emotional and educational needs, child abuse and neglect and ensure the safety, permanency and well-being of children and families.

Child Care Provider - A person, group of persons, or agency that is responsible for the education and supervision of the child/children in their care in exchange for money, goods, or services.

Child Care Provider Licensing - County social service offices conduct child care licensing studies, investigate complaints, and issue correction orders. The Department of Human Services' regional child welfare administrators review applications and studies, and issue licenses, denials, revocations, and suspensions. The Department's "State Office," which includes the Children and Family Services Division and the Legal Unit, develops and reviews regulations, policies, and procedures; conducts licensing training; reviews notices before issuance; and provides technical assistance.

Child Care Resource and Referral (CCR&R) – In North Dakota, two CCR&R agencies assist families searching for licensed child care and educate families about what to look for in providers. They also collect and maintain a database of providers, compile supply and demand information, provide and coordinate provider training, provide technical assistance to help providers become licensed and to improve quality, support child care programs in other ways, and work with communities to address child care issues. Established in 1992 by the North Dakota Legislature, the CCR&R programs in the state are supported by public funding (mainly from the ND Department of Human Services) and private funding.

Child Fatality Review Panel - A multi-professional group that meets to review the deaths of all minors in the state and identifies trends or patterns in the deaths of minors.

CHIP - Children's Health Insurance Program. See Healthy Steps and State Children's Health Insurance entries.

Chore Service - These tasks enable a client to remain in the home. Tasks include heavy housework and periodic cleaning, professional extermination, snow removal, and the task must be the responsibility of the client and not the responsibility of the landlord. Emergency Response Systems (ERS), such as electronic devices enabling the client to secure help in an emergency by activating the "help" button, are also available under this service.

CIL - Center for Independent Living. The four CILs in North Dakota provide services to individuals with disabilities so they can live and work more independently in their homes and communities.

Client Assistance Program (CAP) - Designed to inform and advise all Vocational Rehabilitation clients and applicants about the benefits available under the Federal Rehabilitation Act of 1973, and to assist clients in securing those services.

CMHS Block Grant - Community Mental Health Service Block Grant

Congregate Care - Refers to a specialized group residential facility that provides programming for elderly individuals with mental retardation to help them maintain their current level of functioning. The health and medical conditions of the individuals served are stable and do not require continued nursing or medical care.

Continuum of Care - A functional philosophy that seeks to ensure clients receive the right service in the right place at the right time.

Co-occurring Disorders (COD) - Individual has one or more substance-related disorders along with one or more mental disorders.

Corporate Guardianship - A service purchased on behalf of individuals eligible for developmental disabilities case management services when a district court has determined the individual requires a guardian and no one else is available to serve as guardian.

The Council for Quality and Leadership - Often referred to as "The Council" or "CQL," this entity accredits providers of services for mentally retarded/developmentally disabled people.

CP - For child support purposes, the Custodial Parent is the person (generally a parent) who has primary care, custody, and control of a child or, if a court has made a custody determination, the person who has legal custody of a child.

CPS - Child Protection Services protect the health and welfare of children by encouraging the reporting of children known to be or suspected of being abused or neglected; provide services for the protection and treatment of abused and neglected children to protect them from further harm.

CPS Assessment - A fact finding process designed to provide information that enables a determination to be made whether services are required for the protection and treatment of a child. These assessments are completed by County Social Service Board social workers.

CPS Assessment Decision - The result of a CPS assessment, which reflects whether services are required for the protection and treatment of an abused or neglected child.

Criminal Background Check - Fingerprints are taken and sent to the North Dakota Bureau of Criminal Investigation (BCI) and the Federal Bureau of Investigation (FBI) to determine if there is any criminal history record information regarding the person. This type of background check is being proposed for child care providers and is currently in place in North Dakota for foster care and non-relative adoptions, as well as North Dakota's CareCheck Registry – the existing voluntary criminal background check process for child care providers. (See *Background Check entry.*)

CRU - Crisis Residential Units provide generally short-term stabilization and support to individuals diagnosed with mental illness and/or chemical dependence who are experiencing crisis as a result of exacerbation of symptoms.

CSAP - Center for Substance Abuse Prevention is the sole federal organization with responsibility for improving accessibility and quality of substance abuse prevention services.

CSAT - Center for Substance Abuse Treatment is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), that works to expand the availability of effective treatment and recovery services for alcohol and drug problems.

CSCC - Children Services Coordinating Committee

CSHCN - Children with Special Health Care Needs. As defined at the federal level, this population of children has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions requiring health and related services of a type or amount beyond that required by children generally.

CSHS - Children's Special Health Services (formerly Crippled Children's Services) is part of the Department of Health; it provides services directly or through contracts to children with special health care needs and their families.

Custodial Parent – See *Parent Who Has Primary Residential Responsibility.*

Day Supports - This is a single day program, which encompasses services previously known as Developmental Day Activity, Developmental Work Activity, Prevocational Work Activity and Adult Day Care. Day supports may include assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills; provision of social, recreational, and therapeutic activities to maintain physical, recreational, personal care, and community integration skills; development of non-job task oriented prevocational skills such as compliance, attendance, task completion, problem solving and safety; and supervision for health and safety. Services are provided in settings appropriate to an individual's needs.

DC - Refers to the Developmental Center. Located in Grafton, N.D., it provides residential and other services to individuals with developmental disabilities.

DD - Refers to the Developmental Disabilities service system, which provides case management, day supports, residential services, and family support services to individuals with mental retardation or developmental disabilities of all ages, and early intervention services to infants and toddlers who are at risk for, or experiencing developmental delays.

DD Program Management - A function where a professional program manager assesses client need, authorizes payment for services, and assures that appropriate quality services are provided.

DDS - Disability Determination Services makes eligibility decisions for Social Security Disability Insurance and Supplemental Security Income so that eligible individuals can receive disability benefits. This is part of the ND Department of Human Services.

Debit Card - A card that may be used to electronically withdraw account deposits at an Automated Teller Machine (ATM) or a bank teller window, or to use at a point-of-sale (POS) machine to purchase goods, or services, or to obtain cash. Debit cards are used by the Department of Human Services to pay cash assistance under TANF programs and to distribute child support payments to custodial parents. Custodial parents receiving child support payments may also choose "direct deposit" as an alternative.

Determination - The result of an assessment of suspected institutional child abuse or neglect.

Developmental Disability - Refers to a severe chronic condition that constitutes a lifelong mental or physical impairment, which became apparent during childhood and has hampered an individual's ability to participate in mainstream society, either socially or vocationally.

Direct Deposit - For child support purposes, it is a process involving the electronic funds transfer of support payments from the State Disbursement Unit (SDU) into a custodial parent's bank account. This is done only upon the request of the custodial parent. Custodial parents may also choose to receive payments via a debit card.

Disease Management - A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant (for example, Medicaid recipients). Disease management: (1) supports the physician or practitioner/patient relationship and plan of care, (2) emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and empowerment strategies, and (3) evaluates clinical, quality of life and economic outcomes on an on-going basis with a goal of improving participants overall health.

Diversion Assistance - An alternative to Temporary Assistance for Needy Families (TANF) assistance, Diversion Assistance is available for no more than four months in a year, and is intended to allow individuals to avoid some of the complications of TANF in an effort to quickly achieve self-sufficiency.

DJS - Division of Juvenile Services is a division of the North Dakota Department of Corrections and Rehabilitation. DJS is responsible for the custody of delinquent and unruly children placed in its care by the courts.

DRA - Deficit Reduction Act of 2005 [Pub. L. 109-171; 120 Stat. 4; 42 U.S.C. § 1108, et seq.]

Dual Diagnosed - Diagnosed with two disorders such as those individuals diagnosed with mental illness and chemical dependence or individuals diagnosed with mental illness and developmental disabilities.

Dual Eligibles - Individuals who qualify for both Medicaid (state and federally-funded health coverage for low-income persons) and Medicare (federal health coverage program for persons age 65 and older and other qualifying individuals with disabilities).

DUR Board - Drug Utilization Review Board is a volunteer board whose makeup and duties appear in Code of Federal Regulations and subsequently in state statute. Comprised of pharmacists and physicians, the Board was established to advise the Medicaid program on prior authorization and other pharmacy cost control and utilization matters.

EAP - Economic Assistance Policy is a division of the department that administers policy for and includes the following programs: Child Care Assistance Program, Basic Care Assistance Program, Energy Assistance (also referred to as Low Income Home Energy Assistance, or LIHEAP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF), including Diversion Assistance and Job Opportunities and Basic Skills (JOBS). EAP is also responsible for Medicaid Estate Recovery, Quality Control, and System Support and Development.

Early Head Start - A federally funded program that serves income eligible infants, toddlers and expectant parents. Early Head Start provides services that include prenatal development/healthy pregnancy, child development, health, nutrition, parent education/family development and parent leadership opportunities. Early Head Start reserves 10 percent of its enrollment for children with special needs.

Early Intervention Services - Refers to a statewide program for infants and toddlers who range from newborn to three years of age who have a developmental delay, disability, or a condition that could result in substantial limitations if intervention is not provided. Intervention services are designed to help address the physical and developmental needs of children, and to augment the capacity of their families to meet their special needs.

Early Learning Guidelines - These voluntary guidelines are intended as a resource for parents, child care providers, pre-kindergarten and Head Start teachers, and others. They outline the skills, knowledge, and dispositions young children need prior to entering first grade.

EFT - Electronic Funds Transfer is a process by which money is transmitted electronically from one bank to another.

English Language Learners (ELL) - People who are learning the English. Another related term commonly used is English as a Second Language (ESL).

Environmental Modification - Physical adaptions to the home necessary to ensure the health, welfare, and safety of a client or that enable a client to function with greater independence in his/her home.

Expanded SPED Program - Expanded Service Payments to the Elderly and Disabled Program is a companion program to the Basic Care Assistance Program. It pays for services that can be provided in the home and community so that people can avoid having to move to a basic care facility. The Expanded SPED Program is funded with state general funds.

Extended Personal Care - Includes hands-on care of a medical nature that is specific to the needs of an eligible individual and will enable an individual to live at home. This service is provided by a Qualified Service Provider (QSP), and to the extent permitted by State law, is care that would otherwise be provided by a nurse. A nurse licensed to practice in the state will provide training to a QSP approved by the Department to provide the required care and will provide at a minimum, a review of the client's needs every six months to determine if additional training is required. Activities of daily living (ADL) and instrumental activities of daily living (IADL) are not a part of this service.

Extended Services - This refers to long term supports provided by a job coach for individuals with disabilities employed in the community.

FACSES - The Fully Automated Child Support Enforcement System is the statewide automated system that supports the processing of child support cases in North Dakota and supports the State Disbursement Unit (SDU) in processing child support payments.

Family Caregiver Support Program - Federally funded under the Older Americans Act, this Aging Services program offers help to caregivers who are caring for an adult age 60 or older, or who are themselves age 55 or older and are caring for grandchildren or relatives who are age 18 or younger or for an adult child with a disability who is between 19 and 59 years of age. Services include information and referral, assistance from a trained caregiver coordinator to help caregivers assess needs and access support services, individual and family counseling, support groups, training, and respite care for caregivers.

Family Group Decision Making - Relating to the provision of child welfare services, this is defined as a strengths-based collaborative, coordinated decision making process using family, agency and support service resources to ensure the safety, permanency and well-being of children and families.

Family Home Care - The provision of room, board, supervisory care, and personal care service to an eligible elderly or disabled individual by the spouse or by one the following relatives, or the current or former spouse of one of the following relatives of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew. The family home care provider does not need to be present in the home on a 24-hour basis if the welfare and safety of the client is maintained.

Family Personal Care -This helps individuals remain with their family members and provides extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services.

Family Subsidy - A program that may reimburse a family for excess expenses related to their child's disability. This offers support to enable families to keep their children in their homes when lack of financial support would make it very difficult for families to care for their children at home. A child may be eligible for this program through age 21.

Family Support Services - Refers to services, which are provided for eligible individuals with developmental disabilities to enable them to remain in appropriate home environments. Services are based on the primary caregiver's need for support in meeting the health, safety, developmental and personal care needs of their family member. Personal care needs include activities of daily living such as eating, bathing, dressing, and personal hygiene. When the eligible client is a minor, out-of-home support may also be provided in a licensed family home. This Family Care Option may be appropriate for children who cannot remain in their family home on a full-time basis. It is available only if the child is not considered deprived within the definition of NDCC 27-20-02 (5), and is not considered boarding care according to the definition of the North Dakota Department of Public Instruction.

FFY - Federal Fiscal Year runs from October 1 to September 30.

Fidelity - This is the degree of adherence to essential elements in the implementation of evidence-based clinical practice. Program with high fidelity are expected to have greater effectiveness in achieving desired client outcomes.

FIDM - The Financial Institution Data Match process is operated by the Child Support Enforcement program in coordination with financial institutions and pursuant to federal and state laws. The process provides for a data match system in which account records are matched with child support cases.

FLEP - Family Life Education Program. The department of human services is required by law (NDCC 50-06-06.10) to enter into an agreement with the North Dakota State University extension service for the design of a program to educate and support individuals at all points within the family life cycle. The program must provide support for families and youth with research-based information relating to personal, family, and community concerns and must contain a research component aimed at evaluation of planned methods or programs for prevention of family and social problems. The program must address: 1) child and youth development; 2) parent education with an emphasis on parents as educators; 3) human development; 4) interpersonal relationships; 5) family interaction and family systems;

6) family economics; 7) intergenerational issues; 8) impact of societal changes on the family; 9) coping skills; and 10) community networks and supports for families.

FMAP - Federal Medical Assistance Percentage is the federal matching rate for the Medicaid program. FMAP changes annually on October 1.

Food Stamps - See Supplemental Nutrition Assistance Program or SNAP.

Front End System/FRAME - An added component to the Department's current child welfare computer system that makes intake and data entry more efficient and user-friendly and supports enhanced case management services.

GA - General Assistance is a county program designed to cover emergency needs of low-income individuals or families. The covered needs may include rent, fuel and utilities, medical, and burial expenses.

Good Start, Grow Smart - The federal initiative that encouraged states to develop early learning guidelines, professional development systems, and quality rating systems and required Head Start programs to demonstrate progress in children's learning.

Governor's Prevention Advisory Council (GPAC) on Drugs and Alcohol - Formed by an executive order from the Governor's office, the council is charged with oversight and monitoring of substance abuse prevention activities across state agencies in North Dakota. The Department holds two of the eight council membership positions.

Guardian Ad Litem - A court-appointed child advocate mandated by North Dakota law for all abused and neglected children involved in a Juvenile Court proceeding.

HCBS - Home and Community Based Services refers to the array of services that are essential and appropriate to sustain individuals in their homes and communities, and to delay or prevent institutional care.

Head Start - This is a federally funded program for families with pre-school aged children who meet income eligibility guidelines. Head Start is family-focused and provides early literacy and education, child development, child health services (dental, physical, social-emotional, nutrition) and parent education and support services.

Head Start-State Collaboration Office (HS-SCO) - This office is designed to create a visible presence at the state level to assist in the development of significant, multi-agency and public-private partnerships between Head Start and the state. The following are the federally-identified purposes of the HS-SCO: Build early childhood systems and access to comprehensive services and support for all children of families with low-incomes; Create partnership agreements and initiatives between Head Start and appropriate state programs/agencies and encourage Head Start's capacity to be a partner in State initiatives on behalf of children and their families; and Facilitate the involvement of Head Start in State policies, plans, processes and decisions affecting the Head Start target population and other families with low-incomes.

Health Care Trust Fund - This trust fund was established by the 1999 North Dakota Legislature as a source of funding for grants and loans to pay for legislatively approved projects.

Health Tracks - See North Dakota Health Tracks.

Healthy Steps - Is North Dakota's Children's Health Insurance Program that offers comprehensive health coverage for children 18 years of age and younger. To qualify, a child's family must have a net income that is greater than the Medicaid eligibility level, but not exceeding 160% of the federal poverty level. (Deductions for child care, child support, and taxes are allowed when determining eligible income.) Healthy Steps is a state "Children's Health Insurance Program" (CHIP).

HIPAA - Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 42 U.S.C. § 1301 et seq.] that among other things standardizes the format of certain health care information that is transmitted electronically and regulates the release of health care information. HIPAA impacts entities (and their computer systems) that handle individual health care information.

Home Delivered Meal - Provides a well-balanced meal to any qualifying individual who lives alone and is unable to prepare an adequate meal, or who lives with another person who is unable or not available to prepare an adequate meal for the recipient.

Homemaker Service - Includes tasks such as housekeeping, laundry, and shopping, this service allows an individual to maintain or develop the independence needed to remain in the home.

HSC – Human Service Centers are part of the Department and provide help to individuals and families with concerns including family and relationship issues, mental illness, addiction, disabilities, and other needs. Centers are located in Bismarck (WCHSC), Devils Lake (LRHSC), Dickinson (Badlands HSC or BLHSC), Fargo (SEHSC), Grand Forks (NEHSC), Jamestown (SCHSC), Minot (NCHSC), and Williston (NWHSC).

IADL - Instrumental Activities of Daily Living means activities requiring cognitive ability or physical ability, or both. Instrumental activities of daily living include meal preparation, shopping, managing money, doing housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

ICAMA - Interstate Compact on Adoption and Medical Assistance

ICFMR - Intermediate Care Facility for the Mentally Retarded is a residential facility operated pursuant to federal regulations and serving people with developmental disabilities and related conditions. The programming provided is for individuals with extensive needs. Each client must receive a continuous active treatment program, which includes an aggressive and consistent program of training, health services, and related services so that the client acquires the ability to function with as much self-determination and independence as possible.

ICPC - Interstate Compact on the Placement of Children relates to the placement of foster children across state lines.

ICWA - **Indian Child Welfare Act** of 1978 [Pub. L. 95-608; 92 Stat. 3069; 25 USCA § 1901 et seq.] recognizes the importance of allowing tribal courts to assume full responsibility for the placement of Indian children in foster care and adoptive homes. Under ICWA, Indian tribes may intervene in such State court proceedings concerning Indian children, and Indian Tribal courts have exclusive jurisdiction over some such proceedings.

IDDT - Integrated Dual Disorder Treatment is an evidence-based practice that improves the quality of life of people with co-occurring mental and substance use disorders by promoting consumer and family involvement in service delivery, stable housing as a necessary condition of recovery, and employment as an expectation for many. The IDDT model integrates mental health and substance abuse services utilizing treatment that combines pharmacological, psychological, educational, and social interventions to address the needs of consumers and their families and other support system members. The implementation of IDDT promotes system change, organizational change, and clinical change.

Individualized Supported Living Arrangement (ISLA) - This residential service is provided to people with developmental disabilities and/or mental retardation in their own homes or apartments. The level of support provided is individualized to the person's need for training and assistance with personal care, laundry, money management, etc. Individuals who receive ISLA typically need a higher level of support than people in a Supported Living Arrangement (SLA).

Infant Development - Home-based, family focused services that provide supports to families of eligible infants and toddlers at high risk for, or with developmental delays or disabilities. An Individual Family Service Plan is developed that identifies services and learning opportunities that support the family in meeting the needs of their child, enhance their child's development, and increase the child's and family's participation in everyday routines and activities within the home and community. An eligible child may receive Infant Development services until he or she is three years of age.

Institutional Child Abuse or Neglect - Situations of known or suspected child abuse or neglect where the institution responsible for the child's welfare is a residential child care facility, a treatment or care center for the mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state.

Integrated Treatment - The skills and techniques used by treatment providers to comprehensively address both mental health and substance abuse issues in people with co-occurring disorders.

Intensive In-Home Services - Services provided under contract with a private agency to families who have at least one child about to be placed in foster care. The program's purpose is to preserve the family, prevent foster care, and assist with family re-unification of children who are placed in foster care.

Intergovernmental Transfer (IGT) – This is a complex funding process that was used by North Dakota and about 20 other states to access extra federal Medicaid dollars. The Health Care Financing Administration approved the IGT as part of North Dakota's Medicaid State Plan Amendment. Funds generated by the IGT were deposited into the Health Care Trust Fund. In a compromise worked out in Congress, this source of extra federal Medicaid funding has been phased out. The final North Dakota payment was in July 2004.

IPAT - Refers to the Interagency Program for Assistive Technology. IPAT's mission is to increase access to assistive technology devices and services for individuals with disabilities regardless of their type of disability, age, or income level in order to positively impact work, independent living, learning, community involvement and recreation.

IV-D - Refers to Title IV-D of the Social Security Act [Pub. L. 93-647; 42 U.S.C. title IV-D]. A Child Support Enforcement program that provides services to locate parents, to establish paternity, to establish child support and medical support obligations, to enforce child support and medical support obligations, and to review and adjust obligations. Services are provided to families receiving public assistance [through Temporary Assistance for Needy Families (TANF) or Medicaid], in cases in which a child has been placed in foster care or upon application for services from either parent.

IPE - Is an Individualized Plan for Employment. It describes the nature and scope of rehabilitation, employment and training services provided to an individual with a disability to help that individual reach his or her employment goal. A Vocational Rehabilitation counselor and the client write the client's IPE.

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

JOBS - Job Opportunities and Basic Skills program provides vocational training and employment for eligible individuals through TANF for the purpose of entering or reentering the job market. The Department of Human Services Program contracts with Job Service North Dakota, Career Options, Spirit Lake Employment and Training, and Turtle Mountain Tribal Employment and Training to provide JOBS program services.

Kinship Care - A Temporary Assistance for Needy Families (TANF) program that allows relatives, with supportive services, to provide care and protection to children who are under the care, custody, and control of County Social Services and who would otherwise be in foster care.

Licensed Child Care Providers – Are required to maintain at least minimum standards related to physical size of the facility, safety features, cleanliness, staff qualifications, and staff-to-child ratios. See the definitions of the licensed child care provider categories: licensed family child care, licensed group child care, licensed child center, licensed preschools, licensed school-age programs, and multiple license facility. (Unlicensed child care provider categories include: self-declared providers, formerly called "self-certified," approved relative providers, and registered providers.)

Licensed Family Child Care - Care for 7 or fewer children in the provider's own home.

Licensed Group Child Care - Care for 8 to 18 children in the home or other type of facility.

Licensed Child Care Center - Care for 19 or more children in public or private buildings, churches or schools; children are often grouped by age.

Licensed Preschools - Part-time educational and socialization experiences for children age 2 years to kindergarten

Licensed School-Age Programs - The care of 19 or more school-age children before and/or after school; some programs provide care during school holidays and summer vacations.

LIHEAP - Low Income Home Energy Assistance Program that is also referred to as the energy assistance program. It provides heating assistance grants and services for qualifying low-income households. Benefits equal each household's estimated cost of heat minus a percentage of the household's income and are usually paid directly to heating fuel suppliers.

Local Child Protection Team - A multidisciplinary team of staff members from public and private community agencies who assist child protection service agencies to make decisions and recommendations for families involved in Child Protection System (CPS) assessments.

Long Term Care Facility - (As defined by North Dakota law) A skilled nursing facility/nursing home, basic care facility, assisted living facility, or swing bed hospital unit. Common usage generally equates it to a nursing facility.

Long Term Care Ombudsman - A person who identifies, investigates, and resolves complaints made by or on behalf of residents of long term care facilities and tenants of assisted living facilities. The ombudsman also works in other ways to protect the health, safety, welfare, and rights of residents.

LRHSC - Lake Region Human Service Center is located in Devils Lake. (*See HSC entry.*)

MA - Medical Assistance, commonly referred to as "Medicaid," provides medical assistance to certain specified groups of needy low-income individuals as defined by federal law.

Managed Care - A system of health care that combines delivery and payment and influences utilization of services by employing management techniques (i.e., case management, referral for specialty services, etc.) designed to promote the delivery of cost-effective health care.

Matrix – Is an evidence-based treatment for those who are addicted to methamphetamine. It is specifically designed to accommodate the damage done to the brain by methamphetamine use.

MDS - Minimum Data Set is an assessment used to determine a nursing facility resident's classification for rate setting purposes.

Medicaid - See MA above.

Medicaid Systems Project - Also referred to as "The Project," it is the technology project dealing with the replacement of North Dakota's Medicaid Management Information System (MMIS), Pharmacy Point of Sale (POS) system, and the Medicaid Decision Support System.

Medicaid Waiver for Home and Community Based Services - A program authorized by federal law that funds in-home and community based services to individuals who meet Medicaid eligibility standards and require the level of care provided in a nursing facility. This waiver combines the previously separate waivers for aged and disabled and traumatic brain injury populations. The waiver's goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. The waiver provides service options for a continuum of home and community based services in the least restrictive environment.

Medicaid Waiver for Mentally Retarded and Developmentally Disabled - A program authorized by federal law that funds in-home and community based services for individuals with mental retardation and/or developmental disabilities who meet Medicaid eligibility standards and require the level of care provided in an Intermediate Care Facility for Mentally Retarded (ICFMR).

Medicare Part D - The federal Medicare Prescription Drug Program that provides Medicare beneficiaries with access to prescription drug coverage from a host of private plans.

Medicare Savings Programs - Medicaid coverage that pays all or part of the Medicare premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries, Specified Low income Medicare Beneficiaries and Qualifying Individuals.

Mental Retardation - Is a condition diagnosed by age 18 and characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life such as communication, self-care, and getting along in social situations and school activities. Mental retardation is sometimes referred to as a cognitive or intellectual disability.

MFP – Money Follows the Person is a federal Real Choice Systems Change Rebalancing grant that supports the transition of qualifying Medicaid-eligible individuals from institutional settings to home and community-based long term services.

MHSAS - Mental Health & Substance Abuse Services is a division of the Department of Human Services.
MHSIP - Mental Health Statistical Improvement Project is the statistical and outcome measurement system for the Department's community based mental health system of care at the regional human service centers.

MMIS - Medicaid Management Information System is the computer system that processes all Medicaid claims. Developed in 1978, it is also used to monitor utilization and to provide information needed to manage the Medicaid program. (*See Medicaid Systems Project.*)

MSLA - Minimally Supervised Living Arrangement is a community waiver group home or community complex setting, which provides training in community integration, social, leisure, and daily living skills.
Multiple License Facility – Entity that has more than one type of child care license such as a Center and Preschool license.

NCHSC - North Central Human Service Center is located in Minot. (See HSC entry.)

NDSH - North Dakota State Hospital

Neglect - The failure of a caregiver to provide essential services necessary to maintain the physical and mental health of another person in the caregiver's care.

Neglected Child - Uses the definition in juvenile law for a "deprived child." Refers to: A child who is without proper parental care, control, subsistence or education necessary for the child's physical, mental or emotional health or morals. A child who has been placed for care or adoption in violation of law. A child who has been abandoned. A child who is without proper care (as described above) because of the physical, mental, emotional, or other illness, or disability of the parent. A child who is in need of treatment and whose caregiver has refused to participate in treatment, which is court-ordered. A child who was subject to prenatal exposure to chronic or severe use of alcohol or any controlled substance. A child who is present in an environment subjecting the child to exposure to a controlled substance, chemical substance or drug paraphernalia.

NEHSC - Northeast Human Service Center is located in Grand Forks. (*See HSC definition.*)

New Hire Reporting - Under this reporting process mandated by federal and state law, employers must submit new hire information within 20 days of hiring to the State Directory of New Hires, a component of the Child Support Enforcement Division.

NF LOC Determination - Nursing Facility Level of Care Determination is an assessment based on established criteria of an individual's medical needs. A determination must be completed before an individual can receive Medicaid funded nursing facility services or home and community-based services through the Medicaid Waiver for Home and Community Based Services.

Non-Custodial Parent - *See Parent Who Does Not Have Primary Residential Responsibility.*

Non-Medical Transportation - Transportation the enables individuals to access essential community services such as grocery stores, pharmacies, banking, post office, laundromat, utility company, social services, and the social security office, in order to maintain themselves in their home. *Non-Medical Transportation Driver with Vehicle* refers to situations when the driver with the vehicle is considered as solely transporting the client to and from his/her home and points of destination. *Non-Medical Transportation Escort* is solely accompanying the client for the purpose of assisting in boarding and exiting, as well as during transport, in order that the client may complete the activity for which (non-medical) transportation is authorized.

North Dakota Health Tracks - Also known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), this program provides preventive health care to Medicaid eligible individuals up to age 21. Services include physical exams and screenings, immunizations, and referrals.

No Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has not been abused or neglected.

No Services Required, Services Recommended - A CPS assessment decision that reflects the belief that a child has not been abused or neglected, but the family may be in need of preventative services.

NSDUH - National Survey on Drug Use and Health is a survey of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Office of Applied Studies.

Nurse Management - This is an aspect of Attendant Care Services. Nurse Management is the provision of nursing assessment, care planning, training of skilled nursing tasks to an Attendant Care Services (ACS) provider, and monitoring of delegated tasks, for clients who are ventilator-dependent and receiving Attendant Care Services.

Nursing Facility Level of Care Determination - See NF LOC Determination.

NWHSC - Northwest Human Service Center is located in Williston. (*See HSC definition.*)

Obligee - The person to whom a child support obligation is owed, generally the Parent Who Has Primary Residential Responsibility (formerly referred to as custodial parent). It may also be an entity to which a child support obligation is owed.

Obligor - The person who is obliged to pay child support. *(See also Parent Who Does Not Have Primary Residential Responsibility.)*

Older Americans Act (OAA) - The Older Americans Act of 1965 [Pub. L. 89-73; 79 Stat. 219; 42 U.S.C. § 3001 et seq.] provides federal funding for services to older persons, especially those who are low income, socially needy, frail, or minority persons. Among the services offered are nutrition services, support services, Long Term Care Ombudsman program, and information and referral.

Olmstead Commission - Established by an executive order of the Governor, the commission monitors services and conducts planning in order to comply with the United States Supreme Court's Olmstead decision related to providing appropriate community-based services for individuals with disabilities, consistent with needs and available resources of the state.

Olmstead Decision - A 1999 U.S. Supreme Court decision, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176 (1999), in which the Court held that it is a form of discrimination under the Americans With Disabilities Act of 1990 (ADA) if a state fails to find community placements for institutionalized individuals if: 1) the state's treatment professionals have determined that community placement is appropriate, 2) the individual does not oppose the transfer to a community setting, and 3) the placement can be reasonably accommodated taking into account the resources available to the state and the needs of others with disabilities.

Outreach - Actions and communication initiated by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits.

PACE - Program of All-inclusive Care for the Elderly involves Northland Healthcare Alliance and Medicaid and began operation in August 2008. It is a managed care program providing patient-centered, coordinated care to frail elderly individuals who are eligible for Medicare and Medicaid and live in the community. The goal is to meet individual health needs through a care team so participants can remain living independently in the community.

PAR - Progress Assessment Review is a written instrument used as the basis of the eligibility process within Developmental Disabilities. The instrument includes an assessment of needs, which helps determine level of care and authorization of services.

Parent Aides - Individuals who, through training and support, work with parents who are at risk of abusing or neglecting their children. County social service boards employ the aides.

Parent Who Does Not Have Primary Residential Responsibility – (*formerly referred to as Non-Custodial Parent*) For child support purposes, this is the parent who does not have primary care, custody, and control of the child(ren) or, if a court has made a custody determination, the parent who does not have legal custody of the child(ren).

Parent Who Has Primary Residential Responsibility - The parent to whom a child support obligation is owed. (Formerly referred to as *Custodial Parent*.)

Part C - Is a section within the federal law of the Individuals with Disabilities Education Act (IDEA) [Pub. L. 94-142; 84 Stat. 175; 20 U.S.C. § 1400 et seq.] that entitles a child under the age of three years and their family to certain supports, services, and rights, which in North Dakota are known as Early Intervention Services for Infants and Toddlers. Part C provides federal financial assistance to states to develop and implement a collaborative statewide system of services for these children and their families.

Participant Directed Service - Sometimes called Self-Directed Supports, this option gives the individual the most control over his or her services and supports and also the most responsibility.

Partnerships Program - Integrated comprehensive services for children with serious emotional disorders.

PASRR - Pre-Admission Screening and Resident Review is a federal requirement that every person who seeks admission to a nursing facility be screened by the state for evidence of mental retardation or mental illness. If either exists, the screening is intended to determine if nursing facility care is necessary, and if so, to determine if specialized services are needed.

Peer Support Services - These consumer centered services have a rehabilitation and recovery focus and are designed to promote skills for coping with and managing symptoms while facilitating the use of natural resources and the enhancement of community living skills. Support services are provided by a person who has progressed in his or her own mental health or substance abuse recovery and is working to assist other people with those issues. Because of their life experience, peers have expertise that professional training cannot replicate.

Peer Support Specialist - An occupational title for a person who has progressed in his or her own recovery from a mental disorder and is working to assist other people with a mental disorder. Their life experiences give these individuals expertise that cannot be replicated by professional training.

PEPP - Parental Employment Pilot Project. Renamed "PRIDE" (Parental Responsibility Initiative for the Development of Employment) in late 2006. (See PRIDE definition below.)

PERM - Payment Error Rate Measurement is an examination of selected Medicaid and Healthy Steps (SCHIP) provider claims to determine if a service is required and the beneficiary is eligible.

Personal Care Service - A service that provides assistance with bathing, dressing, toileting, continence, transferring, mobility in the home, eating, and personal hygiene, passive range of motion exercises and simple bandage changes. When specified within the plan of care, this service may also include cueing or prompting, housekeeping tasks such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the individual, rather than the individual's family.

Pharmacy Point of Sale - This is a computerized point of sale (POS) system that allows pharmacists to enter claims on a real time basis into the payment system. Within seconds, providers receive confirmation that a claim has been processed for payment or denied. If a claim is denied, providers receive immediate information about the reason. The system also prevents payment of duplicate claims, audits claims to ensure the health of Medicaid recipients is maintained by preventing inappropriate drug dispensing, reduces administrative costs and streamlines identification of recipient liability for pharmacy providers.

Portability - An individual can move from one area of the state to another or from one service to another and his/ her individual budget and waiver eligibility can remain the same.

Preschool - Programs that typically serve children age three through entrance into kindergarten.

Prevention Activities - Activities with goals of eliminating or reducing the factors that cause or predispose individuals to increased risk, disease, problems, or disabilities.

PRIDE - Parental Responsibility Initiative for the Development of Employment provides employment-related services to noncustodial parents who are behind in their child support obligations. It is administered through the Child Support Enforcement Division with TANF funding assistance. The goal is to help the parents obtain work in order to increase their incomes so that they can support their children. This may result in better family relationships and improved visitation. The Department has implemented it in Dickinson and Grand Forks. It was formerly referred to as PEPP (Parental Employment Pilot Project).

Prime Time Care - A prevention program designed to provide temporary child care to families at risk of neglecting or abusing their children.

Program Management for Developmental Disabilities - *See DD Program Management.*

Psychiatric Residential Treatment Facility (PRTF) - (*Formerly called Residential Treatment Center or RTC*) A facility or a distinct part of a facility that provides children and adolescents with a 24-hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family.

QI - Qualifying Individuals are individuals for whom Medicaid pays their Medicare Part B premium. Income must be between 120 percent and 135 percent of poverty level. They cannot be covered by other Medicaid to receive benefits. *See Medicare Savings Programs.*

QMB - Qualified Medicare Beneficiaries are persons for whom Medicaid pays the Medicare premiums, deductibles, and co-insurance. Income cannot exceed 100% of the poverty level. See Medicare Savings Programs.

Qualified Service Provider (QSP) - An agency or independent contractor that agrees to meet standards for services and operations established by the Department of Human Services to provide home and community based long term care services.

Quality Rating and Improvement System - A method to assess (initially and ongoing), improve, and communicate the level of quality in early childhood care and education settings.

RCCF - Residential Child Care Facility (foster care facility)

RCSEU - There are eight Regional Child Support Enforcement Units in North Dakota. These regional offices provide child support enforcement services.

Recipient Liability (*also called **Client Share***) - This is the amount an individual who is eligible for Medicaid under the "Medically Needy" coverage group must contribute toward his or her monthly medical expenses before Medicaid pays for services.

Registered Providers - Child care providers who are eligible to participate in the Child Care Assistance Program and who are generally registered by Tribal entities. These child care providers may be licensed by Tribal entities and subject to their licensing criteria, but are not licensed by the state.

Refugee Cash Assistance - A benefit program available for the first eight months that qualifying refugees are living in the United States.

Rehabilitation Services - Medical, psychological, social, and vocational services, including physical items, which are necessary to assist persons with disabilities to engage in gainful activity.

Rehabilitation Services Administration - The federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

Report of Suspected Child Abuse or Neglect - Information received by child protection services concerning the suspected maltreatment of a child.

Reserved Waiver Capacity - The state may reserve a portion of the participant capacity for specified purposes such as community transition of institutionalized persons or for individuals who may experience a crisis.

Residential Care - Services provided in a facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security.

Respite Care - Temporary relief to a primary caregiver for a specified period of time. The caregiver is relieved of the stress and demands associated with continuous daily care.

Right Track - This Developmental Disabilities program works to identify infants or toddlers who may be at-risk for developmental delays. The program provides developmental screenings in environments natural and familiar to the child, refers families to appropriate supports and shares child development information with them. For this program, at-risk infants and toddlers are defined as children younger than three years of age who have environmental or biological risk factors for developmental delays or parental concern regarding development.

RIS - Regional Intervention Services provide community based intervention for individuals with serious mental health and/or substance abuse needs to determine appropriate level of care. RIS units at the department's human service centers conduct the admission screening for State Hospital admissions.

RMA - Refugee Medical Assistance provides up to eight months of Medical Assistance for qualifying newly arriving refugees. The program is 100 percent federally funded.

ROAP - The Regional Office Automation Project is a technology system that provides a comprehensive and integrated electronic medical records system to manage and support the business functions and requirements of the department's eight regional Human Service Centers and the Central Office.

RSA - Rehabilitation Services Administration is the federal oversight agency responsible for the Rehabilitation Act (Vocational Rehabilitation services).

RTC - Term is no longer used. *See Psychiatric Residential Treatment Facility (PRTF) entry.*

Safety, Strengths, Risk Assessment - Refers to State Form Number (SFN 455) that is used to document the Child Protection Services (CPS) assessment.

SAMHSA - Substance Abuse and Mental Health Services Administration is an agency of the U.S. Department of Health and Human Services (DHHS) that focuses on programs and providing funding to improve the lives of people with or at risk for mental and substance abuse disorders.

SAPT - Substance Abuse Prevention and Treatment block grant

SCHIP - See Healthy Steps Children's Health Insurance Program definition.

SCHSC - South Central Human Service Center is located in Jamestown. (*See HSC definition.*)

SDU - The State Disbursement Unit is the unit within the department's Child Support Enforcement Division that receives, records, and distributes all child support payments in North Dakota.

SED - Serious Emotional Disorder (or Disturbance)

SEHSC - Southeast Human Service Center is located in Fargo. (*See HSC definition.*)

Self-Certified/Self-Declared Child Care Providers - Care for 5 or fewer children or 3 infants in the provider's home. These providers are not licensed or monitored; they are eligible to participate in the Child Care Assistance Program.

Senior Community Services Employment Program - Funded under the Older Americans Act, this program provides career counseling, training, and community service work experience to help low-income persons age 55 and older to secure meaningful employment.

Services Required - A Child Protection Services (CPS) assessment decision, which reflects the belief that a child has been abused or neglected and requires contact with the juvenile court.

SFY - State Fiscal Year is the period of time in the state budget cycle from July 1 to June 30.

Single Plan of Care (SPOC) – This is the computerized treatment/service plan that supports the Wraparound Process in the provision of mental health services to children.

SLA - Supported Living Arrangement is a residential service that provides support to people living in their own homes or apartments. Supportive services include help with budgeting, shopping, laundry, etc. and are provided on an intermittent basis, usually less than 20 hours per month. There is a fixed staff to client ratio. People receiving this service generally need less support than people receiving Individualized Supported Living Arrangement services.

Sliding fee scale – A system of cost sharing based on income and number of persons in the household.

SLMB - Specified Low-Income Medicare Beneficiaries are persons for whom Medicaid pays the Medicare Part B premium. Income must be between 100 percent and 120 percent of poverty level. See Medicare Savings Programs.

Slots - The maximum number of individuals who can be enrolled in the waiver at any one point in time. The number of waiver slots is tied to the amount of funding the state legislature has made available for waiver services. One 'slot' usually equals the average amount of money the state expects to spend for an individual for a full year of services.

SMI - Seriously mentally ill

SNAP - See Supplemental Nutrition Assistance Program (Formerly called the Food Stamp program.)

SPARCS- Structured Psychotherapy for Adolescents Responding to Chronic Stress is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. These include difficulties with regulation and impulsivity, self-perception, relationships, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as world views that make it difficult for them to see a future for themselves. Program goals include helping teens cope more effectively, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning.

Special needs - Refers to the needs of children who have, or are at risk of developing, a developmental, emotional, behavioral, learning or physical condition that requires attention, services, and/or program modifications beyond what is generally needed by other children.

Special Needs Adoption - The classification of adoption for children who have a physical, emotional, and/or psychological disability (or are at risk for such a disability), are older than age seven, part of a sibling group, or are children whose race/ethnicity may be a barrier to placement.

Specialized Equipment and Supplies - Includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Specialized Placement - Refers to a residence for people who are diagnosed as both mentally retarded and mentally ill and whose individualized programs address residential, psychosocial and psychiatric development prior to entry into less restrictive settings.

SPED - Service Payments for Elderly and Disabled is authorized by state law to provide a number of home and community based services to functionally impaired older individuals and people with physical disabilities who require assistance to continue to live in a home-like setting.

SSA - Social Security Administration

SSBG - Social Service Block Grant

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Income

State Child Protection Team - A multidisciplinary team of staff members from public and private agencies (determined by law) that makes the determination whether child abuse or neglect is indicated in cases of suspected institutional child abuse or neglect.

State Interagency Coordinating Council (ICC) - Is a council appointed by the Governor. Federal law under Part C of the Individuals with Disabilities Education Act (IDEA) requires the ICC to advise and assist the designated lead agency (ND Department of Human Services) in the performance of responsibilities set forth under Part C regarding early intervention services and to advise the Department of Public Instruction (DPI) regarding the transition of toddlers with disabilities to preschool and other appropriate services. The council is comprised of parents of infants and toddlers with disabilities and representatives of providers of early intervention services, the state legislature, the Department of Human Services, preschools, the State Insurance Department, Head Start, child care providers, and other members at large.

Subject - In child welfare terminology, the person who is suspected of abuse or neglect of a child or the person who has abused or neglected a child.

Supplemental Nutrition Assistance Program (SNAP) - Formerly called the Food Stamp program, this federally-funded USDA program is intended to raise levels of nutrition among low-income households by supplementing their food purchasing power with monthly benefits distributed through an electronic benefit card.

Supported Employment - Competitive work, in an integrated work environment, with ongoing support services for individuals with the most severe disabilities.

Swing Bed - A licensed hospital bed in a rural hospital that is used to provide nursing facility level of care services to an individual who is not in need of acute care services.

TANF - Temporary Assistance for Needy Families is a federal block grant program established under Title IV-A of the Social Security Act. It serves many needs, such as meeting some of the costs of Foster Care and Child Care Assistance programs. TANF also provides temporary cash assistance to needy families primarily to facilitate the return to or preparation for work.

TBI - Traumatic Brain Injury

TCC - Transitional Child Care provides partial payment of child care to families who lose TANF assistance eligibility.

TCLF - Transitional Community Living Facility is a community waiver group home that provides training for individuals in community integration, social, leisure, and daily living skills in a group living environment. It is preliminary to entry into a lesser restrictive setting.

TECS - Technical Eligibility Computer System is the computer system currently used by county social service boards to manage Supplemental Nutrition Assistance Program cases and some Medicaid cases.

TPL - Third Party Liability describes potential resources that may be available to offset claims against the Medicaid program. They include health insurance, accident insurance, court settlements, and decrees stemming from accidents of various kinds.

Transitional Living Service - Services that train people to live with greater independence in their own homes. This includes training, supervision, or assistance to the individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

Transition Services - Services provided to assist students with disabilities as they move from school to adult services and/or employment.

Transitional Medicaid Benefits - Provides up to 12 months of Medicaid coverage for families who lose eligibility under the Family Coverage group due to earnings.

Tribal NEW - Tribal Native Employment Works program is the tribal equivalent of the Job Opportunities and Basic Skills (JOBS) program. The job placement and education program is available to American Indian TANF recipients.

Tribal TANF - Tribal governments have the option of direct administration of TANF programs. No Tribe in North Dakota has yet exercised this option.

Uniform Interstate Family Support Act (UIFSA) - is a model Act, enacted at the state level, to provide mechanisms for establishing and enforcing child support obligations in interstate cases (cases in which a noncustodial parent lives in a different state than the custodial parent and child).

UPA - Either the Uniform Parentage Act or Unreimbursed Public Assistance. The **Uniform Parentage Act** refers to laws, based on model legislation drafted by the National Conference of Commissioners on Uniform State Laws (NCCUSL), enacted at the state level to provide mechanisms for establishing paternity. **Unreimbursed Public Assistance** refers to money paid in the form of public assistance (for example, Temporary Assistance for Needy Families expenditures), which has not been recovered by retaining assigned child support.

URM - Unaccompanied Refugee Minor is a child between the ages of birth and 18 who enters the United States with refugee immigration status and the parents are deceased or their whereabouts unknown, and the child is without a family connection. URM youth enter a foster care program specifically administered for their care through a voluntary agency with coordination of the Department. URM foster care meets state licensing requirements.

VIPR - The Very Intelligent Payment Recognition system is a computerized check processing system used by the Child Support Enforcement Division to process child support payments quickly and accurately. It interfaces with the Fully Automated Child Support Enforcement System (FACSES) computer system.

Vision - The computer system currently used by county social services to administer Temporary Assistance for Need Families (TANF) benefits and some Medicaid cases.

Vocational Development - A program of vocational preparation prior to competitive or extended employment.

VR - Vocational Rehabilitation provides training and employment services to individuals with disabilities so they can become and/or remain employed. Services are designed to assist business owners and employers in developing short and long term strategies regarding disability-related issues including staffing, education, tapping into financial incentives associated with hiring an individual who has a permanent injury, illness, or impairment; or ensuring accessibility to goods or services.

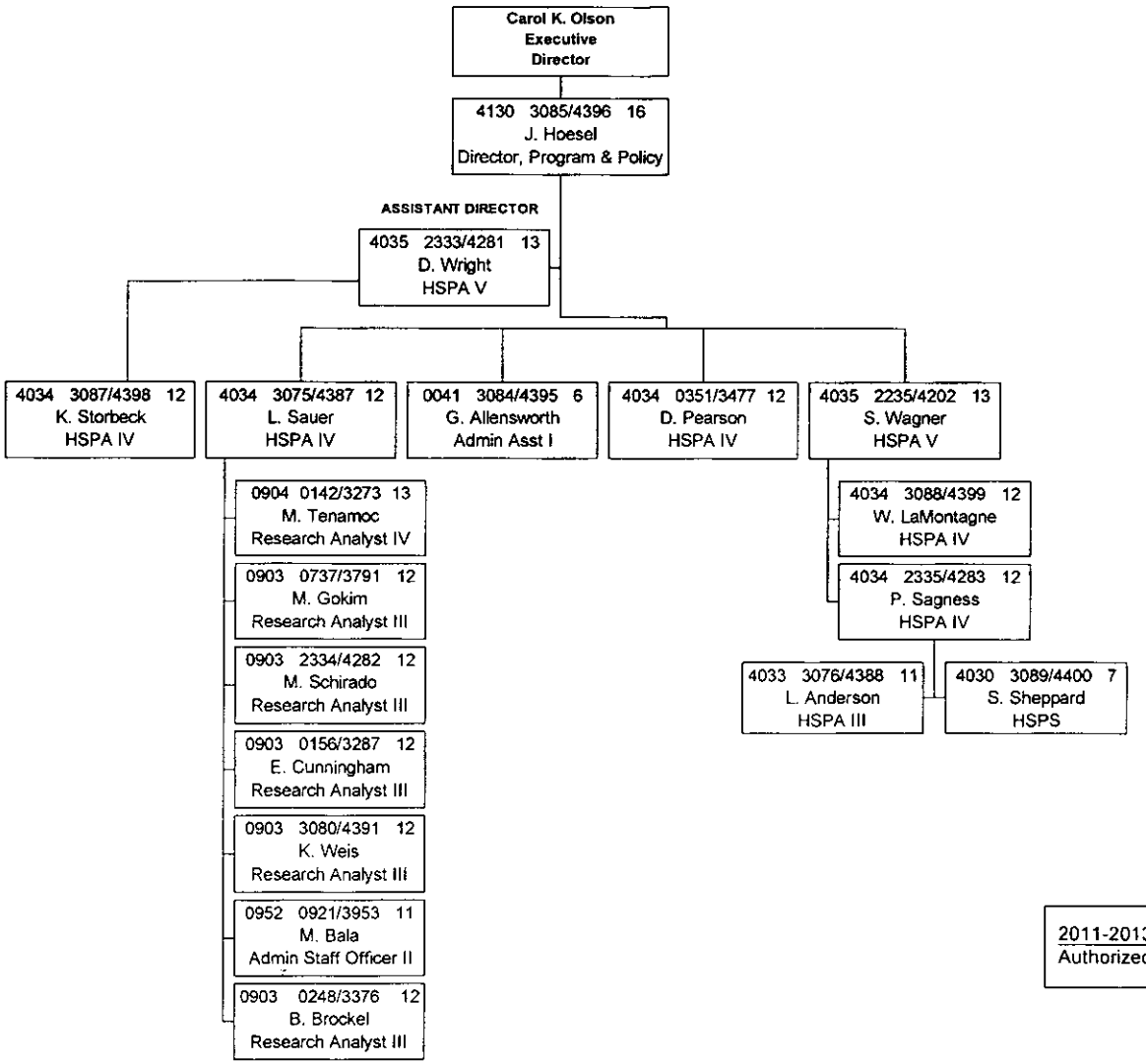
Vulnerable Adult Protective Services - Refers to remedial social, legal, health, mental health, and referral services provided for prevention, correction, or discontinuation of abuse or neglect which are necessary and appropriate under the circumstances to protect an abused or neglected vulnerable adult. Services also ensure that the least restrictive alternatives are provided, prevent further abuse or neglect, and promote self care and independent living. (Reference: North Dakota Century Code Chapter 50-25)

WCHSC - West Central Human Service Center is located in Bismarck. (*See HSC definition.*)

Wraparound - This is a strength-based philosophy of care that includes a definable process involving the child and family that results in a unique set of community services and supports individualized for that child and family. Wraparound is a process. It is not a program. It does not create new programs or services, but is the method of meeting the needs of families through the coordination and identification of natural supports and formal supports, which constitute the Child and Family Team. This process is team driven, focuses on least restrictive methods of care, and uses the family's strengths, preferences, and choices whenever possible. It is a continuum of intensity, which is driven by family needs, complexity, and level of risk.

YRBS - Youth Risk Behavioral Survey is conducted by the North Dakota Department of Health and the North Dakota Department of Public Instruction and monitors health-risk behaviors among youth and young adults including behaviors that contribute to injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, and physical activity.

North Dakota Department of Human Services
Mental Health/Substance Abuse Division



- Attachment ONE
- Joanne Hoesel
- SB 2012
- March 14, 2011

Revised 2/25/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-47 MENTAL HEALTH AND SUBSTANCE ABUSE											
		S101 FULL-TIME EQUIVALENTS (FTEs)		19.000	18.000	0.000	6.000	0.000	24.000	0.000	24.000
32510	B	511000 Salaries - Permanent		1,547,520	1,795,836	854,331	659,626	0	2,455,462	0	2,455,462
32510	B	513000 Temporary Salaries		33,867	55,616	37,167	3,378	0	58,994	0	58,994
32510	B	514000 Overtime		0	10	0	(10)	0	0	0	0
32510	B	516000 Fringe Benefits		504,304	637,981	301,596	250,209	(2)	888,188	0	888,188
32510	B	599110 Salary Increase		0	0	0	0	111,601	111,601	0	111,601
32510	B	599160 Benefit Increase		0	0	0	0	18,876	18,876	0	18,876
32510	B	599161 Health Increase		0	0	0	0	33,480	33,480	0	33,480
32510	B	599162 Retirement Increase		0	0	0	0	25,536	25,536	0	25,536
32510	B	599163 EAP Increase		0	0	0	0	65	65	0	65
			Subtotal:	2,085,691	2,489,443	1,193,094	913,203	189,556	3,592,202	0	3,592,202
32510	F	F_1991 Salary - General Fund		773,928	979,851	407,493	(1,833)	63,938	1,041,956	0	1,041,956
32510	F	F_1992 Salary - Federal Funds		1,290,288	1,499,719	785,601	924,909	125,618	2,550,246	0	2,550,246
32510	F	F_1993 Salary - Other Funds		21,475	9,873	0	(9,873)	0	0	0	0
			Subtotal:	2,085,691	2,489,443	1,193,094	913,203	189,556	3,592,202	0	3,592,202
32530	B	521000 Travel		139,037	205,379	69,917	82,944	0	288,323	0	288,323
32530	B	531000 Supplies - IT Software		1,989	1,200	740	0	0	1,200	0	1,200
32530	B	532000 Supply/Material-Professional		163,658	243,660	114,025	(155,717)	0	87,943	0	87,943
32530	B	533000 Food and Clothing		200	0	0	0	0	0	0	0
32530	B	534000 Bldg, Grounds, Vehicle Supply		32	100	39	(100)	0	0	0	0
32530	B	535000 Miscellaneous Supplies		41,294	108,569	107,395	(88,569)	0	20,000	0	20,000
32530	B	536000 Office Supplies		5,594	5,050	3,894	5,950	0	11,000	0	11,000
32530	B	541000 Postage		14,863	4,050	18	950	0	5,000	0	5,000
32530	B	542000 Printing		51,483	38,660	31,071	60,340	0	99,000	0	99,000
32530	B	551000 IT Equip under $5,000		0	2,500	1,771	500	0	3,000	0	3,000
32530	B	552000 Other Equip under $5,000		0	3,400	1,554	(3,400)	0	0	0	0
32530	B	553000 Office Equip & Furniture-Under		9,697	9,700	8,925	(7,700)	0	2,000	0	2,000
32530	B	582000 Rentals/Leases - Bldg/Land		179,494	166,093	99,711	9,483	0	175,576	0	175,576
32530	B	591000 Repairs		0	70	0	(70)	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-47 MENTAL HEALTH AND SUBSTANCE ABUSE											
32530	B	601000	IT - Data Processing	2,281	3,810	2,929	(10)	0	3,800	0	3,800
32530	B	602000	IT-Communications	1,157	1,040	403	9,540	0	10,580	0	10,580
32530	B	603000	IT Contractual Services and Re	8,207	100	40	(100)	0	0	0	0
32530	B	611000	Professional Development	137,361	202,893	94,571	(43,274)	0	159,619	0	159,619
32530	B	621000	Operating Fees and Services	5,691,487	7,640,856	3,113,395	3,180,088	0	10,820,944	0	10,820,944
			Subtotal:	6,447,834	8,637,130	3,650,398	3,050,855	0	11,687,985	0	11,687,985
32530	F	F_3991	Operating - General Fund	2,700,553	4,274,357	1,652,296	(263,917)	0	4,010,440	0	4,010,440
32530	F	F_3992	Operating - Federal Funds	3,674,738	4,292,847	1,934,087	3,252,918	0	7,545,765	0	7,545,765
32530	F	F_3993	Operating - Other Funds	72,543	69,926	64,015	61,854	0	131,780	0	131,780
			Subtotal:	6,447,834	8,637,130	3,650,398	3,050,855	0	11,687,985	0	11,687,985
32560	B	712000	Grants, Benefits & Claims	2,468,637	2,382,446	1,021,376	2,063,138	0	4,445,584	0	4,445,584
			Subtotal:	2,468,637	2,382,446	1,021,376	2,063,138	0	4,445,584	0	4,445,584
32560	F	F_6991	Grants - General Fund	1,138,685	926,310	421,424	1,149,935	0	2,076,245	0	2,076,245
32560	F	F_6992	Grants - Federal Funds	884,046	951,276	416,289	978,983	0	1,930,259	0	1,930,259
32560	F	F_6993	Grants - Other Funds	334,000	334,000	183,663	(65,780)	0	268,220	0	268,220
32560	F	F_6995	Grants - County Funds	111,906	170,860	0	0	0	170,860	0	170,860
			Subtotal:	2,468,637	2,382,446	1,021,376	2,063,138	0	4,445,584	0	4,445,584
			Subdivision Budget Total:	11,002,162	13,509,019	5,864,868	6,027,196	189,556	19,725,771	0	19,725,771
300-47 MENTAL HEALTH AND SUBSTANCE ABUSE			**General Funds:**	4,613,166	6,180,518	2,481,213	884,185	63,938	7,128,641	0	7,128,641
			Federal Funds:	5,849,072	6,743,842	3,135,977	5,156,810	125,618	12,026,270	0	12,026,270
			Other Funds:	428,018	413,799	247,678	(13,799)	0	400,000	0	400,000
			SWAP Funds:	0	0	0	0	0	0	0	0
			County Funds:	111,906	170,860	0	0	0	170,860	0	170,860
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	11,002,162	13,509,019	5,864,868	6,027,196	189,556	19,725,771	0	19,725,771

Mental Health & Substance Abuse - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Prairie Hills Plaza office space	5,242.91	15.34	49,818	111,034	-	160,852
Prairie Hills Plaza storage space	500.00	6.12		6,120	-	6,120
Miscellaneous rent (booth & room rentals)				8,604		8,604
			$ 49,818	**$ 125,758**	**$ -**	**$ 175,576**

Mental Health & Substance Abuse - 2011-13 Biennium Budget

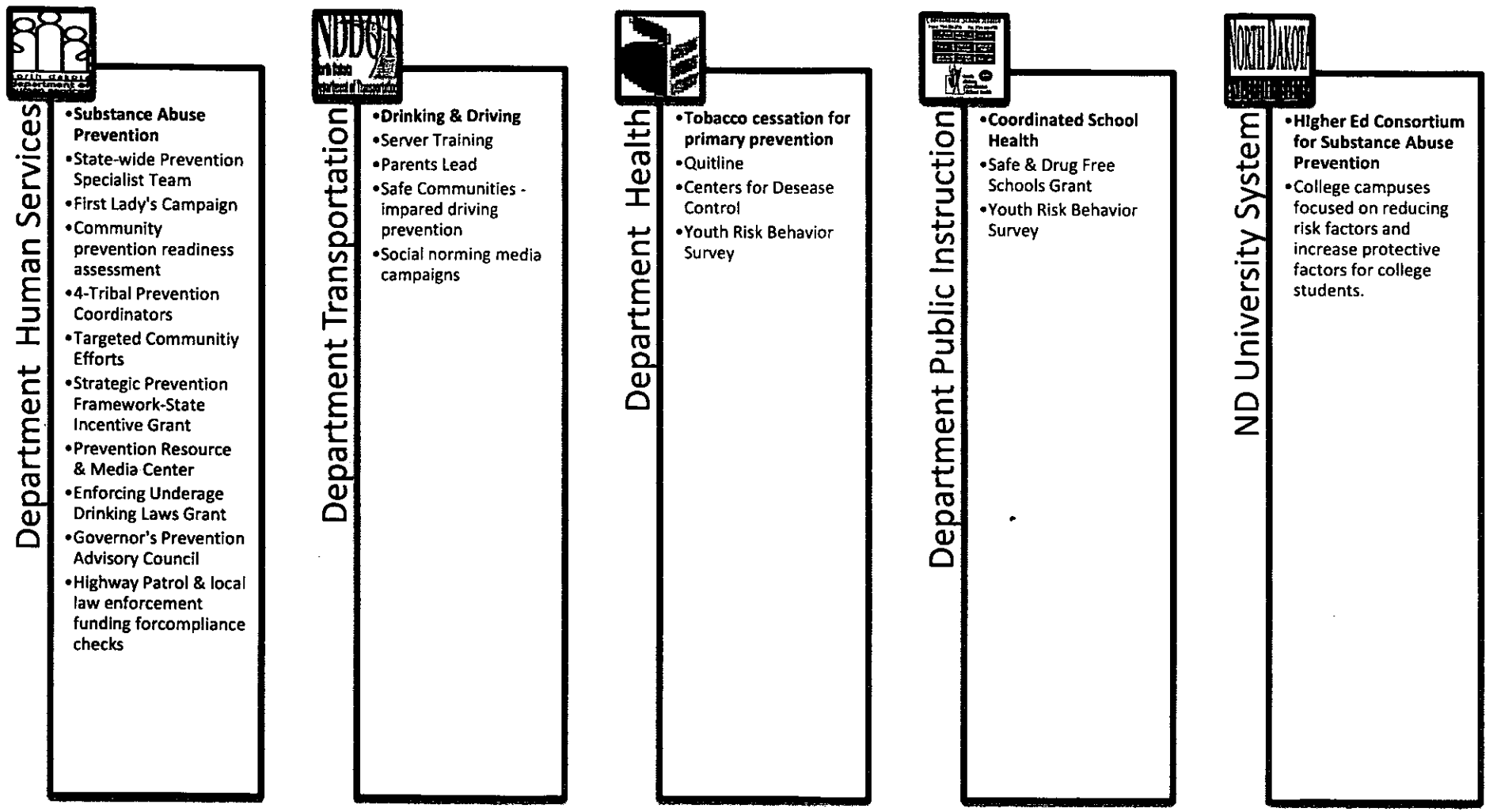
Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Social worker and addiction counselor licenses	278	947	-	1,225
Advertising costs for public notices	486	1,014	-	1,500
Annual MH and SA conferences: Clinic Forum, Summit, Prevention	84,881	250,119	-	335,000
TCTY trainings	18,676	152,866	-	171,542
Licensing of providers (HSCs and private)	17,880	51,120	-	69,000
Conference and event underwriting	8,273	23,227	-	31,500
State epidemiology outcomes workgroup contracts	-	111,436	-	111,436
Enforcing underage drinking laws (media, conference, prevention)	-	247,800	-	247,800
Sex offender treatment contracts	1,863,055	-	-	1,863,055
Robinson Recovery treatment contract	1,594,025	-	-	1,594,025
Gambling treatment and 2-1-1 contracts	80,211	-	128,339	208,550
Tribal prevention coordination, strategies & surveys	-	620,000	-	620,000
SYNAR tobacco compliance check	2,528	27,472	-	30,000
Governor's Prevention committee support	80,000	-	-	80,000
Prevention awareness strategies	-	180,000	-	180,000
MATRIX and motivational interviewing training	25,425	103,075	-	128,500
BRFFS questions for health dept survey	2,655	1,845	-	4,500
MH Consumer and Family Network contract	27,792	97,208	-	125,000
IDDT training & consultation	5,558	19,442	-	25,000
Recovery Center mini grants	-	100,000	-	100,000
Telephone recovery contract	-	150,000	-	150,000
TBI training per SB 2198	16,836	40,764	-	57,600
Freight and shipping costs	-	29,000	-	29,000
Safe and Drug Free Communities contracts	-	240,000	-	240,000
Prevention Infrastructure grant	-	4,416,711	-	4,416,711
	$ 3,828,559	**$ 6,864,046**	**$ 128,339**	**$ 10,820,944**

Mental Health & Substance Abuse - 2011-13 Biennium Budget

Budget Account Code 712000 - Grants, Benefits & Claims

Description	General Fund	Federal Funds	Other Funds	Total
Voluntary Treatment Program	140,000	372,580	170,860	683,440
Transition flex funds	340	1,160	-	1,500
Parent to Parent contract	34,021	115,979	-	150,000
Aging and Mental Health contract	13,608	46,392	-	60,000
Head Injury Association of North Dakota contract	118,634	55,994	-	174,628
HIT, Inc. contract	38,420	1,684	-	40,104
Community Options contract	58,195	53,345	-	111,540
DHHS - Health Resources and Services Administration grant	-	743,125	-	743,125
Mental health extended services	1,405,389	140,000	-	1,545,389
Gambling treatment services	167,638	-	268,220	435,858
Substance abuse prevention	100,000	-	-	100,000
Tribal law enforcement of underage drinking laws	-	20,000	-	20,000
State and local law enforcement of underage drinking laws	-	380,000	-	380,000
	$2,076,245	**$1,930,259**	**$ 439,080**	**$4,445,584**



North Dakota Substance Abuse Prevention State Agencies – Direct Funded - Prepared by Department of Human Services- March 2011

- Attachment TWO
- SB 2012
- March 14, 2011
- JoAnne Hoesel

- JoAnne Hoesel
- March 14, 2011

- Attachment THREE
- SB 2012

Mental Health & Substance Abuse Testimony

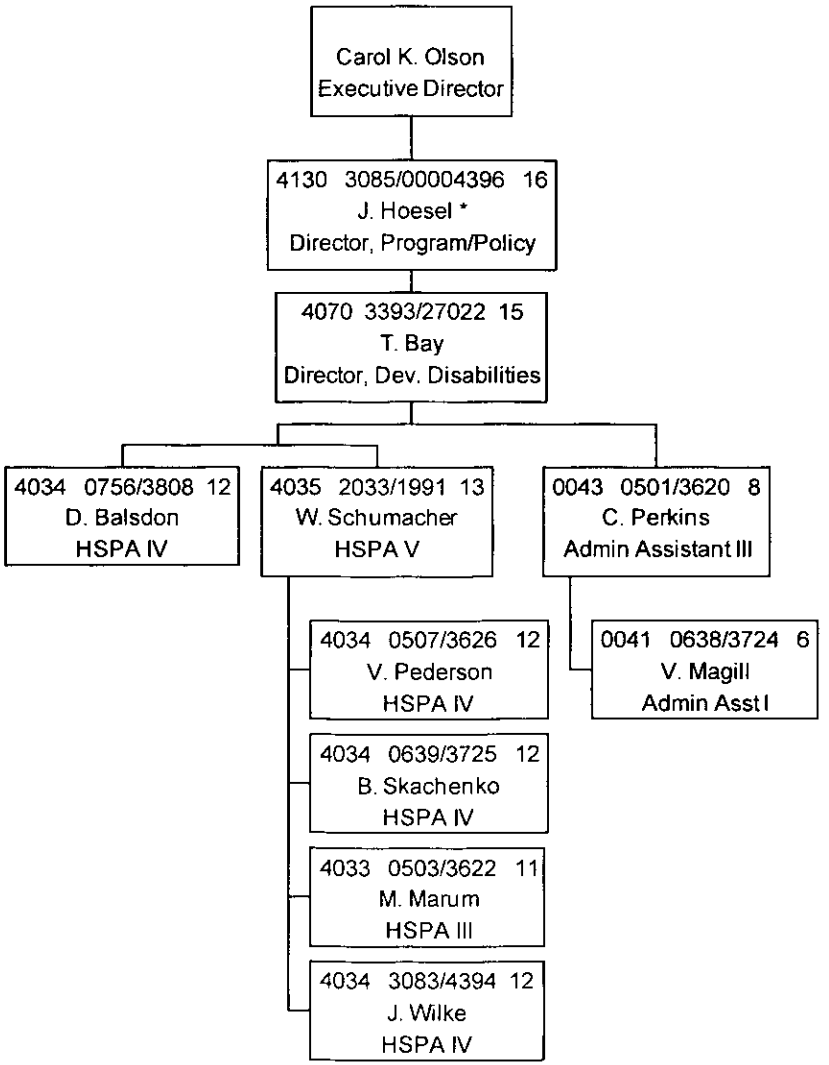
	Trend		
	2008	2007	2006
In 2009, 5,819 arrests were made for driving under the influence of alcohol (BCI)	5,815	6,085	6,488

	2007	2006	2002
46.1% of all arrests in 2008 were for DUI, Liquor law, and drug abuse violations. (BCI, 2009)	47%	47%	42%

	2010	2009	2008	2007
In March 2010, upon admission to the ND State Penitentiary, 77% of males and 74% of females had a drug and/or alcohol abuse/ dependency diagnosis. (DOCR)	86% of males new admissions*			
	93% of female new admissions*			

* (DOCR, 2011) New admissions for all of DOCR, calculated by the number of admissions received to a male or female facility against the number of offenders assessed and diagnosed within that same time.

North Dakota Department of Human Services
Developmental Disabilities



* FTE located under MH/SA

2011-2013 Budget
Authorized: 9 FTEs

- Tina Bay
- Attachment Four
- March 14, 2011
- SB 2012

Revised 2/25/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-52 DEVELOPMENTAL DISABILITIES DIVISION										
S101		FULL-TIME EQUIVALENTS (FTEs)	8.000	9.000	0.000	0.000	0.000	9.000	0.000	9.000
32510	B	511000 Salaries - Permanent	751,075	857,712	493,564	117,119	0	974,831	0	974,831
32510	B	516000 Fringe Benefits	268,456	328,524	183,620	17,525	0	346,049	0	346,049
32510	B	599110 Salary Increase	0	0	0	0	36,847	36,847	0	36,847
32510	B	599160 Benefit Increase	0	0	0	0	6,231	6,231	0	6,231
32510	B	599161 Health Increase	0	0	0	0	13,099	13,099	0	13,099
32510	B	599162 Retirement Increase	0	0	0	0	10,058	10,058	0	10,058
32510	B	599163 EAP Increase	0	0	0	0	25	25	0	25
		Subtotal:	1,019,531	1,186,236	677,184	134,644	66,260	1,387,140	0	1,387,140
32510	F	F_1991 Salary - General Fund	469,052	514,346	320,458	(70,135)	23,980	468,191	0	468,191
32510	F	F_1992 Salary - Federal Funds	550,479	661,975	356,726	121,173	42,280	825,428	0	825,428
32510	F	F_1993 Salary - Other Funds	0	9,915	0	83,606	0	93,521	0	93,521
		Subtotal:	1,019,531	1,186,236	677,184	134,644	66,260	1,387,140	0	1,387,140
32530	B	521000 Travel	193,085	187,965	94,765	226,309	0	414,274	0	414,274
32530	B	531000 Supplies - IT Software	8,197	850	465	400	0	1,250	0	1,250
32530	B	532000 Supply/Material-Professional	144,738	10,000	8,419	47,500	0	57,500	0	57,500
32530	B	534000 Bldg, Grounds, Vehicle Supply	10	0	0	0	0	0	0	0
32530	B	535000 Miscellaneous Supplies	93,685	12,300	7,769	(9,300)	0	3,000	0	3,000
32530	B	536000 Office Supplies	9,183	8,100	8,085	(800)	0	7,300	0	7,300
32530	B	541000 Postage	441	1,400	217	(1,000)	0	400	0	400
32530	B	542000 Printing	25,434	31,700	16,536	4,400	0	36,100	0	36,100
32530	B	551000 IT Equip under $5,000	19,110	8,700	8,689	(8,700)	0	0	0	0
32530	B	552000 Other Equip under $5,000	257,181	13,083	0	136,917	0	150,000	0	150,000
32530	B	553000 Office Equip & Furniture-Under	8,982	1,700	689	1,080	0	2,780	0	2,780
32530	B	582000 Rentals/Leases - Bldg/Land	54,726	47,512	31,509	15,335	0	62,847	0	62,847
32530	B	591000 Repairs	0	25,717	19,287	29,283	0	55,000	0	55,000
32530	B	601000 IT - Data Processing	860	1,050	1,013	(250)	0	800	0	800
32530	B	602000 IT-Communications	566	570	567	2,430	0	3,000	0	3,000
32530	B	603000 IT Contractual Services and Re	6,000	0	0	6,000	0	6,000	0	6,000

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-52 DEVELOPMENTAL DISABILITIES DIVISION											
32530	B	611000	Professional Development	57,914	89,224	19,312	(3,932)	0	85,292	0	85,292
32530	B	621000	Operating Fees and Services	4,019,614	7,116,592	2,634,571	(651,600)	0	6,464,992	0	6,464,992
32530	B	623000	Fees - Professional Services	0	16,977	0	(16,977)	0	0	0	0
32530	B	625000	Medical, Dental and Optical	1,593	0	0	0	0	0	0	0
			Subtotal:	4,901,319	7,573,440	2,851,893	(222,905)	0	7,350,535	0	7,350,535
32530	F	F_3991	Operating - General Fund	1,815,172	2,347,113	1,162,806	251,712	0	2,598,825	0	2,598,825
32530	F	F_3992	Operating - Federal Funds	3,086,147	5,226,327	1,689,087	(531,099)	0	4,695,228	0	4,695,228
32530	F	F_3993	Operating - Other Funds	0	0	0	56,482	0	56,482	0	56,482
			Subtotal:	4,901,319	7,573,440	2,851,893	(222,905)	0	7,350,535	0	7,350,535
32560	B	712000	Grants, Benefits & Claims	191,767	166,767	97,803	271,440	0	438,207	0	438,207
			Subtotal:	191,767	166,767	97,803	271,440	0	438,207	0	438,207
32560	F	F_6991	Grants - General Fund	85,677	85,556	42,169	(1,143)	0	84,413	0	84,413
32560	F	F_6992	Grants - Federal Funds	106,090	81,211	55,634	272,583	0	353,794	0	353,794
			Subtotal:	191,767	166,767	97,803	271,440	0	438,207	0	438,207
			Subdivision Budget Total:	6,112,617	8,926,443	3,626,880	183,179	66,260	9,175,882	0	9,175,882
			General Funds:	2,369,901	2,947,015	1,525,433	180,434	23,980	3,151,429	0	3,151,429
			Federal Funds:	3,742,716	5,969,513	2,101,447	(137,343)	42,280	5,874,450	0	5,874,450
300-52 DEVELOPMENTAL DISABILITIES DIVISION			**Other Funds:**	0	9,915	0	140,088	0	150,003	0	150,003
			SWAP Funds:	0	0	0	0	0	0	0	0
			County Funds:	0	0	0	0	0	0	0	0
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	6,112,617	8,926,443	3,626,880	183,179	66,260	9,175,882	0	9,175,882

Developmental Disabilites - 2011-13 Biennium Budget

Budget Account Code 712000 - Grants, Benefits & Claims

Description	General Fund	Federal Funds	Other Funds	Total
Minot State University training modules contract	84,413	82,354		166,767
Infants & Toddlers Part C contracts		200,000		200,000
Protection & Advocacy follow up investigations		71,440		71,440
	$ 84,413	**$ 353,794**	**$ -**	**$ 438,207**

Developmental Disabilities - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Prairie Hills Plaza office space	1,885.48	15.34	27,112	30,735	-	57,847
Miscellaneous rent (booth & room rentals)				5,000	-	5,000
			$ 27,112	**$ 35,735**	**$ -**	**$ 62,847**

Developmental Disabilities - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other	Total
Advertising services for public notices	841	7,482	177	8,500
Catholic Charities guardianship contract	2,030,217	-	-	2,030,217
Section 11 Support Living contracts	297,358	-	-	297,358
Acumen contract for self-directed supports	117,759	207,669	24,799	350,227
Quality assurance	93,628	165,115	19,717	278,460
Part C Right Track contracts	-	1,800,000	-	1,800,000
Part C contracts for training, parent support, research, etc.	-	1,250,000	-	1,250,000
Part C ARRA funded contracts	-	450,000	-	450,000
Storage and handling costs of DD files	77	137	16	230
	$ 2,539,880	**$ 3,880,403**	**$ 44,709**	**$ 6,464,992**

- Attachment ONE
- Debra McDermott
- March 14, 2011
- SB 2012

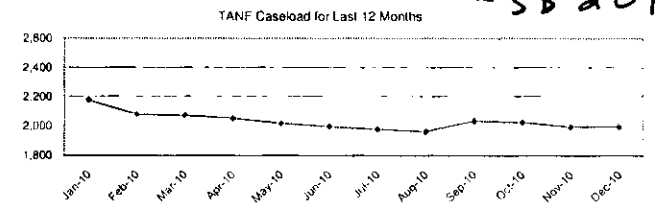
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2009 - DECEMBER 2010

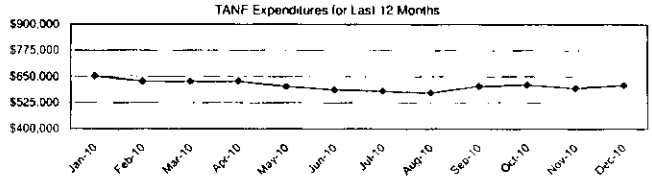
Section 1: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)
APPROPRIATION 2009-2011 BIENNIUM $23,987,922

BUDGET (7/09-12/10)		ACTUAL (7/09-12/10)			
Monthly Avg Cases	Monthly Avg Cost per Case	Monthly Avg Cases	Monthly Avg Cost per Case	Spent to Date	Percent of Appropriation Used*
2,807	$ 343	2,098	$ 300	$ 11,334,297	47.3%

PROGRAM NOTES:

Average monthly TANF recipients:	5,152
Average number of children receiving TANF benefits:	3,961
Average number of child only cases:	915
Average number of individuals participating in work activities:	1,138
Amount of Child Support Collections used to pay TANF grants (see section 6):	2,184,044



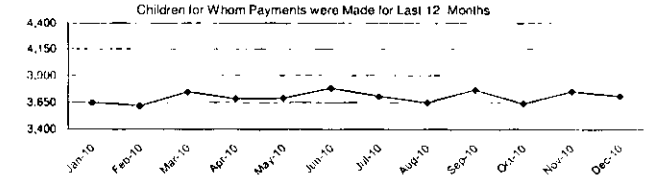


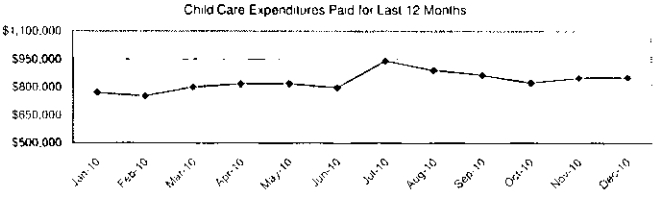
Section 2: CHILD CARE ASSISTANCE (CCA)
APPROPRIATION 2009-2011 BIENNIUM $22,359,834

BUDGET (8/09-12/10)		ACTUAL (8/09-12/10)			
Monthly Avg Children for whom CCA paid	Monthly Avg Cost per Child	Monthly Avg Children for whom CCA paid	Monthly Avg Cost per Child	Spent to Date	Percent of Appropriation Used**
4,143	$ 223	3,758	$ 225	$ 14,376,686	64.3%

PROGRAM NOTES:

Average number of Non-TANF children:	2,943
Average number of TANF children:	797
Average number of families receiving payments:	2,316
Average payment per family:	$365



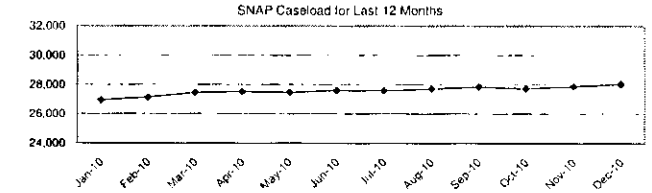


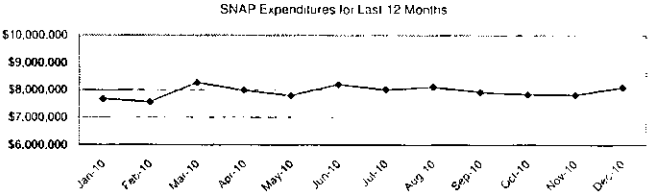
Section 3: SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)
APPROPRIATION 2009-2011 BIENNIUM $211,436,375

BUDGET (7/09-12/10)		ACTUAL (7/09-12/10)			
Monthly Avg Cases	Monthly Avg Cost per Case	Monthly Avg Cases	Monthly Avg Cost per Case	Spent to Date	Percent of Appropriation Used*
29,767	$ 285	27,063	$ 290	$ 141,154,518	66.8%

PROGRAM NOTES:

Average number of individuals receiving SNAP:	59,480
Average number of children under 18 receiving SNAP:	26,460
Average number of cases with an elderly person (60 or older) :	4,472
Average number of cases with earned income:	11,216





*Percent of Biennium Expired 75.0% - Payments for TANF, SNAP, and Adoption are made at the beginning of the month for the current month. Payments for Foster Care are made the last day of the month for the current month. Therefore 18 months of payments have been made or 75.0% (18/24) of the biennium has expired.

**Percent of Biennium Expired 70.8% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 17 months of payments have been made or 70.8% (17/24) of the biennium has expired.

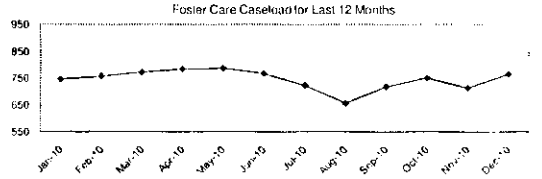
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2009 - DECEMBER 2010

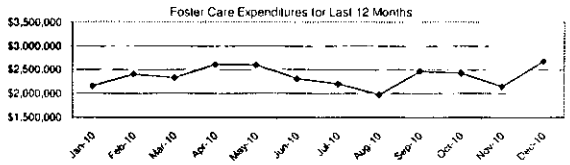
Section 4: FOSTER CARE (MAINTENANCE AND REHAB)
APPROPRIATION 2009-2011 BIENNIUM $58,089,459

BUDGET (7/09-12/10)		ACTUAL (7/09-12/10)			
Monthly Avg Cases	Monthly Avg Cost	Monthly Avg Cases	Monthly Avg Cost	Spent to Date	Percent of Appropriation Used *
785	*Varied by placement*	$ 753	*See program notes*	$ 41,908,087	72.1%

PROGRAM NOTES:

Average monthly cost foster care family homes (45% of caseload):	$1,002
Average monthly cost therapeutic family foster care (26% of caseload):	$3,650
Average monthly cost Residential Child Care Facilities/Group Homes (29% of caseload):	$5,258
Amount of Child Support Collections used to pay Foster Care grants (see section 6):	$2,341,013



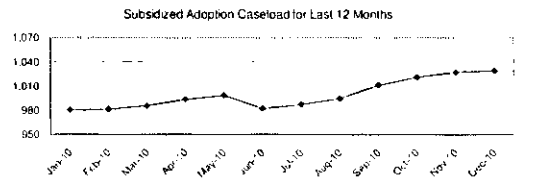


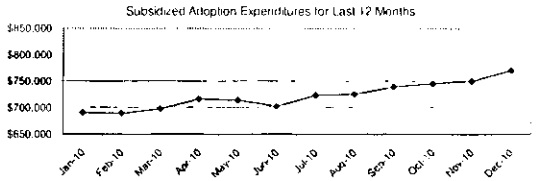
Section 5: SUBSIDIZED ADOPTION FOR SPECIAL NEEDS CHILDREN
APPROPRIATION 2009-2011 BIENNIUM $17,847,086

BUDGET (7/09-12/10)		ACTUAL (7/09-12/10)			
Monthly Avg Cases	Monthly Avg Cost	Monthly Avg Cases	Monthly Avg Cost	Spent to Date	Percent of Appropriation Used*
980	$ 742	991	$ 714	$ 12,734,422	71.4%

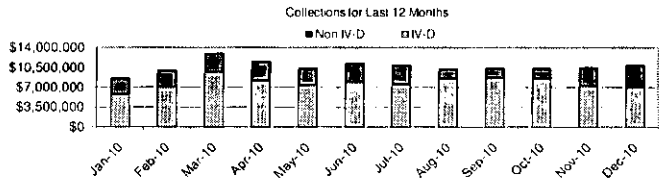
PROGRAM NOTES:

A special needs child is a child legally available for adoptive placement and who is seven years of age or older; under eighteen years of age with a physical, emotional, or mental disability or has been diagnosed to be a high risk for such a disability; a member of a minority; or a member of a sibling group.

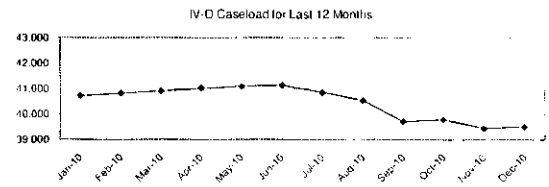




Section 6 - CHILD SUPPORT ENFORCEMENT



Total Collections for Last 12 Months	$128,973,685
% of Collections Received from	
-IV-D clients	72.6%
-Non-IV-D clients	27.4%
	100.0%
Collections Distributed to	
-TANF Grant Program (see section 1)	1.2%
-Foster Care Program (see section 4)	1.3%
-Federal government reimbursement	2.4%
-IV-D Families	59.3%
-Non-IV-D Families	27.4%
-Other States	4.9%
-Other	3.5%
	100.00%



PROGRAM NOTES:

A IV-D case is a case in which a parent has assigned the rights to receive support payments to the State as a condition of receiving public assistance or has filed as application for services provided by the Child Support Enforcement Agency.

A Non-IV-D case is a case in which a parent has neither assigned the right to receive support to the State nor has filed an application for services provided by the Child Support Enforcement Agency or once had a IV-D case that was subsequently closed.

The decrease in IV-D case is due to a change in the interpretation of federal policy. The change relates to the ability to discontinue referring Medical Services related cases where the only eligible individuals are children or cases in which the caretakers are not required to cooperate with Child Support. Historically these cases have had no activity related to them.

*Percent of Biennium Expired 75.0% - Payments for TANF, SNAP, and Adoption are made at the beginning of the month for the current month. Payments for Foster Care are made the last day of the month for the current month. Therefore 18 months of payments have been made or 75.0% (18/24) of the biennium has expired.

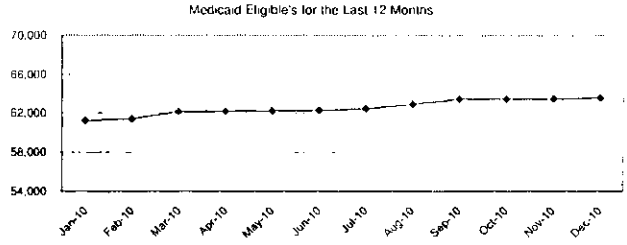
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2009 - DECEMBER 2010 (continued)

Section 7 - MEDICAID ELIGIBLES
2009 - 2011 BIENNIUM

Comparison of Eligible's	Jan-10	Dec-10	Difference
Under age 21	35,280	36,269	989
Over age 65 (Aged)	6,004	6,265	261
Disabled	8,624	9,153	529
Adults	11,346	11,897	551
Total	61,254	63,584	2,330

PROGRAM NOTES:
Eligible's include all Medical Assistance and Long Term Care Continuum Medicaid eligible's with the exception of SPED, Expanded SPED and Basic Care.

For the last twelve months approximately 57% of the above eligible's were under the age of 21, 10% were classified as aged, 14% were disabled, and 19% were adults.

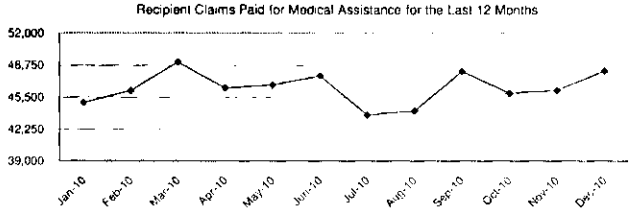


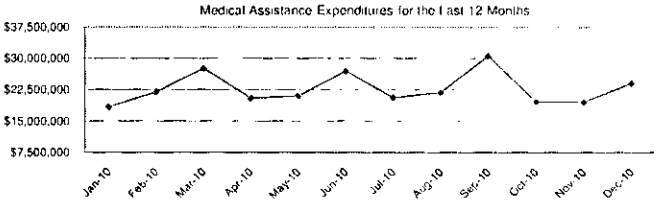
Section 8 - MEDICAL ASSISTANCE
APPROPRIATION 2009 - 2011 BIENNIUM $519,584,774

	Actual Paid (8/09-12/10)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
Inpatient Hospital	1,220	4,988	103,467,183	72.5%
Outpatient Hospital	9,055	302	46,557,356	75.2%
Physician	23,921	177	72,156,803	72.4%
Net Drugs (Includes Rebates)	18,728	95	30,318,568	59.6%
Dental	3,938	245	16,372,597	96.2%
Healthy Steps	3,460	229	13,465,413	62.2%
			90,692,398	72.1%
Medical Assistance Expenditures to Date			$ 373,030,318	71.8%

PROGRAM NOTES:
Effective July 1, 2009 eligibility for Healthy Steps was increased from 150% to 160% of the federal poverty level based on net income.

A portion of the increase in September 2010 was due to a $6.3 million dollar correction to the payment methodology used to reimburse Indian Health Services Pharmacies.

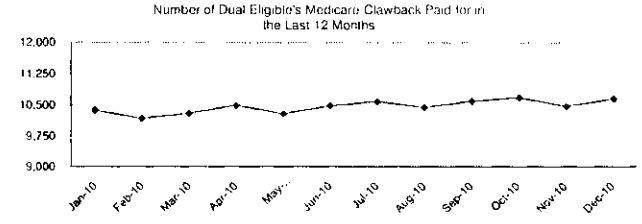


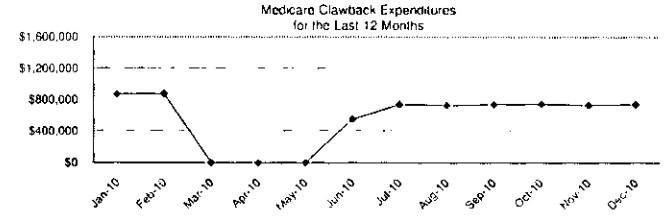


Section 9 - MEDICARE CLAWBACK
APPROPRIATION 2009 - 2011 BIENNIUM $19,416,262

Budget (8/09-12/10)		Actual Paid (8/09-12/10)			
Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
9,450	86	10,352	76	$ 10,958,706	56.4%

PROGRAM NOTES:
Payments made from October 2009-February 2010 were made using the FFY 2010 FMAP, however the Centers for Medicare and Medicaid reversed their decision and now allow the enhanced ARRA FMAP to be used in the Medicare Clawback calculation. This decision resulted in a $2.4 million credit for payments made from October 2008 - January 2010 and was applied to payments made from March 2010 - June 2010. Payments made through June 2011 will be at the ARRA FMAP and the total impact for the 2009-2011 biennium is estimated to be $5.2 million. However, the effect of ARRA is offset by the increased caseload.





Percent of Biennium Expired 70.8% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 17 months of payments have been made or 70.8% (17/24) of the biennium has expired.

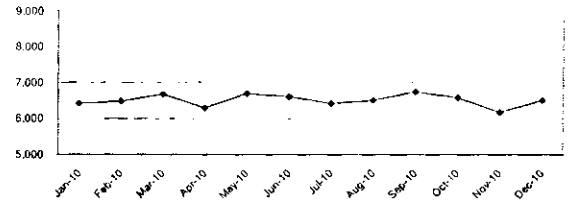
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
QUARTERLY BUDGET INSIGHT
BIENNIUM TO DATE INFORMATION ON SELECTED DEPARTMENT PROGRAMS
JULY 2009 - DECEMBER 2010 (continued)

Section 10 - LONG TERM CARE CONTINUUM
APPROPRIATION 2009 - 2011 BIENNIUM $514,995,382

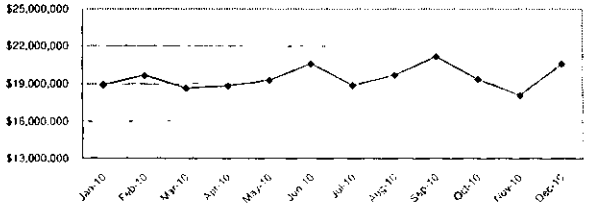
	Budget (8/09-12/10)		Actual Paid (8/09-12/10)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
Nursing Homes (& Hospice)	3,324	5,222	3,142	5,172	276,206,930	63.8%
Basic Care	453	1,639	497	1,805	15,255,812	84.2%
SPED	1,562	451	1,306	379	8,421,928	48.1%
Expanded SPED	125	233	117	242	480,323	66.1%
TBI - Waiver	27	3,293	28	3,386	1,591,455	73.7%
Aged & Disabled Waiver	297	880	264	914	4,103,807	62.7%
Targeted Case Management	458	176	471	123	983,643	50.2%
Personal Care Option	653	1,543	622	1,538	16,262,412	64.9%
Tech. Dep. Waiver	2	8,766	1	10,017	170,286	32.0%
Medically Fragile Waiver	10	4,240	3	1,153	32,281	2.8%
PACE	69	4,054	44	4,028	3,032,919	41.0%
Total Long-Term Care Continuum Expenditures to Date					$ 326,541,796	63.4%

PROGRAM NOTES:
The nursing home expenditures are less than budgeted due to nursing home construction projects being completed at a later date than anticipated, and nursing home occupancy rates being less than budgeted.

Recipient Claims Paid for the Long Term Care Continuum for the Last 12 Months



Long Term Care Continuum Expenditures for the Last 12 Months

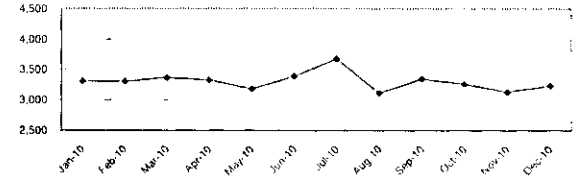


Section 11 - DEVELOPMENTAL DISABILITIES
APPROPRIATION 2009 - 2011 BIENNIUM $346,197,746

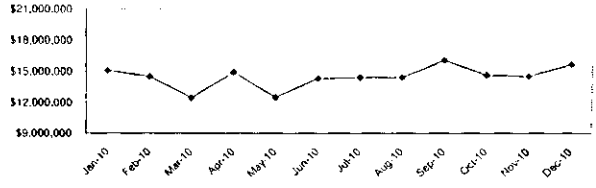
	Actual Paid (8/09-12/10)			
Service	Monthly Average Number of People Receiving	Monthly Average Cost Per Person	Spent to Date	Percentage of Appropriation Used to Date**
ICF/MR	433	10,879	80,148,968	70.6%
ISLA	711	4,160	50,294,017	61.3%
MSLA	198	5,396	18,183,308	85.7%
Day Supports	1,047	2,139	38,078,237	73.4%
Other			53,259,207	68.6%
Total Developmental Disabilities Expenditures to Date			$ 239,963,737	69.3%

PROGRAM NOTES:
Fluctuations in expenses due to the timing of when payments are made.

Recipient Claims Paid for Developmental Disabilities for the Last 12 Months

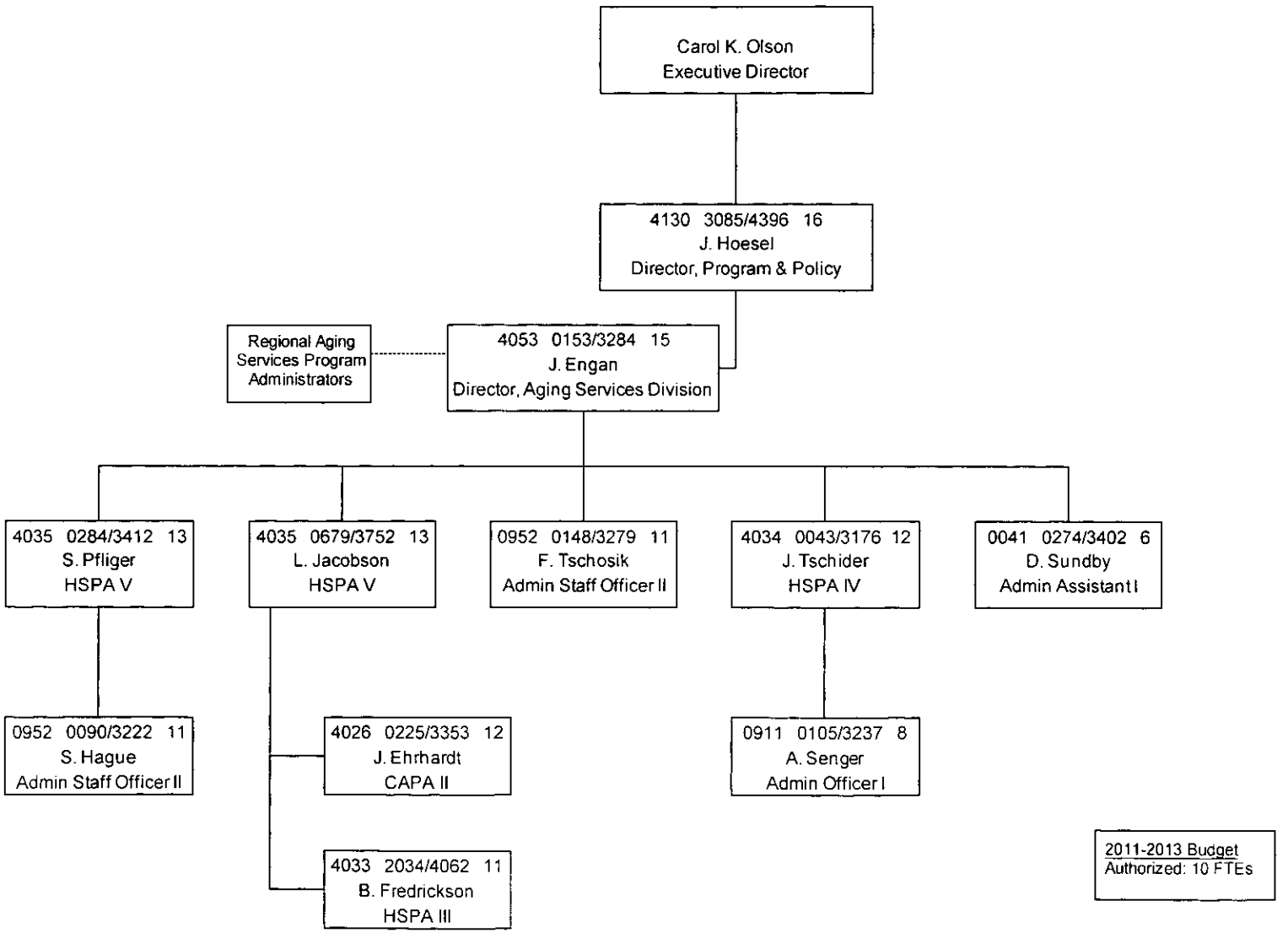


Developmental Disabilities Expenditures for the Last 12 Months



**Percent of Biennium Expired 70.8% - Payments for Child Care, Developmental Disabilities, Long Term Care, Medical Assistance and Medicare Clawback are made when a billing for the previous month's services have been received. Therefore, approximately 17 months of payments have been made or 70.8% (17/24) of the biennium has expired.

North Dakota Department of Human Services
Aging Services Division



- Jan Engan
- SB 2012
- March 14, 2011
- Attachment Two

Revised 2/25/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-43 AGING SERVICES											
		S101 FULL-TIME EQUIVALENTS (FTEs)		10.000	10.000	0.000	0.000	0.000	10.000	0.000	10.000
32510	B	511000 Salaries - Permanent		878,708	1,009,609	481,130	(529)	0	1,009,080	0	1,009,080
32510	B	516000 Fringe Benefits		297,667	370,579	173,219	2,961	(2)	373,538	0	373,538
32510	B	599110 Salary Increase		0	0	0	0	45,862	45,862	0	45,862
32510	B	599160 Benefit Increase		0	0	0	0	7,754	7,754	0	7,754
32510	B	599161 Health Increase		0	0	0	0	14,556	14,556	0	14,556
32510	B	599162 Retirement Increase		0	0	0	0	10,494	10,494	0	10,494
32510	B	599163 EAP Increase		0	0	0	0	30	30	0	30
			Subtotal:	1,176,375	1,380,188	654,349	2,432	78,694	1,461,314	0	1,461,314
32510	F	F_1991 Salary - General Fund		382,952	455,419	313,929	344,563	78,696	878,678	0	878,678
32510	F	F_1992 Salary - Federal Funds		788,835	924,769	340,420	(342,131)	(2)	582,636	0	582,636
32510	F	F_1993 Salary - Other Funds		4,588	0	0	0	0	0	0	0
			Subtotal:	1,176,375	1,380,188	654,349	2,432	78,694	1,461,314	0	1,461,314
32530	B	521000 Travel		55,859	79,962	35,436	49,716	0	129,678	0	129,678
32530	B	531000 Supplies - IT Software		5,260	5,000	3,833	1,500	0	6,500	0	6,500
32530	B	532000 Supply/Material-Professional		4,400	3,339	1,060	(701)	0	2,638	0	2,638
32530	B	534000 Bldg, Grounds, Vehicle Supply		18	30	0	(30)	0	0	0	0
32530	B	535000 Miscellaneous Supplies		10,541	7,100	4,415	(2,000)	0	5,100	0	5,100
32530	B	536000 Office Supplies		3,418	3,300	1,053	2,600	0	5,900	0	5,900
32530	B	541000 Postage		173	910	20	1,190	0	2,100	0	2,100
32530	B	542000 Printing		21,136	13,300	10,621	13,911	0	27,211	0	27,211
32530	B	552000 Other Equip under $5,000		295	0	0	0	0	0	0	0
32530	B	553000 Office Equip & Furniture-Under		4,314	6,800	6,526	(3,500)	0	3,300	0	3,300
32530	B	561000 Utilities		516	600	204	0	0	600	0	600
32530	B	571000 Insurance		0	1,200	0	300	0	1,500	0	1,500
32530	B	582000 Rentals/Leases - Bldg/Land		49,553	56,350	29,224	19,160	0	75,510	0	75,510
32530	B	591000 Repairs		1,653	2,328	284	(1,747)	0	581	0	581
32530	B	601000 IT - Data Processing		403	500	271	100	0	600	0	600
32530	B	602000 IT-Communications		4,797	4,800	2,520	2,529	0	7,329	0	7,329

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Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-43 AGING SERVICES											
32530	B	611000 Professional Development		25,177	27,810	16,405	(3,549)	0	24,261	0	24,261
32530	B	621000 Operating Fees and Services		12,299,242	12,827,401	6,478,032	642,402	0	13,469,803	0	13,469,803
			Subtotal:	12,486,755	13,040,730	6,589,904	721,881	0	13,762,611	0	13,762,611
32530	F	F_3991 Operating - General Fund		1,163,887	2,129,423	1,051,021	458,175	0	2,587,598	0	2,587,598
32530	F	F_3992 Operating - Federal Funds		11,319,797	10,911,115	5,538,883	263,898	0	11,175,013	0	11,175,013
32530	F	F_3993 Operating - Other Funds		3,071	192	0	(192)	0	0	0	0
			Subtotal:	12,486,755	13,040,730	6,589,904	721,881	0	13,762,611	0	13,762,611
32550	B	683000 Other Capital Payments		187	0	0	0	0	0	0	0
			Subtotal:	187	0	0	0	0	0	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		61	0	0	0	0	0	0	0
32550	F	F_5992 Land & Cptl Imprv - Fed Funds		125	0	0	0	0	0	0	0
32550	F	F_5993 Land & Cptl Imprv - Other Fnds		1	0	0	0	0	0	0	0
			Subtotal:	187	0	0	0	0	0	0	0
32560	B	712000 Grants, Benefits & Claims		2,158,702	2,935,668	916,235	(28,726)	0	2,906,942	(10,000)	2,896,942
			Subtotal:	2,158,702	2,935,668	916,235	(28,726)	0	2,906,942	(10,000)	2,896,942
32560	F	F_6991 Grants - General Fund		0	1,200,000	113	10,000	0	1,210,000	(10,000)	1,200,000
32560	F	F_6992 Grants - Federal Funds		1,716,298	1,425,668	816,278	(8,726)	0	1,416,942	0	1,416,942
32560	F	F_6993 Grants - Other Funds		442,404	310,000	99,844	(30,000)	0	280,000	0	280,000
			Subtotal:	2,158,702	2,935,668	916,235	(28,726)	0	2,906,942	(10,000)	2,896,942

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-43 AGING SERVICES										
		Subdivision Budget Total:	15,822,019	17,356,586	8,160,488	695,587	78,694	18,130,867	(10,000)	18,120,867
		General Funds:	1,546,900	3,784,842	1,365,063	812,738	78,696	4,676,276	(10,000)	4,666,276
	300-43 AGING SERVICES	Federal Funds:	13,825,055	13,261,552	6,695,581	(86,959)	(2)	13,174,591	0	13,174,591
		Other Funds:	450,064	310,192	99,844	(30,192)	0	280,000	0	280,000
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	15,822,019	17,356,586	8,160,488	695,587	78,694	18,130,867	(10,000)	18,120,867

Aging Services - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Prairie Hills Plaza	1,970.90	15.34	34,987	25,481		60,468
ADRC office space				13,692		13,692
Various Aging Booth Rentals			886	464		1,350
Total Rentals/Leases - Bldg/Land			**35,873**	**39,637**	-	**75,510**

Aging Services - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Funds	Total
Guardianship (Purchase of Service & Coop Agreement)	40,000			40,000
QSP Training (Purchase of Service & Coop Agreement)	48,494	46,506		95,000
State Funds to Providers (Purchase of Service & Coop Agreement)	1,174,668			1,174,668
Committee on Aging (Purchase of Service & Coop Agreement)	4,000			4,000
ADRC (Purchase of Service & Coop Agreement)		191,014		191,014
Preventive Health (Purchase of Service & Coop Agreement)		210,261		210,261
Title III-B Support Community Service (Purchase of Service & Coop Agreement)		2,501,851		2,501,851
Title III C-1 Congregate Nutrition (Purchase of Service & Coop Agreement)	1,200,000	3,173,510		4,373,510
Title III C-2 Home Delivered Nutrition (Purchase of Service & Coop Agreement)		2,154,992		2,154,992
NSIP (Purchase of Service & Coop Agreement)		1,612,266		1,612,266
Title III -E Family Caregiver Support Program (Purchase of Service & Coop Agreement)		1,020,496		1,020,496
Advertising Fee (Administration)	2,802	2,048		4,850
Service Awards	716	524		1,240
Freight & Express	121	89		210
Research Fees (Administration)	58	42		100
Advertising Fee (ADRC)		66,945		66,945
Research Fees (ADRC)		18,400		18,400
Total Operating Fees and Services	**2,470,859**	**10,998,944**	**-**	**13,469,803**

Aging Services - 2011-13 Biennium Budget

Budget Account Code 712000 - Grants, Benefits & Claims

Description	General Fund	Funds	Funds	Total
Telecommunications Equip Dist			280,000	280,000
Alzheimer's Demonstration Proj	1,200,000			1,200,000
Senior Employment		1,416,942		1,416,942
Total Grants,Benefits & Claims	**$ 1,200,000**	**$ 1,416,942**	**$ 280,000**	**$ 2,896,942**

-Jan Engan -Attachment THREE
-SB 2012 -March 14, 2011

facilities, assisted living, swing bed, transitional care units and basic care facilities. State and Federal law address the requirements of the program. There has been an increase in both nursing facility and basic care beds and assisted living units in North Dakota. For example: Bismarck-Mandan increased nursing facility and basic care beds 21% from 2008 to 2009 with an additional increase of 14.5% in 2010; this community also increased assisted living units by 105% from 2008 to 2009 with an additional 4% increase expected in 2010.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Salary and Wages	1,380,188	81,126	1,461,314		1,461,314
Operating	13,040,730	721,881	13,762,611		13,762,611
Grants	2,935,668	(28,726)	2,906,942	(10,000)	2,896,942
Total	17,356,586	774,281	18,130,867	(10,000)	18,120,867
General Funds	3,784,842	891,434	4,676,276	(10,000)	4,666,276
Federal Funds	13,261,552	(86,961)	13,174,591		13,174,591
Other Funds	310,192	(30,192)	280,000		280,000
Total	17,356,586	774,281	18,130,867	(10,000)	18,120,867
FTE	10	0	10		10

Budget Changes from Current Budget to the Executive Budget:

The Salary and Wages line item is increased by $81,126:

- An increase of $78,694 in total funds of which $78,696 is general fund needed to fund the Governor's salary package for state employees.
- An increase of $25,750 in total funds of which $15,228 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.

- Operating Fees and Services has a net increase of $642,402 that mainly includes the following:
  - An increase in federal funds of $99,967 related to the ADRC demonstration project (the $99,967 increase includes the $19,579 moved from salaries to operating fees and services);
  - An increase in federal funds of $35,000 related to increasing the funding available for QSP training;
  - A general fund increase of $83,468 for State Funds to Providers to continue the inflationary increase provided for in the 2009-2011 biennium and to provide a 3% per year inflationary increase in the 2011-2013 biennium;
  - An increase in Title-III federal funding of $649,359 for: Title III-B Support ($115,607), Home Delivered Meals ($235,796), Family Caregiver Support ($71,454) and Congregate Nutrition ($226,502);
  - A general fund increase of $300,000 for Congregate Nutrition;
  - A decrease in federal funds of $485,000 due to the removal of ARRA funds of $325,000 related to congregate nutrition and $160,000 for home delivered nutrition;
  - Decrease in federal funds to the Nutrition Services Incentive Program of $45,384.

The Grants line item decreased by $28,726 and is a combination of the following increases and decreases:

- A federal funds increase of $41,274 in the Senior Employment program comprised of a decrease of $143,288 due to the removal of ARRA funds and an increase of $184,562 due to increased federal funding.
- A general fund increase of $10,000 for the Silver Haired Assembly.

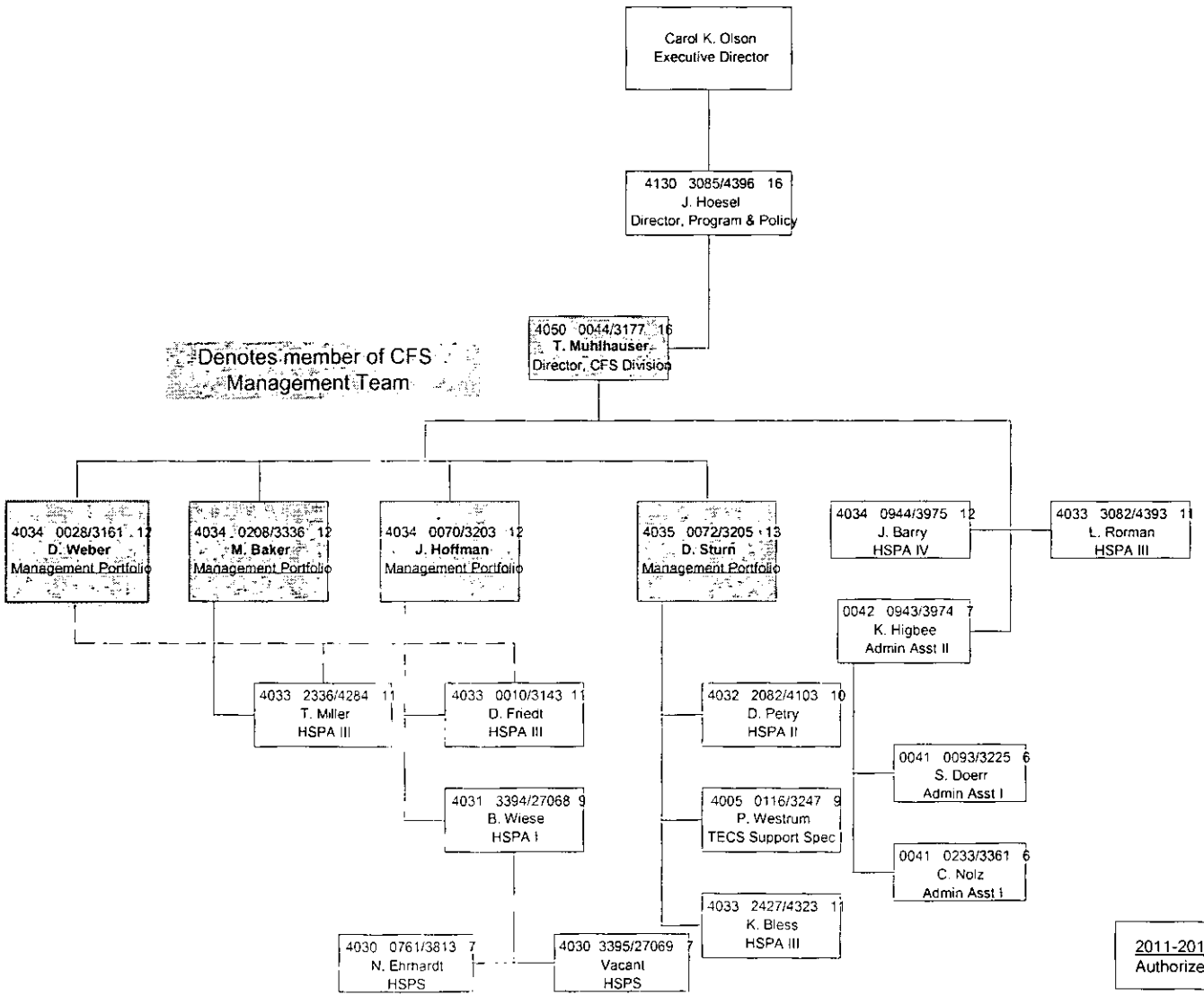
- A decrease of $30,000 of other funds in Telecommunications Equipment because less authority is needed this biennium as a result of less tax being collected for distribution.
- A federal funds decrease of $50,000 due to Senior Legal Hotline federal grant ending.

Senate Changes:

The Senate reduced grants by $10,000 from the general fund due to the removal of the grant for the Silver Haired Assembly.

This concludes my testimony on the 2011 – 2013 budget request for Aging Services Division of the Department. I would be happy to answer any questions.

North Dakota Department of Human Services
Children & Family Services Division



- March 14, 2011 - Attachment Four
- Tara Muhlhauser
- SB 2012

Revised 3/8/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-46 CHILDREN AND FAMILY SERVICES											
		S101 FULL-TIME EQUIVALENTS (FTEs)		17.000	17.000	0.000	0.000	0.000	17.000	0.000	17.000
32510	B	511000 Salaries - Permanent		1,518,132	1,892,665	770,897	(261,241)	0	1,631,424	0	1,631,424
32510	B	513000 Temporary Salaries		64,676	60,000	39,390	76,508	0	136,508	0	136,508
32510	B	514000 Overtime		4,569	7,501	3,011	(4,499)	0	3,002	0	3,002
32510	B	516000 Fringe Benefits		525,324	618,009	301,769	36,542	(1)	654,550	0	654,550
32510	B	599110 Salary Increase		0	0	0	0	74,148	74,148	0	74,148
32510	B	599160 Benefit Increase		0	0	0	0	12,561	12,561	0	12,561
32510	B	599161 Health Increase		0	0	0	0	26,199	26,199	0	26,199
32510	B	599162 Retirement Increase		0	0	0	0	16,964	16,964	0	16,964
32510	B	599163 EAP Increase		0	0	0	0	52	52	0	52
			Subtotal:	2,112,701	2,578,175	1,115,067	(152,690)	129,923	2,555,408	0	2,555,408
32510	F	F_1991 Salary - General Fund		593,925	989,448	374,570	(104,142)	65,838	951,144	0	951,144
32510	F	F_1992 Salary - Federal Funds		1,468,010	1,518,072	716,187	(22,116)	64,086	1,560,042	0	1,560,042
32510	F	F_1993 Salary - Other Funds		50,766	70,655	24,310	(26,432)	(1)	44,222	0	44,222
			Subtotal:	2,112,701	2,578,175	1,115,067	(152,690)	129,923	2,555,408	0	2,555,408
32530	B	521000 Travel		301,982	413,849	87,295	(93,068)	0	320,781	0	320,781
32530	B	531000 Supplies - IT Software		4,273	4,070	124	(3,822)	0	248	0	248
32530	B	532000 Supply/Material-Professional		20,545	25,550	4,999	600	0	26,150	0	26,150
32530	B	535000 Miscellaneous Supplies		996	2,020	82	(2,020)	0	0	0	0
32530	B	536000 Office Supplies		10,100	14,375	6,681	(562)	0	13,813	0	13,813
32530	B	541000 Postage		494	2,900	23	(2,300)	0	600	0	600
32530	B	542000 Printing		65,107	80,547	33,889	(546)	0	80,001	0	80,001
32530	B	553000 Office Equip & Furniture-Under		4,937	1,700	1,260	(700)	0	1,000	0	1,000
32530	B	571000 Insurance		30	240	180	(40)	0	200	0	200
32530	B	582000 Rentals/Leases - Bldg/Land		5,039	9,661	2,359	(3,072)	0	6,589	0	6,589
32530	B	591000 Repairs		312	320	171	14	0	334	0	334
32530	B	601000 IT - Data Processing		8,774	9,483	4,181	(6,564)	0	2,919	0	2,919
32530	B	602000 IT-Communications		2,597	4,530	833	(2,616)	0	1,914	0	1,914
32530	B	611000 Professional Development		163,190	299,387	72,168	(67,862)	0	231,525	0	231,525

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-46 CHILDREN AND FAMILY SERVICES										
32530	B	621000 Operating Fees and Services	4,550,727	4,947,791	3,132,821	110,565	0	5,058,356	0	5,058,356
32530	B	623000 Fees - Professional Services	241	1,400	660	(1,200)	0	200	0	200
		Subtotal:	5,139,344	5,817,823	3,347,726	(73,193)	0	5,744,630	0	5,744,630
32530	F	F_3991 Operating - General Fund	1,889,327	2,309,154	1,101,821	(863,545)	0	1,445,609	0	1,445,609
32530	F	F_3992 Operating - Federal Funds	3,201,668	3,454,403	2,216,679	791,633	0	4,246,036	0	4,246,036
32530	F	F_3993 Operating - Other Funds	48,349	54,266	29,226	(1,281)	0	52,985	0	52,985
		Subtotal:	5,139,344	5,817,823	3,347,726	(73,193)	0	5,744,630	0	5,744,630
32560	B	712000 Grants, Benefits & Claims	103,944,314	120,930,241	57,888,536	5,863,720	0	126,793,961	0	126,793,961
		Subtotal:	103,944,314	120,930,241	57,888,536	5,863,720	0	126,793,961	0	126,793,961
32560	F	F_6991 Grants - General Fund	19,062,256	21,761,627	9,578,031	6,894,857	0	28,656,484	0	28,656,484
32560	F	F_6992 Grants - Federal Funds	71,139,611	80,222,450	39,970,497	(3,050,470)	0	77,171,980	0	77,171,980
32560	F	F_6993 Grants - Other Funds	2,406,653	5,983,660	2,628,156	(736,211)	0	5,247,449	0	5,247,449
32560	F	F_6994 Grants - Retained Funds	244,576	132,837	127,126	475,979	0	608,816	0	608,816
32560	F	F_6995 Grants - County Funds	11,091,218	12,829,667	5,584,726	2,279,565	0	15,109,232	0	15,109,232
		Subtotal:	103,944,314	120,930,241	57,888,536	5,863,720	0	126,793,961	0	126,793,961
		Subdivision Budget Total:	111,196,359	129,326,239	62,351,329	5,637,837	129,923	135,093,999	0	135,093,999
300-46 CHILDREN AND FAMILY SERVICES		**General Funds:**	21,545,508	25,060,229	11,054,422	5,927,170	65,838	31,053,237	0	31,053,237
		Federal Funds:	75,809,289	85,194,925	42,903,363	(2,280,953)	64,086	82,978,058	0	82,978,058
		Other Funds:	2,505,768	6,108,581	2,681,692	(763,924)	(1)	5,344,656	0	5,344,656
		SWAP Funds:	244,576	132,837	127,126	475,979	0	608,816	0	608,816
		County Funds:	11,091,218	12,829,667	5,584,726	2,279,565	0	15,109,232	0	15,109,232
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	111,196,359	129,326,239	62,351,329	5,637,837	129,923	135,093,999	0	135,093,999

Children and Family Services - 2011-2013 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Paulette Westrum rent in NW Human Service Center	153.00	8.50	1,392	1,397		2,789
Meeting Rooms for licensor training & Booth Rental			307	3,493		3,800
			$ 1,699	**$ 4,890**	**$ -**	**$ 6,589**

Children and Family Services - 2011-2013 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Funds	Other Funds	Total
CFS Conference speaker fees	2,750	8,250		11,000
Years of Service Awards	633	1,251	1	1,885
Dues and memberships	433	865	2	1,300
AASK Contract	1,500,463	910,064		2,410,527
Five Year grant application		20,000		20,000
NARA licenser training		20,000		20,000
Advertising Rule changes	1,698	3,452		5,150
Background Checks - adoptions, child care, foster care	108,865	107,809	26,862	243,536
Intensive In-Home contract	238,864	1,667,190		1,906,054
County Wide Cost Allocation contract		429,234		429,234
Legal Fees & Transcripts	198	4,102		4,300
Other Miscellaneous Fees & Services	1,188	4,182		5,370
	$ 1,855,092	**$ 3,176,399**	**$ 26,865**	**$ 5,058,356**

Children & Family Services - 2011-13 Biennium
County Breakdown

Name	County		
Foster Care	10,922,294		
Subsidized Adoption	3,154,514		
Wraparound Targeted Case Mgmt	969,850	1,032,424	"Family Preservation & Family Services Grants"
Intensive In-Home Medicaid	62,574		
Total	15,109,232		

Department of Human Services
Children and Family Services Division
Grants Summary 2011-2013 Biennium

Dept Desc	Bgt Acct Desc	Current Budget 2009 - 2011	Cont Prgm Changes	Cost Changes	Caseload Changes	FMAP Changes	Remove One-Time Funding	Executive Budget Recommendation	Total Budget Changes	2011-2013 To House
Child Abuse & Prevention	General Fund	$839,680	($108,754)						($108,754)	$730,926
Child Abuse & Prevention	Federal Funds	$1,010,387	$111,293						$111,293	$1,121,680
Child Abuse & Prevention	Other Funds	$424,837	($102,539)						($102,539)	$322,298
Child Abuse & Prevention	**Grants**	$2,274,904	($100,000)						($100,000)	$2,174,904
Independent Living Programs	Federal Funds	$1,926,396	$6,170				($870,667)		($864,497)	$1,061,899
Independent Living Programs	**Grants**	$1,926,396	$6,170				($870,667)		($864,497)	$1,061,899
Refugee Grants	Federal Funds	$3,966,410	($2,722,300)						($2,722,300)	$1,244,110
Refugee Grants	**Grants**	$3,966,410	($2,722,300)						($2,722,300)	$1,244,110
Child Care Licensing Pmts to Counties	General Fund	$57,842	$9,130					$31,683	$40,813	$98,655
Child Care Licensing Pmts to Counties	Federal Funds	$630,117							$0	$630,117
Child Care Licensing Pmts to Counties	**Grants**	$687,959	$9,130					$31,683	$40,813	$728,772
Child Care grants to nonprofit Agencies	General Fund	$166,221							$0	$166,221
Child Care grants to nonprofit Agencies	Federal Funds	$5,844,000	$602,626				($3,644,000)		($3,041,374)	$2,802,626
Child Care grants to nonprofit Agencies	Other Funds	$815,842	($815,842)						($815,842)	$0
Child Care grants to nonprofit Agencies	**Grants**	$6,826,063	($213,216)				($3,644,000)		($3,857,216)	$2,968,847
Child Abuse/Neglect Assessment Pmts	General Fund	$956,034	$112,887					$264,366	$377,253	$1,333,287
Child Abuse/Neglect Assessment Pmts	Federal Funds	$4,747,706							$0	$4,747,706
Child Abuse/Neglect Assessment Pmts	**Grants**	$5,703,740	$112,887					$264,366	$377,253	$6,080,993
Reimbursement to Counties	General Fund	$3,005,383	($409,954)						($409,954)	$2,595,429
Reimbursement to Counties	Federal Funds	$9,492,820	($1,064,832)						($1,064,832)	$8,427,988
Reimbursement to Counties	Other Funds	$23,760							$0	$23,760
Reimbursement to Counties	Retained Funds	$132,837	$475,979						$475,979	$608,816
Reimbursement to Counties	**Grants**	$12,654,800	($998,807)						($998,807)	$11,655,993
Family Preservation & Family Services	General Fund	$1,761,670	($431,071)					$216,248	($214,823)	$1,546,847
Family Preservation & Family Services	Federal Funds	$6,449,761	$1,743,720					$102,544	$1,846,264	$8,296,025
Family Preservation & Family Services	Other Funds		$300,000						$300,000	$300,000
Family Preservation & Family Services	County Funds	$56,376	$931,202					$44,846	$976,048	$1,032,424
Family Preservation & Family Services	**Grants**	$8,267,807	$2,543,851					$363,638	$2,907,489	$11,175,296
Foster Care-Training	General Fund	$688,586	($32,632)						($32,632)	$655,954
Foster Care-Training	Federal Funds	$1,201,806	$32,632						$32,632	$1,234,438
Foster Care-Training	**Grants**	$1,890,392							$0	$1,890,392
Subsidized Adoption	General Fund	$7,003,216		($1,751)	$826,827	$930,345		$401,328	$2,156,749	$9,159,965
Subsidized Adoption	Federal Funds	$8,437,106		$77,973	$296,884	($1,261,486)		$343,768	($542,861)	$7,894,245
Subsidized Adoption	County Funds	$2,406,764		$61	$278,228	$331,141		$138,320	$747,750	$3,154,514
Subsidized Adoption	**Grants**	$17,847,086		$76,283	$1,401,939			$883,416	$2,361,638	$20,208,724
Foster Care	General Fund	$7,282,995	($85,181)	$250,747	$1,464,291	$1,789,927		$1,666,421	$5,086,205	$12,369,200
Foster Care	Federal Funds	$36,515,941	($1,964)	$1,566,723	$3,036,952	($2,196,565)		$790,059	$3,195,205	$39,711,146
Foster Care	Other Funds	$4,719,221		($117,830)					($117,830)	$4,601,391
Foster Care	County Funds	$10,356,527		($763,973)	$431,447	$406,638		$481,655	$555,767	$10,922,294
Foster Care	**Grants**	$58,884,684	($87,145)	$935,667	$4,932,690			$2,938,135	$8,719,347	$67,604,031
Total	General Fund	$21,761,627	($945,575)	$248,996	$2,291,118	$2,720,272	$0	$2,580,046	$6,894,857	$28,656,484
Total	Federal Funds	$80,222,450	($1,292,655)	$1,644,696	$3,333,836	($3,458,051)	($4,514,667)	$1,236,371	($3,050,470)	$77,171,980
Total	Other Funds	$5,983,660	($618,381)	($117,830)	$0	$0	$0	$0	($736,211)	$5,247,449
Total	Retained Funds	$132,837	$475,979	$0	$0	$0	$0	$0	$475,979	$608,816
Total	County Funds	$12,829,667	$931,202	($763,912)	$709,675	$737,779	$0	$664,821	$2,279,565	$15,109,232
Grand Total	**Grants**	$120,930,241	($1,449,430)	$1,011,950	$6,334,629	$0	($4,514,667)	$4,481,238	$5,863,720	$126,793,961

* The Senate made no changes in this area of the budget.

-Attachment FIVE
-LC
-March 14, 2011
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15. Provides $396,996,033, of which $174,231,307 is from the general fund, for **developmental disabilities services** under the long-term care program compared to $341,542,546, of which $110,730,341 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$13,015,970	$25,476,514	$38,492,484
Adds general fund support as a result of FMAP changes	$36,993,542	($36,993,542)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$23,091,088	($23,091,088)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$7,475,018	$9,503,377	$16,978,395
The Senate added funding of $11,364,049, of which $5,021,489 is from the general fund, for a supplemental payment to developmental disabilities providers to allow for a 50-cent per hour salary and benefit increase for employees beginning July 1, 2011.			
16. Provides $66,850,710, of which $12,122,010 is from the general fund, for **foster care services** compared to $58,089,459, of which $6,961,934 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$1,703,728	$4,119,388	$5,823,116
Adds general fund support as a result of FMAP changes	$455,959	($455,959)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$1,683,112	($1,683,112)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$1,666,421	$1,271,714	$2,938,135
17. Provides $20,208,724, of which $9,159,965 is from the general fund, for **subsidized adoption** compared to the 2009-11 biennium appropriation of $17,847,086, of which $7,003,216 was from the general fund	$2,156,749	$204,889	$2,361,638
18. Provides funding and 7 FTE positions to perform functions necessary to comply with the provisions of federal health care reform	$225,507	$305,588	$531,095
19. Adds funding for a grant to the Silver Haired Legislative Assembly. **The Senate removed this funding.**	$10,000		$10,000
20. Increases funding for senior service providers to assist with the costs of providing meals to the elderly	$300,000		$300,000
21. Provides one-time federal funding for completion of vocational rehabilitation training and information technology contracts funded with federal fiscal stimulus funds in the 2011-13 biennium		$519,175	$519,715
22. Adds 1 FTE position in medical services as requested by the department in its hold-even budget request	$19,668	$61,236	$80,904
23. Adds 6 FTE positions in mental health and substance abuse as requested by the department in its hold-even budget request	$23,730	$861,666	$885,396
State Hospital			
1. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$337,029	($337,029)	$0
2. Reflects the additional state matching funds required due to changes in the state's FMAP	$97,624	($97,624)	$0
3. Adds 1 FTE pharmacist position	$190,305	$45,105	$235,410

Children & Family Services

Listing of All Grants:

Child Abuse & Prevention Activities	$	2,200,000
Independent Living Programs	$	1,100,000
Refugee Grants	$	1,200,000
Child Care Licensing Payments to Counties	$	700,000
Child Care grants to nonprofit Agencies	$	3,000,000
Child Abuse/Neglect Assessment Payments to Counties	$	6,000,000
Reimbursement to Counties for Administration of Child Welfare Programs	$	11,700,000
Family Preservation & Family Services Grants	$	11,200,000
Training Child Welfare Professionals and Family Foster Parents	$	1,900,000
Subsidized Adoption Grants	$	20,200,000
Foster Care Maintenance, Therapeutic and Subsidized Guardianship	$	67,600,000

Cost & Caseload Comparison
2011-2013 Biennium to Senate
Compared to 2009-2011 Biennium

Description	2009-2011 Budgeted Avg Monthly Caseload	2011-2013 Budgeted Avg Monthly Caseload	Difference - Increase (Decrease)		2009-2011 Budgeted Avg Monthy Cost per Case	2011-2013 Budgeted Avg Monthy Cost per Case	Difference - Increase (Decrease)
Therapeutic Foster Care	242	245	3		1,095.20	1,080.65	(14.55)
Services Foster Care	196	217	21		545.15	688.51	143.36
Foster Care - Family Homes	523	597	74		1,677.99	1,705.35	27.36
Foster Care - RCCF & GH	252	264	12		4,755.12	5,238.70	483.58
Subsidized Adoptions	992	1,073	81		749.11	785.11	36.00

Attachment A
- SB 2012
- March 14, 2011
- Tara Muhlhauser
- Attachment SIX

2011 House Bill 1018
601 Department of Commerce
Childcare Funding Comparison

	2009-2011 Appropriation				2011-2013 Executive Recommendation			
	General Fund	Federal Funds	Special Funds	Total Funds	General Fund	Federal Funds	Special Funds	Total Funds
One-Time Funding								
Childcare Grants	$ 520,338	$ -	$ -	$ 520,338	$ 520,338			$ 520,338
Childcare Loans	1,299,662	-	-	1,299,662	400,000	-	-	400,000
Childcare Training	-	-	-	-	150,000	-	-	150,000
Ongoing Funding								
Childcare Service Provider Workforce Recruitment, Training, and Retention	-	-	-	-	-	-	-	-
Carryover from 2009-11 (one-time GPARC)	-	-	-	-	-	-	-	-
Total Appropriation	**$ 1,820,000**	**$ -**	**$ -**	**$ 1,820,000**	**$ 1,070,338**	**$ -**	**$ -**	**$ 1,070,338**

	2011-13 House Version				Changes from Executive Budget			
	General Fund	Federal Funds	Special Funds	Total Funds	General Fund	Federal Funds	Special Funds	Total Funds
One-Time Funding								
Childcare Grants	$ 120,338	$ -	$ -	$ 120,338	$ (400,000)	$ -	$ -	$ (400,000)
Childcare Loans	250,000	-	-	250,000	(150,000)	-	-	(150,000)
Childcare Training	-	-	-	-	(150,000)	-	-	(150,000)
Ongoing Funding								
Childcare Service Provider Workforce Recruitment, Training, and Retention	4,935,000	-	-	4,935,000	4,935,000	-	-	4,935,000
Carryover from 2009-11 (one-time GPARC)	65,000	-	-	65,000	65,000	-	-	65,000
Total Appropriation	**$ 5,370,338**	**$ -**	**$ -**	**$ 5,370,338**	**$ 4,300,000**	**$ -**	**$ -**	**$ 4,300,000**

- March 14, 2011
- SB 2012
- OMB
- Attached SEVEN

- Attachment ONE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 15, 2011

Chairman Pollert, members of the House Appropriation Committee – Human Resources Division, I am Marilyn Rudolph, Director of Northwest Human Service Center (NWHSC) and North Central Human Service Center (NCHSC) of the Department of Human Services (DHS). I am here today to provide you an overview of the budgets for both Northwest and North Central Human Service Centers.

Northwest Human Service Center

Caseload / Customer Base

- Northwest HSC serves the three county area of Divide, McKenzie and Williams counties, with an estimated population of 28,211.
- Northwest HSC serves 1,545 unduplicated clients annually.
- In addition Northwest Human Service Center's Vocational Rehabilitation program serves 401 individuals.
- The impact of the growing population is evident in the number of calls for information and referral. In 2009, Northwest HSC received 181 calls, and in 2010 that number increased to 465. Information and referral calls often eventually become ongoing clients.

Program Trends / Major Program Changes

- Northwest Human Service Center has developed a full continuum of Alcohol and other Drug Treatment since 2009. The Center has drawn staff from the allocated 45.75 FTE's by reclassifying positions that were vacated in Outpatient and Extended Care. This has all units operating at capacity.
- Catholic Health Initiatives, the parent company of Mercy Hospital, notified Northwest Human Service Center of its intention to close Mercy Mental Health Unit and eventually Mercy Recovery Center. Two thousand ten has been a year of challenge because of the closing of Mercy Mental Health.
- In 2009 seventy-six individuals were referred for commitment to the North Dakota State Hospital; fifty-two were placed in community based treatment because we could stabilize individuals in the Mercy Mental Health Unit and then place them in a safe community setting. After closure of Mercy Mental Health, we had seventy-one individuals referred for commitment; twenty-three were served in the community, thirty were placed in the North Dakota State Hospital and eighteen were transferred to Trinity Hospital in Minot for stabilization or detoxification. Having the mental health unit allowed twice as many individuals to be served in the community, which is more cost effective, as well as providing "close to home" care for the clients. It also does not burden partnering agencies, such as the Sheriff's Department, with the cost of transportation to Minot or Jamestown. I must commend Trinity Hospital for being and excellent resource when detoxification or mental health stabilization was necessary in the short term, prior to admission to the North Dakota State Hospital.
- A critical resource for Williston has been our partnership with North Dakota Association for the Disabled and the ability to contract to

develop residential options to provide safe supervised living situations for individuals in crisis or in treatment. Williston has twenty-six beds available ranging from crisis residential, to long term addiction treatment, to supportive housing for individuals with serious mental illness. This allows clients to maintain stability and receive the full benefit of treatment. The availability of these beds allows for medication monitoring, maintenance of nutritional meals and the ability for community based care, as opposed to hospitalization. It is a cost effective solution.

- In the past year, staff from Northwest responded to a critical community incident. In Williston, a team of three clinicians assisted school counselors and ministerial staff in grief counseling and debriefing after the tragic murder/suicide of two young people. Family and community members wrote notes to us thanking us for the availability of our staff and the support.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Senate Changes	Increase/Decrease
Northwest HSC	8,510,654	8,749,068	0	238,414
General Funds	4,724,962	4,958,832	0	233,870
Federal Funds	3,436,804	3,321,230	0	(115,574)
Other Funds	348,888	469,006	0	120,118
Total	8,510,654	8,749,068	0	238,414
FTE	45.75	45.75	0.00	0.00

Budget Changes from Current Budget to the Executive Budget:

Salaries and benefits increased by $197,803 and can be attributed to the following:

- $332,043 in total funds of which $257,326 is general fund needed to fund the Governor's salary package for state employees.

- $142,174 in total funds of which $110,928 is general fund needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.
- An increase of $68,293 to cover underfunding of salaries from the 2009 – 2011 budgets.
- A decrease of $32,035 to underfund the 2011 – 2013 pay plans.
- The remaining decrease of $312,672 is based on the replacement of long time staff with new staff and the reclassification of positions as well as lower temporary salaries, overtime and fringe benefit cost.

Operating expenses decreased by $22,518 (2.1%). This reduction is a combination of increases expected next biennium offset by decreases as follows:

- A decrease in the travel budget based on usage when the budget was being prepared.
- A decrease in the purchase of office equipment and furniture.
- A decrease in building rent.
- A decrease in professional development based on the setting of a consistent amount per FTE.
- Smaller decreases in miscellaneous supplies, postage, IT equipment and medical supplies account for balance of the overall reduction.

Total budgeted expenses for grants increased $63,129 (4.9%). The inflationary increase of 3%/3% accounts for $58,663 of the total increase. Without the inflationary increase the biennium to biennium increase would be $4,466 (.3%).

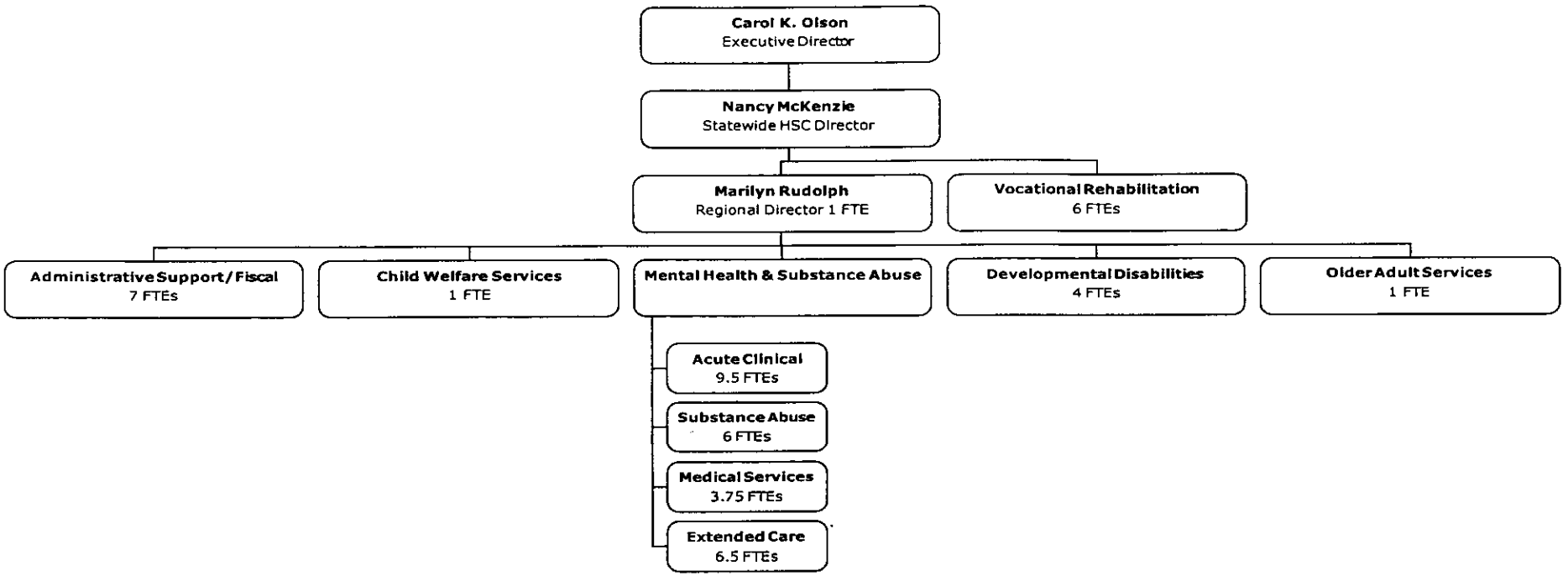
The general fund request increased $233,870. The governor's salary package for state employees included $257,326 in general fund.

Federal funds decreased $115,574 while other funds increased $120,118.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

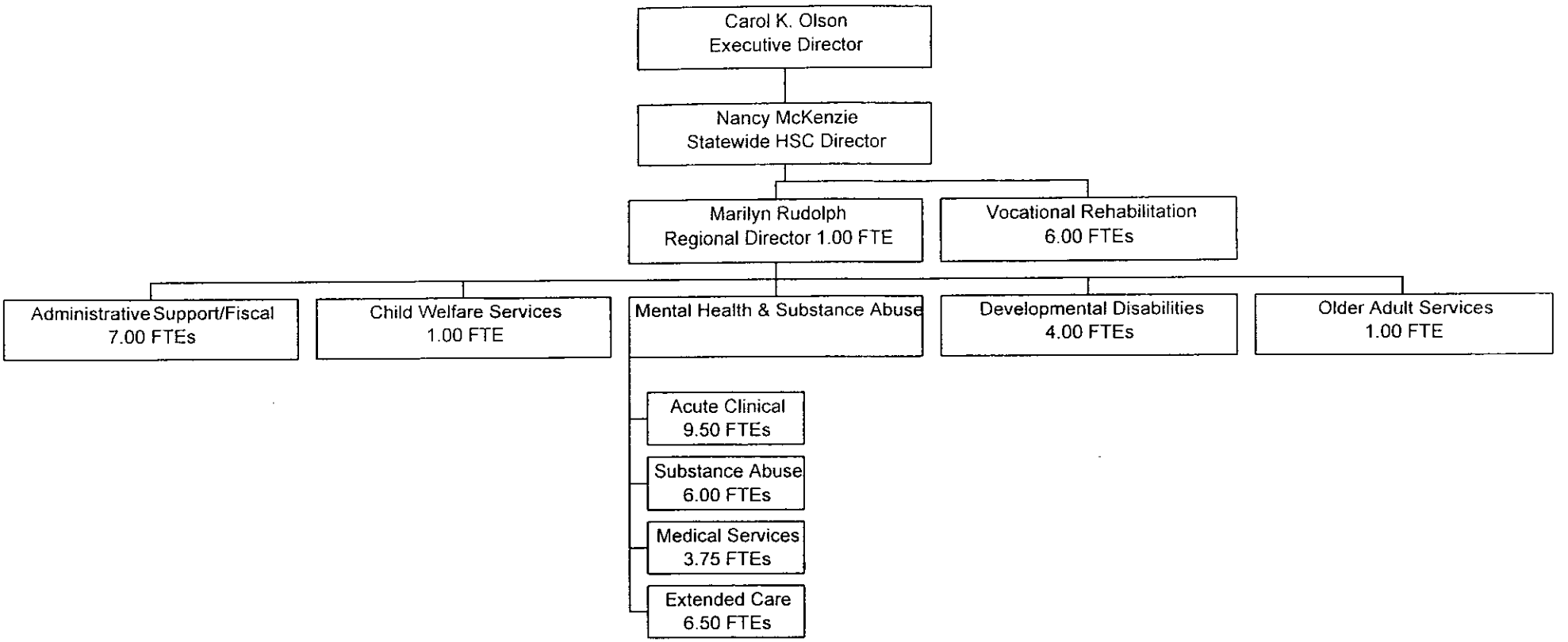
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTHWEST HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 45.75 FTEs

Revised 3/4/11

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTHWEST HUMAN SERVICE CENTER



2011 - 2013
45.75 Budgeted FTEs

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-71 NORTHWEST HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	44.750	45.750	0.000	0.000	0.000	45.750	0.000	45.750
32570	B	511000 Salaries - Permanent	3,342,899	4,203,882	1,925,281	(53,834)	0	4,150,048	0	4,150,048
32570	B	513000 Temporary Salaries	194,638	228,338	109,571	(26,064)	0	202,274	0	202,274
32570	B	514000 Overtime	7,396	3,500	1,368	(3,500)	0	0	0	0
32570	B	516000 Fringe Benefits	1,254,730	1,693,667	804,563	(18,807)	2	1,674,862	0	1,674,862
32570	B	519100 Reduction in Salary - Budget	0	0	0	(32,035)	0	(32,035)	0	(32,035)
32570	B	521000 Travel	171,896	213,174	87,019	(36,363)	0	176,811	0	176,811
32570	B	531000 Supplies - IT Software	15,498	7,672	4,913	3,028	0	10,700	0	10,700
32570	B	532000 Supply/Material-Professional	17,276	14,570	8,366	480	0	15,050	0	15,050
32570	B	533000 Food and Clothing	4,225	5,492	2,686	558	0	6,050	0	6,050
32570	B	534000 Bldg, Grounds, Vehicle Supply	4,513	3,147	2,024	1,353	0	4,500	0	4,500
32570	B	535000 Miscellaneous Supplies	16,849	12,357	5,157	(155)	0	12,202	0	12,202
32570	B	536000 Office Supplies	14,281	8,054	7,404	7,946	0	16,000	0	16,000
32570	B	541000 Postage	6,482	17,616	5,233	(2,616)	0	15,000	0	15,000
32570	B	542000 Printing	5,561	2,725	2,455	5,775	0	8,500	0	8,500
32570	B	551000 IT Equip under $5,000	0	125	125	(125)	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	17,231	18,392	12,464	(13,392)	0	5,000	0	5,000
32570	B	581000 Rentals/Leases-Equip & Other	5,323	2,988	2,399	1,512	0	4,500	0	4,500
32570	B	582000 Rentals/Leases - Bldg/Land	424,187	601,587	297,061	(16,152)	0	585,435	0	585,435
32570	B	591000 Repairs	77,474	61,990	28,848	972	0	62,962	0	62,962
32570	B	599110 Salary Increase	0	0	0	0	188,473	188,473	0	188,473
32570	B	599160 Benefit Increase	0	0	0	0	31,898	31,898	0	31,898
32570	B	599161 Health Increase	0	0	0	0	68,409	68,409	0	68,409
32570	B	599162 Retirement Increase	0	0	0	0	43,123	43,123	0	43,123
32570	B	599163 EAP Increase	0	0	0	0	138	138	0	138
32570	B	602000 IT-Communications	72,360	72,799	37,621	3,629	0	76,428	0	76,428
32570	B	611000 Professional Development	9,243	12,508	11,378	(5,315)	0	7,193	0	7,193
32570	B	621000 Operating Fees and Services	38,784	37,984	17,142	26,994	0	64,978	0	64,978
32570	B	625000 Medical, Dental and Optical	314	2,147	754	(647)	0	1,500	0	1,500
32570	B	691000 Equipment Over $5000	31,411	0	0	0	0	0	0	0
32570	B	712000 Grants, Benefits & Claims	1,597,144	1,285,940	612,991	63,129	0	1,349,069	0	1,349,069

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-71 NORTHWEST HSC									
	Subtotal:	7,329,715	8,510,654	3,986,823	(93,629)	332,043	8,749,068	0	8,749,068
32570 F	F_7091 HSCs & Institutions - Gen Fund	4,123,162	4,724,962	2,228,588	(23,456)	257,326	4,958,832	0	4,958,832
32570 F	F_7092 HSCs & Institutions - Fed Fnds	2,840,758	3,436,804	1,639,332	(190,291)	74,717	3,321,230	0	3,321,230
32570 F	F_7093 HSCs & Institutions - Oth Fnds	365,795	348,888	118,903	120,118	0	469,006	0	469,006
	Subtotal:	7,329,715	8,510,654	3,986,823	(93,629)	332,043	8,749,068	0	8,749,068
	Subdivision Budget Total:	7,329,715	8,510,654	3,986,823	(93,629)	332,043	8,749,068	0	8,749,068
	General Funds:	4,123,162	4,724,962	2,228,588	(23,456)	257,326	4,958,832	0	4,958,832
	Federal Funds:	2,840,758	3,436,804	1,639,332	(190,291)	74,717	3,321,230	0	3,321,230
410-71 NORTHWEST HSC	**Other Funds:**	365,795	348,888	118,903	120,118	0	469,006	0	469,006
	SWAP Funds:	0	0	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0	0	0
	Subdivision Funding Total:	7,329,715	8,510,654	3,986,823	(93,629)	332,043	8,749,068	0	8,749,068

NW Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/11/2011

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	8.50	425,355	110,387	314,968
A&D Residential Program	8.50	91,800	91,800	0
A&D Residential Apartments		52,800	52,800	0
Crosby Office		6,000	2,389	3,611
Watford City Office		8,400	3,345	5,055
Total Rentals & Leases Budget Account Code		**584,355**	**260,721**	**323,634**

NW Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Advertising Services	1,488	1,115	373
Service Awards	2,650	1,345	1,305
Freight and Express	3,150	2,072	1,078
Licenses & Taxes - Staff Licenses	3,485	1,812	1,673
Other Miscellaneous - Assistance for Homeless clients	4,000	1,957	2,043
Other Miscellaneous	6,525	4,559	1,966
Purchase of Services - After-hours emergency answering services	3,000	1,147	1,853
Purchase of Services - Aging Services Outreach Program	38,730	0	38,730
Radio-TV-Newspaper Service	1,200	899	301
Research Fees - Background checks	750	562	188
Total Operating Fees & Services Budget Account Code	**64,978**	**15,468**	**49,510**

- Attachment TWO
- Marilyn Rudolph
- March 15, 2011
- SB2012

North Central Human Service Center

Caseload / Customer Base

- North Central Human Service Center serves the seven county area of Bottineau, Burke, McHenry, Mountrail, Pierce, Renville and Ward counties, with an estimated population of 83,384.
- Annually North Central HSC serves 3,225 unduplicated clients.
- In addition North Central Human Service Center's Vocational Rehabilitation program serves 351 individuals.
- The number of information and referral calls increased from 104 in 2009 to 268 in 2010.

Program Trends / Major Program Changes

- North Central Human Service Center has been the pilot site for specialized services for transition youth, ages 18-24 years. The challenge is securing housing and work for youth who often have no credit history or work experience and usually exhibit behaviors that create poor impressions. Bonnie Schriock has worked diligently with community partners to secure housing and provide guidance and direction for transition youth. Usually these individuals have been receiving services from the human service center or the county in the form of case management or foster care thus the transition care facilitator assists in that leap to adulthood.
- One area of concern is the shortage of psychiatrists nationwide and the need for psychiatric care in rural areas. North Central Human Service Center section of the DHS budget includes one additional FTE to hire a full time psychiatrist. If a full time psychiatrist is hired, this position would serve both North Central and Northwest Human Service Center providing psychiatric expertise and collaboration to all staff.
- The Governor's Budget includes funding to fill a capacity gap by implementing a crisis stabilization unit to specifically serve individuals with serious mental

illness. This would allow Region II the ability to serve individuals who need immediate supervision and structure in a safe environment in the community, reducing the need for local hospitalization or transport to the North Dakota State Hospital. This allocation includes funds to contract for staffing to serve ten individuals including psychiatric time, psychiatric nursing, a program supervisor and direct care staff for 24/7 coverage. The ability to serve individuals close to home reduces trauma, allows family input, reduces length of stay and is cost effective.

- North Central staff responded to the community of Stanley after young man's suicide. Three clinicians were available at the school to counsel students, faculty and community members. Staff successfully intervened on three occasions of potential suicide attempts. The interventions involved talking the individual down, confiscating weapons and follow up to assure community safety. Again we have received notes from these individuals expressing gratitude.

Overview of Budget Changes

Description	2009 - 2011 Budget	2011 - 2013 Budget	Senate Changes	Increase/Decrease
North Central HSC	19,382,601	22,433,884	0	3,051,283
General Funds	10,459,768	13,410,027	0	2,950,259
Federal Funds	8,073,938	8,104,420	0	30,482
Other Funds	848,895	919,437	0	70,542
Total	19,382,601	22,433,884	0	3,051,283
FTE	116.78	117.78	0.00	1.00

Budget Changes from Current Budget to the Executive Budget:

North Central Human Service Center's budget includes one new FTE. This FTE will be used to hire a full time psychiatrist.

Salaries and benefits increased by $1,392,768 and can be attributed to the following:

- $807,765 in total funds of which $618,694 is general fund needed to fund the Governor's salary package for state employees.
- $312,818 in total funds of which $245,183 is general fund needed to fund the second year employee increase for 24 months versus 12 months that are contained in the current budget.
- An increase of $86,078 to cover underfunding of salaries from the 2009 – 2011 budget.
- A decrease of $70,821 to underfund the 2011 – 2013 pay plan.
- The remaining $256,928 is a combination of increases and decreases needed to sustain the salary of the 117.78 FTE in this area of the budget.

Operating expenses increased by $272,957 (15.4%). Two major items created this increase.

- Building rent is increasing $170,840 because of the following:
    - The center's lease includes a 4% increase. This amounts to $21,620 for the biennium.
    - The center leased and additional 5,661 square feet for Rehab Employment Services Assistive Technology Lab that was not in the 2009-11 budget. The lease for this space is $113,220.
    - Since 2002 space has been rented for an A&D residential program called The House. The cost of this rent has been paid for by a grant in the Mental Health & Substance Abuse Division until June 30, 2010 when the grant ran out. The cost to continue renting space for this program is $36,000. This

supportive housing provides a much needed option for individuals completing treatment and beginning employment.

- North Central was asked to operate the Aging Services Outreach program for Region II during the current biennium. The center pays for a number of option counselors, located throughout its catchment area, to visit seniors to assess what services they may be eligible for to assist them to continue to live independently in their own homes. The budget for the option counselors is $102,320 in federal funds.
- After the above, other operating increases and decreases come to a net decrease of $203.

Budgeted expenses for grants increased $1,385,558 (36.3%) with the majority of the increase explained as follows:

- The inflationary adjustment of 3%/3% accounts for $163,259 of the increase.
- The governor's budget for North Central includes $1,444,661 to fill a capacity gap by implementing an SMI crisis stabilization unit. This would give Region II the ability to serve individuals who need more structured, supervised care in the community reducing the need for local hospitalization or referral to the State Hospital.
- The center reduced other grants $255,543 to offset part of the expense for the psychiatric position in the budget. These were contract dollars for nurse practitioner services.

The general fund request increase is $2,950,259. The following items account for 83.7% of the total general fund increase:

- Governor's salary package - $618,694

- Continuation of the second year salary increase - $245,183
- 3%/3% increase for contracted providers - $161,668
- SMI crisis stabilization unit - $1,444,661
- The remaining increase of $480,053 is associated with the overall changes in the center's budgeted expenses and revenue sources.

Federal funds increased $30,482. Other funds increased $70,542.

Northwest and North Central North Dakota are experiencing an influx of population from every part of the United States. New clients often seek help with psychiatric medication; some come with prescriptions from other states but more often, they come with only a story and need to maintain their mental health

The economic prosperity comes with a price as you have often heard. People are living in campers, insulated with snow, eating sack lunches and showering at the local Recreation Center. It is a tough life and its toll is sleep deprivation and family disruption resulting in increased traffic to the Human Service Centers.

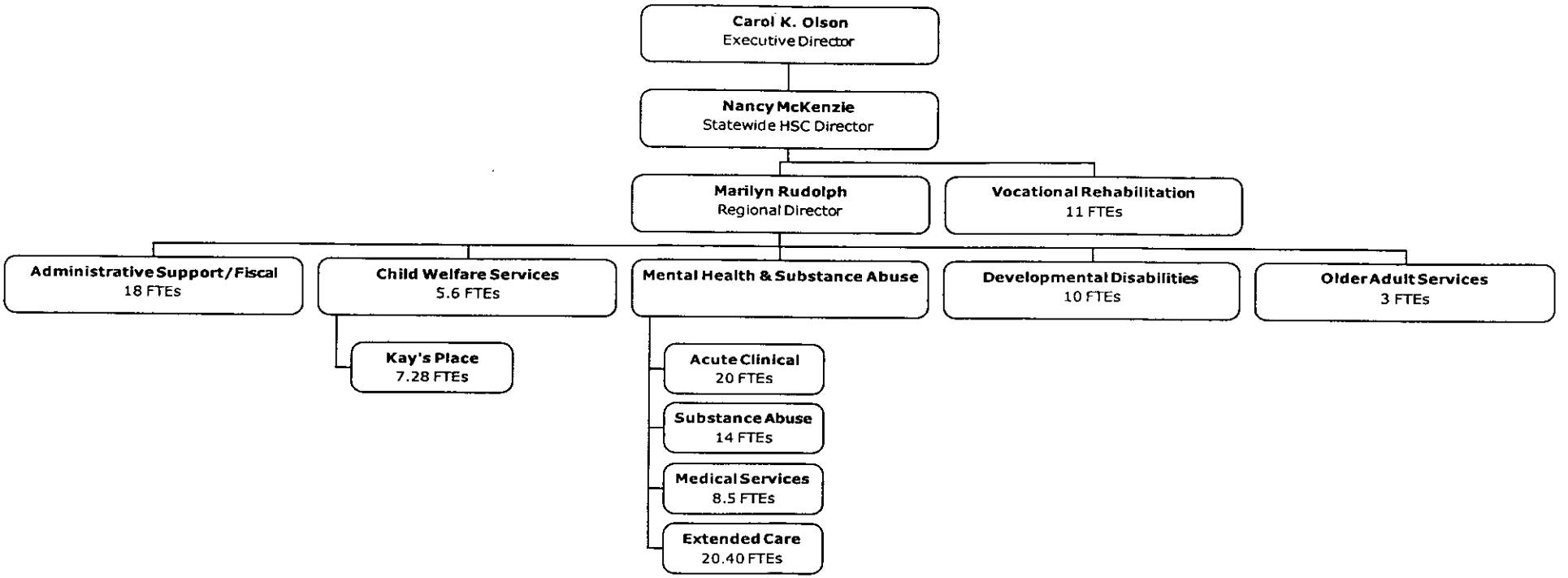
Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony. I would be happy to answer any questions.

Thank you.

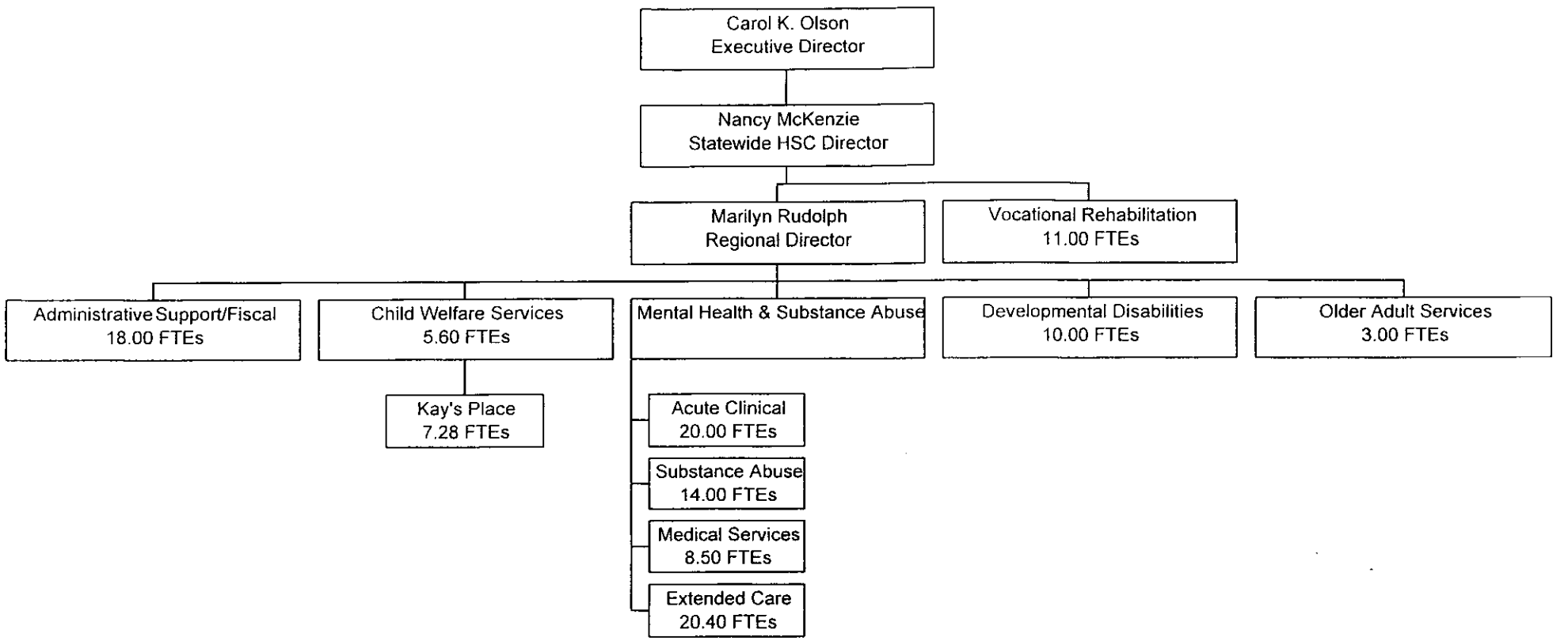
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH CENTRAL HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 117.78 FTEs

Revised 3/4/11

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH CENTRAL HUI SERVICE CENTER



2011 - 2013
117.78 Budgeted FTEs

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-72 NORTH CENTRAL HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	116.780	116.780	0.000	1.000	0.000	117.780	0.000	117.780
32570	B	511000 Salaries - Permanent	8,070,484	9,506,892	4,488,498	510,620	0	10,017,512	0	10,017,512
32570	B	512000 Salaries-Other	13,128	27,168	6,529	(14,088)	0	13,080	0	13,080
32570	B	513000 Temporary Salaries	190,513	189,504	130,830	82,010	0	271,514	0	271,514
32570	B	514000 Overtime	41,705	34,500	20,299	(1,334)	0	33,166	0	33,166
32570	B	516000 Fringe Benefits	3,244,269	4,043,102	1,934,384	78,616	0	4,121,718	0	4,121,718
32570	B	519100 Reduction in Salary - Budget	0	0	0	(70,821)	0	(70,821)	0	(70,821)
32570	B	521000 Travel	253,706	271,678	136,538	(14,670)	0	257,008	0	257,008
32570	B	531000 Supplies - IT Software	23,431	16,800	6,699	0	0	16,800	0	16,800
32570	B	532000 Supply/Material-Professional	11,938	23,412	9,844	(1,048)	0	22,364	0	22,364
32570	B	533000 Food and Clothing	65,713	61,000	34,882	9,500	0	70,500	0	70,500
32570	B	534000 Bldg, Grounds, Vehicle Supply	16,860	8,100	6,917	3,900	0	12,000	0	12,000
32570	B	535000 Miscellaneous Supplies	61,452	32,221	13,921	(891)	0	31,330	0	31,330
32570	B	536000 Office Supplies	18,548	16,449	10,710	4,051	0	20,500	0	20,500
32570	B	541000 Postage	34,252	29,943	7,770	1,807	0	31,750	0	31,750
32570	B	542000 Printing	20,801	15,042	11,177	6,479	0	21,521	0	21,521
32570	B	551000 IT Equip under $5,000	0	140	140	(140)	0	0	0	0
32570	B	552000 Other Equip under $5,000	15,454	369	365	(369)	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	27,660	9,114	8,485	(4,114)	0	5,000	0	5,000
32570	B	561000 Utilities	10,167	11,150	4,277	(1,300)	0	9,850	0	9,850
32570	B	581000 Rentals/Leases-Equip & Other	0	50	50	(50)	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	968,283	920,717	549,369	170,840	0	1,091,557	0	1,091,557
32570	B	591000 Repairs	75,478	66,052	44,510	15,379	0	81,431	0	81,431
32570	B	599110 Salary Increase	0	0	0	0	455,085	455,085	0	455,085
32570	B	599160 Benefit Increase	0	0	0	0	76,435	76,435	0	76,435
32570	B	599161 Health Increase	0	0	0	0	171,758	171,758	0	171,758
32570	B	599162 Retirement Increase	0	0	0	0	104,138	104,138	0	104,138
32570	B	599163 EAP Increase	0	0	0	0	349	349	0	349
32570	B	602000 IT-Communications	150,940	136,844	69,852	3,530	0	140,374	0	140,374
32570	B	611000 Professional Development	22,062	38,442	16,184	(18,752)	0	19,690	0	19,690
32570	B	621000 Operating Fees and Services	117,226	100,045	69,174	100,555	0	200,600	0	200,600
32570	B	623000 Fees - Professional Services	3,847	2,600	0	(2,600)	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-72 NORTH CENTRAL HSC											
32570	B	625000	Medical, Dental and Optical	9,581	7,629	3,908	850	0	8,479	0	8,479
32570	B	691000	Equipment Over $5000	14,858	0	0	0	0	0	0	0
32570	B	712000	Grants, Benefits & Claims	3,193,249	3,813,638	1,903,036	1,385,558	0	5,199,196	0	5,199,196
			Subtotal:	16,675,605	19,382,601	9,488,348	2,243,518	807,765	22,433,884	0	22,433,884
32570	F	F_7091	HSCs & Institutions - Gen Fund	8,725,072	10,459,768	4,574,002	2,331,565	618,694	13,410,027	0	13,410,027
32570	F	F_7092	HSCs & Institutions - Fed Fnds	7,124,982	8,073,938	4,524,198	(158,589)	189,071	8,104,420	0	8,104,420
32570	F	F_7093	HSCs & Institutions - Oth Fnds	741,834	748,895	309,886	20,542	0	769,437	0	769,437
32570	F	F_7095	HSCs & Institutions - County	83,717	100,000	80,262	50,000	0	150,000	0	150,000
			Subtotal:	16,675,605	19,382,601	9,488,348	2,243,518	807,765	22,433,884	0	22,433,884
			Subdivision Budget Total:	16,675,605	19,382,601	9,488,348	2,243,518	807,765	22,433,884	0	22,433,884
410-72 NORTH CENTRAL HSC			**General Funds:**	8,725,072	10,459,768	4,574,002	2,331,565	618,694	13,410,027	0	13,410,027
			Federal Funds:	7,124,982	8,073,938	4,524,198	(158,589)	189,071	8,104,420	0	8,104,420
			Other Funds:	741,834	748,895	309,886	20,542	0	769,437	0	769,437
			SWAP Funds:	0	0	0	0	0	0	0	0
			County Funds:	83,717	100,000	80,262	50,000	0	150,000	0	150,000
			IGT Funds:	0	0	0	0	0	0	0	0
			Subdivision Funding Total:	16,675,605	19,382,601	9,488,348	2,243,518	807,765	22,433,884	0	22,433,884

NC Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/11/2011

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	10.00	839,415	533,184	306,231
Kay's Place	14.41	114,240	34,479	79,761
New Town Office		400	177	223
The House A&D Program		36,000	36,000	0
Rugby Office		9,000	3,993	5,007
Stanley Office		2,400	1,065	1,335
Supported Living - Rent Assistance		26,240	26,240	0
Transitional Living Facility Rent	9.17	63,862	47,994	15,868
Total Rentals & Leases Budget Account Code		**1,091,557**	**683,132**	**408,425**

NC Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Service Awards	8,150	5,039	3,111
Extermination Services	250	74	176
Freight & Express	1,050	491	559
Licenses & Taxes - Staff Licenses	8,480	4,021	4,459
Other Miscellaneous - Assistance for homeless clients	8,000	3,381	4,619
Other Miscellaneous - Flex Funds for MH Partnership Program	15,000	9,174	5,826
Other Miscellaneous - Wrap around funds	3,500	0	3,500
Other Miscellaneous	24,250	14,468	9,782
Purchase of Services - Aging Services Outreach Program	102,320	0	102,320
Purchase of Services - Short-term respite care	25,000	0	25,000
Radio - TV - Newspaper Service	3,600	2,379	1,221
Research Fees - Background checks	1,000	856	144
Total Operating Fees & Services Budget Account Code	**200,600**	**39,883**	**160,717**

Grant Summary

Department of Human Services
NC Human Service Center

Description		Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
DD Services					
Experienced Parent - $35,000		General Funds	3,192	0	(3,192)
Inflation - $1,591		Federal Funds	35,000	36,591	1,591
		Special Funds	0	0	0
			38,192	36,591	(1,601)
Psychiatric/Psychological/Medical Services					
Contracted Psychiatric Services - $263,628		General Funds	209,996	197,711	(12,285)
Inflation - $11,985		Federal Funds	254,076	37,857	(216,219)
		Special Funds	71,664	40,045	(31,619)
			535,736	275,613	(260,123)
Sex Offender Treatment					
Sex Offender Services $150,000		General Funds	27,608	73,374	45,766
Inflation - $6,819		Federal Funds	91,070	67,380	(23,690)
		Special Funds	21,322	16,065	(5,257)
			140,000	156,819	16,819
Recovery Center					
Recovery Center - $229,751		General Funds	179,751	240,195	60,444
Inflation - $10,444		Federal Funds	0	0	0
		Special Funds	0	0	0
			179,751	240,195	60,444
Residential Services					
CD Residential Adult - $1,852,045		General Funds	1,356,823	3,529,062	2,172,239
CD Women's/Childrens - $542,592		Federal Funds	999,843	419,096	(580,747)
Crisis Stabilization Unit - $1,444,661		Special Funds	37,971	0	(37,971)
Inflation - $108,860			2,394,637	3,948,158	1,553,521

Grar. Summary

Department of Human Services
NC Human Service Center

Description		Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Substance Abuse Treatment and Prevention					
Native American Access Program - $109,176		General Funds	9,176	14,139	4,963
Inflation - $4,963		Federal Funds	100,000	100,000	0
		Special Funds	0	0	0
			109,176	114,139	4,963
Respite Care					
Crisis/Respite Beds		General Funds	7,754	9,801	2,047
Inflation - $682		Federal Funds	7,246	5,881	(1,365)
		Special Funds	0	0	0
			15,000	15,682	682
Case Aides					
Partnership - $194,084		General Funds	103,972	126,807	22,835
Inflation - $8,823		Federal Funds	97,174	76,100	(21,074)
		Special Funds	0	0	0
			201,146	202,907	1,761
Inpatient Hospitalization					
A&D and SMI $200,000		General Funds	200,000	209,092	9,092
Inflation - $9,092		Federal Funds	0	0	0
		Special Funds	0	0	0
			200,000	209,092	9,092
	Total Grants		**3,813,638**	**5,199,196**	**1,385,558**

- Brenda Weisz
- Attachment THREE
- March 15, 2011
- SB 2012

DHS
2011 - 2013 Budget
OAR - Psychiatric Inpatient Days

Hospital	Projected Patient Days for Biennium*	Medicaid Rate as of July 1, 2010	Projected Biennial Cost
Prairie St. John's	1,000	801	801,000
Trinity Medical	1,000	696	696,000
Med Center One	1,000	1,081	1,081,000
St. Alexius	492	797	392,124
Sanford Health **	1,000	854	854,000
Altru	368	1,012	372,416
Stadter Psychiatric	72	885	63,720
Total	4,932		$ 4,260,260
Less amount in base budget for inpatient days***:			(829,243)
OAR request			$ 3,431,017

* - based on information provided to Alex Schweitzer, Superintendent One Center

** - Formerly Merit Care

*** - Breakdown

NC	200,000
NE	165,400
SE	233,843
WC	150,000
BL	80,000
	$ 829,243

- Attachment FOUR

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 15, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Kate Kenna, Director of the Lake Region Human Service Center (LRHSC) and Northeast Human Service Center (NEHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of both centers' budget requests.

Lake Region Human Service Center

The Lake Region Human Service Center provides services to the six counties of Ramsey, Cavalier, Rolette, Towner, Benson, and Eddy. In 2010 the population estimate in Region III was 40,143, or 6.2% of the total state population. Services are provided throughout Region III with one office in Devils Lake and an outreach office in Rolla. Case managers, clinicians, and program staff travel to other outreach sites in each of our six counties.

Caseload / Customer Base

The Lake Region Human Service Center provided services to 2,484 individuals in State Fiscal Year 2010 - 1,863 adults and 621 children received services. In addition, 407 individuals received Vocational Rehabilitation services and 131 received Older Blind services in Federal Fiscal Year 2010.

Program Trends

- The poverty rate and unemployment rate in Region III remains at essentially twice the state average. Based on data collected over the past decade, the percent of Region III recipients that benefit from DHS Programs (excluding child support, abuse and neglect, and Older American's Act recipients) is about twice the statewide average (one in three residents).
- Data from October, 2010 indicates that Temporary Aid to Needy Families (TANF) continues to be a major resource to low income families. Currently Region III has 2,065 TANF recipients – 42 percent of all TANF recipients in North Dakota. Rolette County alone has 1,500 recipients, essentially equal to the TANF caseloads of Grand Forks, Burleigh, and Cass counties combined (1,500 vs. 1,537 recipients).
- During SFY 2010, LRHSC saw 992 Native American consumers which are 40% of all LRHSC consumers served. This number represents 34% of the total 2,886 Native American consumers seen statewide by the Human Service Centers.
- During SFY 2010, LRHSC provided services to 105 consumers, age 80 and older, which is 32% of the 327 age 80+ consumers seen statewide by the Human Service Centers.
- The flood remains a vexing problem including offering ongoing challenges to human service, faith based organizations, and volunteer agencies active in this disaster. While there continue to be signs of substantial resiliency across the Region, the battle is a sustained one. People are experiencing loss and grief as well as financial losses in many cases.

- Regional population appears to be remaining stable and demand for clinical services has risen moderately by an additional 111 consumers for SFY 2010 compared to the numbers reported during the prior testimony we made before this body. Region III remains a designated Mental Health Professional Shortage area by the National Health Service Corp. All six counties have a shortage score of "18" which are the highest scores in North Dakota.
- Crisis Line calls numbered 460 for SFY 2010 with 70 admissions to the North Dakota State Hospital. These numbers suggest that increased efforts to screen potential NDSH admissions continue to be successful. In the mid-1980's, Region III averaged 322 NDSH admissions per year; in the mid-1990's, the average was 207; and in the early 2000's, this number hovered around 100. In the past three years the number has hovered around 60 to 70 admissions.
- Region III consumers report that transportation is a continuing barrier to accessing services. Outreach is important as part of the solution. One flood-related impact of the flood is that, in addition to the damaged or destroyed township roads affecting consumer access, there are major and long-duration road construction projects on the majority of highways around Devils Lake. Lake Region HSC is in the process of expanding telemedicine as an alternative means to sustain services to some populations served.
- The loan repayment offered by the National Health Service Corp has been helpful in recruitment on the mental health side. Lake Region HSC recently was able to hire two new psychologists allowing us to start to offer psychological evaluations and consultation to our Lake Region Outreach office in Rolla. Addiction counselors continue to be challenging to recruit and retain and do not qualify for this loan repayment.

- Health care reform, if it moves forward, may afford disproportionately higher benefits to the residents within Region III. For example, if implemented as currently proposed, the component that will offer Medicaid to cover single individuals who are at or below the 133 percent of poverty threshold, will include a potentially significant number of individuals particularly from Benson, Ramsey, and Rolette counties.
- Transition from Prison to Community Initiative: Under the local guidance of Judge Donovan Foughty a substantial number of stakeholders have implemented coordinated transition services with the goal of reducing recidivism and increasing community safety. Lake Region HSC is an active participant in this initiative at both the advisory committee and working committee levels and is broadly engaged as a treatment provider, particularly of mental health and substance abuse services. We have also implemented the Commitment to Change Program which is a cognitive behavioral group, known to be effective with populations who have criminal justice issues along with behavioral health problems.
- Both LRHSC and NEHSC continue to gain experience in evidenced-based models of service delivery. The Division of Mental Health and Substance Abuse recently secured and delivered training in Motivational Interviewing to substantial numbers of staff from all eight human service centers which has provided one more tool for the staff member's tool box. Motivational Interviewing is useful in conjunction with a variety of other services and is helpful in assisting consumers in exploring and resolving their ambivalence about facing some problems.
- Two new Suicide Prevention Committees have been formed; one represents the greater Devils Lake area and the other Spirit Lake

Nation. Staff of LRHSC has been very active with both committees. Lake Region HSC continues to participate in an array of community activities. Examples include Teen Maze and the Foster Care Recruitment and Retention Committee, and we have played a lead role in delivering community screenings during National Depression Screening Day.

- Current reports suggest the flooding in the Devils Lake Basin will likely continue in 2011. In partnership with Bonnie Turner, Lutheran Disaster Response, LRHSC coordinated an initial meeting of local representatives of faith-based, VOAD, agricultural, Tribal, and local helping agencies to discuss human service challenges and establish connections that should enhance a coordinated response when the need arises.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Budget	Senate Changes	To House
Lake Region HSC	10,955,142	463,089	11,418,231		11,418,231
General Funds	6,066,003	816,187	6,882,190		6,882,190
Federal Funds	4,450,221	(386,622)	4,063,599		4,063,599
Other Funds	438,918	33,524	472,442	-	472,442
Total	10,955,142	463,089	11,418,231		11,418,231
FTE	60	0	60		60

Budget Changes from Current Budget to Executive Budget:

- Salary and Wages related expenses increased by $479,115 and can be attributed to the following:
  - $432,484 in total funds of which $332,923 is general funds to fund the Governor's salary package for state employees.

- 89,977 in temporary salaries which represents a .7 fte for the Family Caregiver/Adult Protective Services program and a .25 fte for a SMI case manager.
- An increase of $73,337 to cover an underfunding of salaries from the 2009-2011 budget.
- An increase of $165,099 in total funds of which $124,747 is general funds needed to fund the second year employee increase to 24 months versus the 12 months that are contained in the current budget.
- A decrease of 40,856 to underfund the 2011-2013 payplan.
- The remaining decrease of $240,926 in the Salaries and Fringe Benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 60 FTEs in this area of the budget.

- The Operating cost increased by $59,287. While most all line items had small inflationary increases, the larger increases consisted of the following items:

  - An increase of $13,943 in travel related expenses. This increase represents the increased need for outreach services, the increases allowed in lodging rates, personal mileage reimbursement, and increased requests for local mileage reimbursement by staff as a result of increasing gas prices.
  - IT Communications increase of $8,872 based on projected increased telecommunications costs.
  - An increase of $2650 in Professional Development to increase the funds available for staff from the current $100/fte to $150/fte.

- An increase of $17,923 in Operating Fees and Services. This increase is largely the result of Federal funding for Aging outreach services in the amount of $15,848.
- An increase of $3000 for Fees- Professional Services. This increase is the result of the increased use of sign language interpreters required in serving the deaf population.

- The Grants costs decreased $75,313. The following items make up this decrease:

  - A transfer of $111,076 of adolescent alcohol and drug federal funds to the NEHSC's program to fund two beds for Lake Region adolescents.
  - A decrease of $109,360 in long term A&D residential funding.
  - An increase of $25,000 to fund the Peer Support program at the Recovery Center for SMI clients.
  - An increase of $38,090 to fund the second year of last biennium's provider inflationary increases.
  - An increase of $82,033 to fund the Governors request for a 3% and 3% inflationary increase for the 2011-2013 biennium.

- The general fund request increased by $816,187 with 66% of that increase ($539,703) related to the Governors salary package for state employees and the 3% and 3% provider inflationary increases. The remaining increase of $276,484 is associated largely with the cost to continue the second year of provider inflationary increases from the 2009-2011 biennium, increased operating costs, and a decrease in the Federal Medical Assistance Percentage (FMAP).

Senate Changes

The Senate made no changes in this section of the Department's budget.

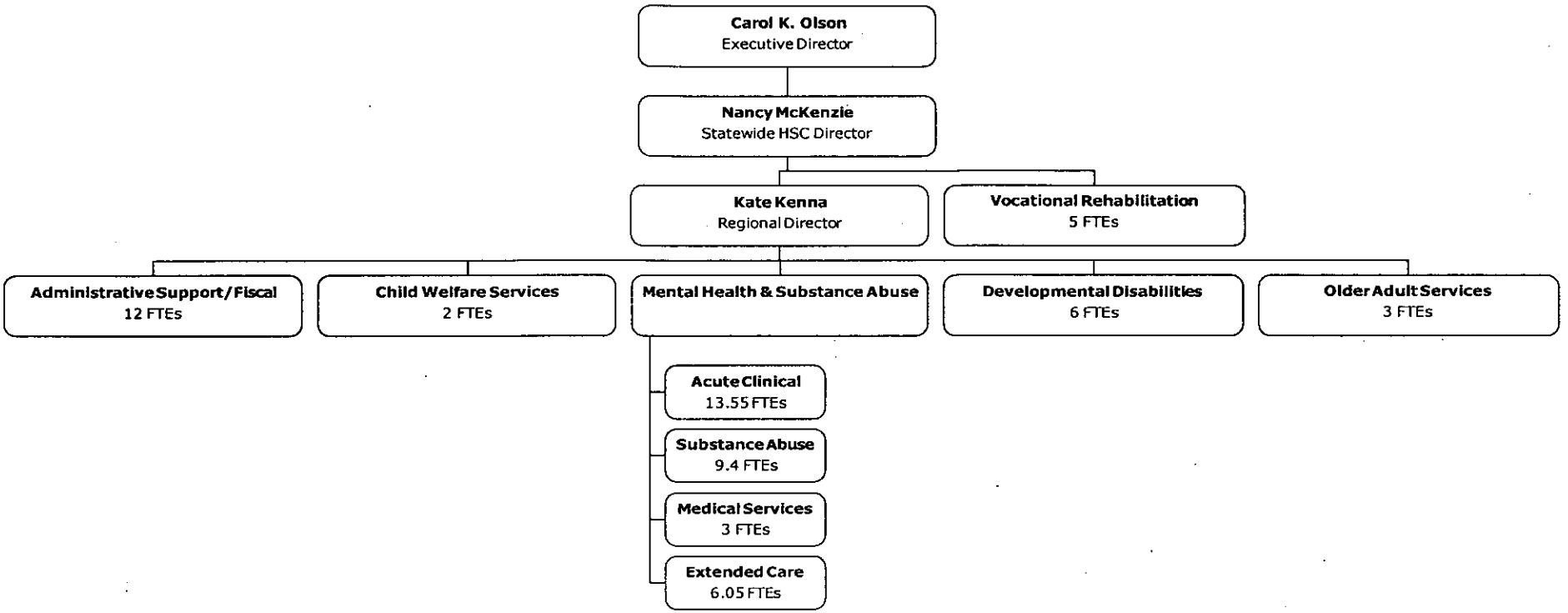
Northeast Human Service Center

This area of the budget includes the programs of the Northeast Human Service Center (NEHSC). The NEHSC serves the citizens of Grand Forks, Nelson, Walsh, and Pembina counties. The center is located in Grand Forks with a satellite office in Grafton and an outreach site in Cavalier.

Caseload / Customer Base

- The population in Region IV is approximately 87,733; this represents 14 percent of the state's population. Twelve percent of the state's children, nearly 17,360, reside in our region.
- The Northeast HSC provided clinical services to 3,557 individuals in SFY 2010; 2,570 adults and 987 children received services. This represented a 6 percent increase in clients over SFY 2008. During SFY 2010, we averaged over 49 addiction evaluations per month and 35 clinical intakes per month.
- Vocational Rehabilitation (VR) served 1,174 clients; 135 clients were served through the Older Blind program.
- Other residents of our counties received indirect services provided through Aging Services, Foster Grandparent Program, Child Welfare, and community education.
- Priority is placed on serving the Region's most vulnerable individuals, including those who cannot otherwise access services.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
LAKE REGION HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 60 FTEs

Revised 3/4/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-73 LAKE REGION HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	62.000	60.000	0.000	0.000	0.000	60.000	0.000	60.000
32570	B	511000 Salaries - Permanent	4,641,989	5,415,801	2,488,691	37,477	0	5,453,278	0	5,453,278
32570	B	513000 Temporary Salaries	5,286	62,425	10,322	89,977	0	152,402	0	152,402
32570	B	514000 Overtime	632	348	261	(348)	0	0	0	0
32570	B	516000 Fringe Benefits	1,672,146	2,180,535	965,910	(39,619)	2	2,140,918	0	2,140,918
32570	B	519100 Reduction in Salary - Budget	0	0	0	(40,856)	0	(40,856)	0	(40,856)
32570	B	521000 Travel	178,386	202,745	90,172	13,973	0	216,718	0	216,718
32570	B	531000 Supplies - IT Software	11,914	11,340	6,061	0	0	11,340	0	11,340
32570	B	532000 Supply/Material-Professional	37,952	43,300	20,864	2,000	0	45,300	0	45,300
32570	B	534000 Bldg, Grounds, Vehicle Supply	397	200	55	0	0	200	0	200
32570	B	535000 Miscellaneous Supplies	9,153	12,312	5,982	1,847	0	14,159	0	14,159
32570	B	536000 Office Supplies	28,671	28,600	9,858	3,000	0	31,600	0	31,600
32570	B	541000 Postage	27,804	24,302	6,623	350	0	24,652	0	24,652
32570	B	542000 Printing	6,646	8,600	3,421	1,500	0	10,100	0	10,100
32570	B	551000 IT Equip under $5,000	547	3,000	1,812	(3,000)	0	0	0	0
32570	B	571000 Insurance	5,420	4,500	1,860	800	0	5,300	0	5,300
32570	B	581000 Rentals/Leases-Equip & Other	21	840	420	120	0	960	0	960
32570	B	582000 Rentals/Leases - Bldg/Land	440,971	425,580	198,481	4,752	0	430,332	0	430,332
32570	B	591000 Repairs	14,492	17,150	6,981	1,000	0	18,150	0	18,150
32570	B	599110 Salary Increase	0	0	0	0	247,606	247,606	0	247,606
32570	B	599160 Benefit Increase	0	0	0	0	40,710	40,710	0	40,710
32570	B	599161 Health Increase	0	0	0	0	87,338	87,338	0	87,338
32570	B	599162 Retirement Increase	0	0	0	0	56,654	56,654	0	56,654
32570	B	599163 EAP Increase	0	0	0	0	174	174	0	174
32570	B	601000 IT - Data Processing	0	100	0	500	0	600	0	600
32570	B	602000 IT-Communications	88,468	83,978	43,614	8,872	0	92,850	0	92,850
32570	B	611000 Professional Development	7,932	6,300	2,199	2,650	0	8,950	0	8,950
32570	B	621000 Operating Fees and Services	50,349	85,563	31,975	17,923	0	103,486	0	103,486
32570	B	623000 Fees - Professional Services	2,641	7,075	3,938	3,000	0	10,075	0	10,075
32570	B	625000 Medical, Dental and Optical	1,441	4,700	486	0	0	4,700	0	4,700
32570	B	691000 Equipment Over $5000	13,129	20,000	0	0	0	20,000	0	20,000
32570	B	712000 Grants, Benefits & Claims	1,715,808	2,305,848	842,150	(75,313)	0	2,230,535	0	2,230,535

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-73 LAKE REGION HSC									
	Subtotal:	8,962,195	10,955,142	4,742,136	30,605	432,484	11,418,231	0	11,418,231
32570 F	F_7091 HSCs & Institutions - Gen Fund	4,999,278	6,066,003	2,737,947	483,264	332,923	6,882,190	0	6,882,190
32570 F	F_7092 HSCs & Institutions - Fed Fnds	3,533,968	4,450,221	1,827,025	(486,183)	99,561	4,063,599	0	4,063,599
32570 F	F_7093 HSCs & Institutions - Oth Fnds	428,949	438,918	177,164	33,524	0	472,442	0	472,442
	Subtotal:	8,962,195	10,955,142	4,742,136	30,605	432,484	11,418,231	0	11,418,231
	Subdivision Budget Total:	8,962,195	10,955,142	4,742,136	30,605	432,484	11,418,231	0	11,418,231
410-73 LAKE REGION HSC	**General Funds:**	4,999,278	6,066,003	2,737,947	483,264	332,923	6,882,190	0	6,882,190
	Federal Funds:	3,533,968	4,450,221	1,827,025	(486,183)	99,561	4,063,599	0	4,063,599
	Other Funds:	428,949	438,918	177,164	33,524	0	472,442	0	472,442
	SWAP Funds:	0	0	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0	0	0
	Subdivision Funding Total:	8,962,195	10,955,142	4,742,136	30,605	432,484	11,418,231	0	11,418,231

LR Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium

3/10/2011

Rentals & Leases	Rate per Sq Ft	Amount	General	Fed/Other
HSC Building Rent - Devils Lake Office	10.49	383,532	212,666	170,866
Outreach Office - Rolla	9.97	46,800	20,104	26,696
Total Rentals & Leases Budget Account Code		**430,332**	**232,770**	**197,562**

LR Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Experienced Parent Contract	43,050	8,050	35,000
Advertising: Program and client related (ex: Crisis Line)	6,902	3,976	2,926
Client Record Requests to Other Providers	1,925	1,033	892
Flexible Funding for Partnership Children	10,075	2,827	7,248
Records Destruction Costs	500	438	62
Job Announcements and Yearly Civil Rights Legal Notices	5,800	3,341	2,459
Rent/Other Assistance for Homeless clients	8,165	8,165	0
Client assistance with travel and other service related costs	6,200	3,753	2,447
Staff Licenses	3,801	1,872	1,929
Aging Services Outreach	15,848	0	15,848
Freight and other Misc. Operating Expenses:	1,220	930	290
Total Operating Fees & Services Budget Account Code	**103,486**	**34,385**	**69,101**

Grants Summary

Department of Human Services
LR Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Recovery Center	General Funds	$183,601	$229,087	$45,486
Recovery Center - $229,087		$183,601	$229,087	$45,486
Psychiatric / Psychological / Medical Services	General Funds	$49,159	$63,832	$14,673
Contracted Psychiatric Services - $102,988	Federal Funds	$33,052	$27,148	($5,904)
	Special Funds	$17,705	$12,008	($5,697)
		$99,916	$102,988	$3,072
Residential Services	General Funds	$1,508,129	$1,617,916	$109,787
CD Adult Residential $1,449,139	Federal Funds	$252,212	$0	($252,212)
SMI Residential $158,649	Special Funds	$0		$0
Children and Adolescent A&D Services $10128		$1,760,341	$1,617,916	($142,425)
Respite Care	General Funds	$43,630	$45,612	$1,982
Respite Providers - $43,630	Federal Funds			$0
		$43,630	$45,612	$1,982
Substance Abuse Treatment and Prevention	General Funds	$18,360	$58,005	$39,645
Spirit Lake Tribe $117,466	Federal Funds	$200,000	$176,927	($23,073)
Turtle Mtn Tribe $117,466		$218,360	$234,932	$16,572
TOTAL GRANTS		**$2,305,848**	**$2,230,535**	**($75,313)**
Per tbl_BgtM, Bgt_Acct 712000 - Grants, Benefits & Claims		2,305,848	2,230,535	(75,313)
Difference		**0**	**0**	**0**

-Kate Kenna
-Attachment FIVE
-March 15, 2011
-SB 2012

Senate Changes

The Senate made no changes in this section of the Department's budget.

Northeast Human Service Center

This area of the budget includes the programs of the Northeast Human Service Center (NEHSC). The NEHSC serves the citizens of Grand Forks, Nelson, Walsh, and Pembina counties. The center is located in Grand Forks with a satellite office in Grafton and an outreach site in Cavalier.

Caseload / Customer Base

- The population in Region IV is approximately 87,733; this represents 14 percent of the state's population. Twelve percent of the state's children, nearly 17,360, reside in our region.
- The Northeast HSC provided clinical services to 3,557 individuals in SFY 2010; 2,570 adults and 987 children received services. This represented a 6 percent increase in clients over SFY 2008. During SFY 2010, we averaged over 49 addiction evaluations per month and 35 clinical intakes per month.
- Vocational Rehabilitation (VR) served 1,174 clients; 135 clients were served through the Older Blind program.
- Other residents of our counties received indirect services provided through Aging Services, Foster Grandparent Program, Child Welfare, and community education.
- Priority is placed on serving the Region's most vulnerable individuals, including those who cannot otherwise access services.

Program Trends

- The Northeast HSC has had difficulty recruiting/retaining a psychologist, community home counselors, and fully qualified mental health clinicians.
- The Northeast Human Service Center has been successful in recruiting an additional full time psychiatrist.
- In addiction services, Northeast HSC continues to see an increased use of prescription medication, a decrease in methamphetamine as a primary substance of use, a need for longer residential stays and an increase in clients from County Social Services and the Department of Corrections and Rehabilitation who require additional case management and more frequent involuntary commitments.
- Northeast's addiction services noticed a significant surge in the use of synthetic marijuana, which is undetectable by traditional drug screening. A number of clients had their treatment impacted by this undetected continued use.
- Northeast has 37 clients involved in adult drug court and 12 clients involved in juvenile drug court.
- In Developmental Disabilities (DD), more families are struggling economically and are requesting assistance in helping meet the excess costs of having a child with a disability. Developmental Disability Program Managers (DDPM) are spending more time helping families meet basic needs. The number of clients in DD program management continues to grow each biennium, currently at 709 active cases. Developmental Disability Program Managers are working with the implementation of the Medicaid autism waiver, a new data system and the implementation of many policy changes for the Medicaid waiver renewal of 2009.

- Ruth Meiers Adolescent Center has experienced an increase in private placements in the facility over the past 2 years, including 42% of placements in 2009. The number of younger youth, ages 11- 13, increased for the second straight year, accounting for 26% of those admitted to the program. The program continues to see an increase in younger youth (ages 11-14) with sub 70 full-scale I.Q.'s referred for treatment. The percentage of youth served that are adopted or have no biological parents actively involved in their life increased to 36% of the youth admitted in the last 18 months. In 2009, 23% of youth admitted to the program were Native American and 42% of the youth discharged from the program were Native Americans, continuing a disproportionate (statistically according to census) number of Native American youth receiving RMAC services. The staff retention rate over the last 18 months was the best in over a decade.
- In Children and Family Services, from December, 2009 to December 2010 there has been an overall increase in licensed child care (primarily Family providers) and a decrease in Self-Declaration providers (a standard below licensing). Self-Declaration is a category that has no monitoring and cares for fewer children. This is the category that we have historically had a high number of revocations and denials, as there were few screening tools or monitoring. The initiation of fingerprinting and criminal background checks appears to be the primary factor in the decrease in numbers and capacity. As it was intended, criminal background checks has served as a screening tool for applications for child care. Consequently, as more screening occurs prior to the license being issued, the number of revocations and denials of child care licenses has decreased this year. Region IV has 265 licensed child

care providers with a capacity of 5,611 children. A trend in child care over the past biennium is the significant increase in the number of New Americans who are applying for child care. A number of these individuals have limited English capacity to communicate.

- Children and Family Services notes that there were 20 adoptions of foster care children in 2010, compared to 39 in 2008. There are currently 70 foster homes in Region IV and the number of therapeutic foster homes is 24. In the past 11 months, there have been 996 administrative and full Child Protective Services assessments.
- The Northeast HSC has been working with Network for the Improvement of Addiction Treatment (NIATx) to improve services to clients. We have focused on reducing wait time, increased customer satisfaction, and efficiency. This process looks at evaluating services and using a rapid change cycle in the delivery of services. We are currently working on a statewide effort for paperwork reduction.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
Northeast HSC	25,967,419	2,215,190	28,182,609		28,182,609
General	11,259,927	1,949,796	13,209,723		13,209,723
Federal	13,557,216	(589,308)	12,967,908		12,967,908
Other	1,150,276	854,702	2,004,978		2,004,978
Total	25,967,419	2,215,190	28,182,609		28,182,609
FTEs	138.1	0.2	138.3		138.3

The FTE increase of .20 was a transfer from Southeast HSC to Northeast to add to a .80 FTE creating a 1.0 FTE for a psychiatrist.

Salary and Wages increased by $1,987,716 and can be attributed to the following:

- $990,524 in total funds of which $685,880 is general fund needed to fund the Governor's salary package for state employees.
- $320,108 in total funds of which $212,712 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $44,145 to cover an underfunding of salaries from the 2009 – 2011 budget.
- A decrease of $79,177 to underfund the 2011 – 2013 payplan.
- Temporary salaries are increased by $59,308 to meet additional staffing needs in our Ruth Meiers Psychiatric Residential Facility and an additional 50% FTE case aide for adults with Serious Mental Illness.
- Northeast hired an additional full time psychiatrist to replace two contracted part time psychiatrists. The salaries and benefits increase to cover this cost was $505,812.
- The remaining increase of $ 146,996 is a combination of increases and decreases needed to sustain the salary of the 138.3 FTE in this area of the budget.

The Operating budget increased by $82,529 (2.7%) and is a combination of the increases expected next biennium which are offset by decreases as follows:

- An increase of $ 93,054 in the Northeast's travel budget. This increase results from Northeast using actual motor pool rates and

utilization history in establishing the 2009-11 budget, then using the State Fleet Budget guideline rates for 2011-13. Northeast is also projecting a 52,720 mile increase in utilization for the 11-13 biennium, based on a projection of our current utilization. This increase in utilization results in about $ 19,500 of the budget increase. In addition, the increased costs of the changes to lodging rates and personal mileage rates are included in the budget increase.

- IT Communications increase of $19,863 based on new IT phone rates and increased use of communication devices.

Northeast's Grants cost includes a net increase of $144,945. This includes an increase of $268,856 to cover an inflationary increase of 3% each year offset by decreases of $94,458 from our psychiatry contract budget, $ 3,977 from our Adult Protective Services contract, and $ 25,476 from our SMI Supported Residential contract.

The general fund request increased by $1,949,796 with 35% of that increase ($685,880) related to the Governor's salary package for state employees. $212,712 of the increase is related to continuing 2nd year salary increases for 24 months. $217,111 of the increase is related to the contracted provider increases of 3% for each year of the biennium.

The remaining increase in general funds of $834,093 is a result of reductions in the federal medical assistance percentage (FMAP) and changes in the operating budget described above.

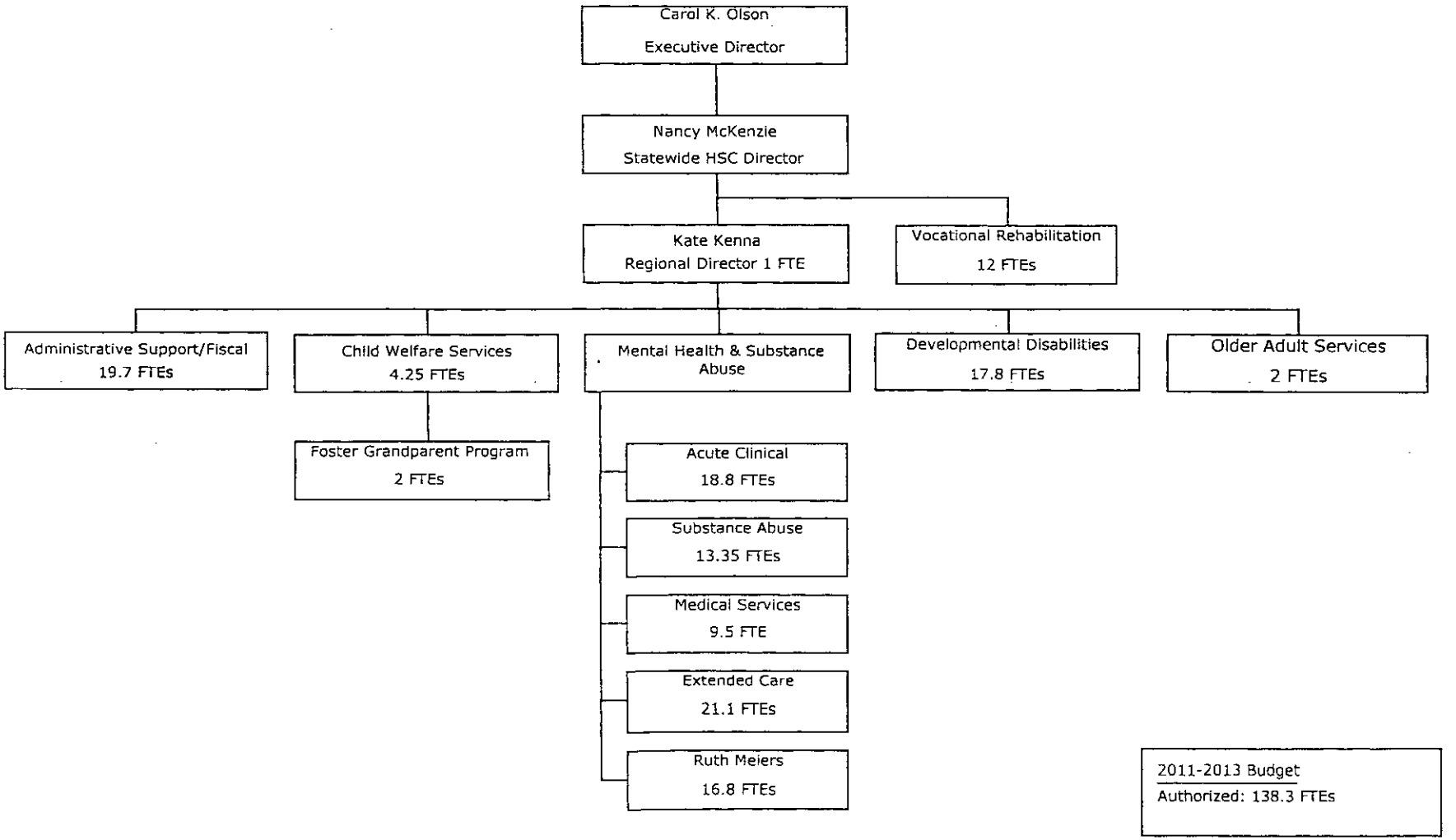
Northeast HSC is projecting an increase in other funding of $ 854,702, largely from increased 3rd party collections for our psychiatric residential treatment program and our CD adolescent treatment program.

Senate Changes

The Senate made no changes in this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget requests for Lake Region Human Service Center and Northeast Human Service Center. I would be happy to answer any questions.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTHEAST HUMAN SERVICE CENTER



DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-74 NORTHEAST HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	137.100	138.100	0.000	0.200	0.000	138.300	0.000	138.300
32570	B	511000 Salaries - Permanent	10,044,757	11,610,615	5,605,086	905,553	0	12,516,168	0	12,516,168
32570	B	512000 Salaries-Other	19,009	19,200	9,670	0	0	19,200	0	19,200
32570	B	513000 Temporary Salaries	264,727	329,732	137,957	59,308	0	389,040	0	389,040
32570	B	514000 Overtime	65,347	63,408	32,451	0	0	63,408	0	63,408
32570	B	516000 Fringe Benefits	3,860,227	4,796,886	2,319,403	111,508	0	4,908,394	0	4,908,394
32570	B	519100 Reduction in Salary - Budget	0	0	0	(79,177)	0	(79,177)	0	(79,177)
32570	B	521000 Travel	439,579	392,826	218,409	93,054	0	485,880	0	485,880
32570	B	531000 Supplies - IT Software	21,459	11,000	2,088	0	0	11,000	0	11,000
32570	B	532000 Supply/Material-Professional	48,447	30,616	26,608	399	0	31,015	0	31,015
32570	B	533000 Food and Clothing	98,778	91,860	45,577	0	0	91,860	0	91,860
32570	B	534000 Bldg, Grounds, Vehicle Supply	32,118	19,584	17,179	(1,352)	0	18,232	0	18,232
32570	B	535000 Miscellaneous Supplies	48,209	43,793	15,954	(5,466)	0	38,327	0	38,327
32570	B	536000 Office Supplies	79,603	64,779	39,912	(4,095)	0	60,684	0	60,684
32570	B	541000 Postage	42,956	40,785	17,595	0	0	40,785	0	40,785
32570	B	542000 Printing	14,938	16,376	9,691	(156)	0	16,220	0	16,220
32570	B	551000 IT Equip under $5,000	6,160	9,000	0	(9,000)	0	0	0	0
32570	B	552000 Other Equip under $5,000	9,468	9,000	0	(9,000)	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	75,207	30,919	30,232	(13,000)	0	17,919	0	17,919
32570	B	561000 Utilities	39,994	42,950	17,810	0	0	42,950	0	42,950
32570	B	571000 Insurance	2,193	1,100	315	0	0	1,100	0	1,100
32570	B	581000 Rentals/Leases-Equip & Other	3,894	6,138	3,072	0	0	6,138	0	6,138
32570	B	582000 Rentals/Leases - Bldg/Land	1,225,557	1,272,514	641,657	8,880	0	1,281,394	0	1,281,394
32570	B	591000 Repairs	52,517	48,664	44,311	800	0	49,464	0	49,464
32570	B	599110 Salary Increase	0	0	0	0	568,650	568,650	0	568,650
32570	B	599160 Benefit Increase	0	0	0	0	91,918	91,918	0	91,918
32570	B	599161 Health Increase	0	0	0	0	199,414	199,414	0	199,414
32570	B	599162 Retirement Increase	0	0	0	0	130,129	130,129	0	130,129
32570	B	599163 EAP Increase	0	0	0	0	413	413	0	413
32570	B	601000 IT - Data Processing	0	253	0	0	0	253	0	253
32570	B	602000 IT-Communications	199,722	184,624	100,332	19,863	0	204,487	0	204,487
32570	B	611000 Professional Development	21,345	18,765	8,927	6,835	0	25,600	0	25,600

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-74 NORTHEAST HSC										
32570	B	621000 Operating Fees and Services	202,011	303,849	88,390	(11,233)	0	292,616	0	292,616
32570	B	623000 Fees - Professional Services	422,982	438,179	170,707	0	0	438,179	0	438,179
32570	B	625000 Medical, Dental and Optical	13,294	30,833	7,663	6,000	0	36,833	0	36,833
32570	B	712000 Grants, Benefits & Claims	4,812,275	6,039,171	2,417,921	144,945	0	6,184,116	0	6,184,116
		Subtotal:	22,166,773	25,967,419	12,028,917	1,224,666	990,524	28,182,609	0	28,182,609
32570	F	F_7091 HSCs & Institutions - Gen Fund	9,739,294	11,259,927	5,140,541	1,263,916	685,880	13,209,723	0	13,209,723
32570	F	F_7092 HSCs & Institutions - Fed Fnds	11,103,745	13,557,216	6,603,017	(802,922)	213,614	12,967,908	0	12,967,908
32570	F	F_7093 HSCs & Institutions - Oth Fnds	1,323,734	1,150,276	285,359	763,672	91,030	2,004,978	0	2,004,978
		Subtotal:	22,166,773	25,967,419	12,028,917	1,224,666	990,524	28,182,609	0	28,182,609
		Subdivision Budget Total:	22,166,773	25,967,419	12,028,917	1,224,666	990,524	28,182,609	0	28,182,609
410-74 NORTHEAST HSC		General Funds:	9,739,294	11,259,927	5,140,541	1,263,916	685,880	13,209,723	0	13,209,723
		Federal Funds:	11,103,745	13,557,216	6,603,017	(802,922)	213,614	12,967,908	0	12,967,908
		Other Funds:	1,323,734	1,150,276	285,359	763,672	91,030	2,004,978	0	2,004,978
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	22,166,773	25,967,419	12,028,917	1,224,666	990,524	28,182,609	0	28,182,609

NE Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/4/2011

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	13.15	1,029,072	499,299	529,773
State Fleet Parking spaces	$ 25 per space p	14,490	12,751	1,739
Storage Space	5.10	6,712	5,906	805
Ruth Meiers PRTF Rent	11.04	206,400	60,989	145,411
Cedar Inn Outreach Office (2 room office)		9,120	1,363	7,757
Cornerstone CD Aftercare Residential Facility	4.13	15,600	10,748	4,852
Total Rentals & Leases Budget Account Code		**1,281,394**	**591,056**	**690,337**

NE Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Bus Transportation and Gas Vouchers for clients	20,808	9,340	11,468
Cable Television at Transitional Living Home, Ruth Meiers PRTF, & Cornerstone Hal	3,292	556	2,736
Flexible Funding for Partnership Children/Parent Nurturing Program	53,876	7,000	46,876
Safety Permanency Funding (Wrap Around)	33,696	10,000	23,696
Freight Costs for Purchased Goods	5,000	4,402	598
Job Announcements/Recruitment and Yearly Civil Rights Legal Notices	12,090	6,057	6,033
Telephone Directory/Yellowbook Listings	11,200	9,860	1,340
Background Checks/Academic Clearing House	2,500	2,201	299
Rent Assistance for Homeless clients	8,000	0	8,000
Respite Care for Families	43,887	10,887	33,000
Document Shredding Costs	5,300	4,666	634
Allowances/Behavioral Rewards for residents of Ruth Meiers PRTF	15,000	7,500	7,500
Activity fees for clients in our residential facilities	12,000	2,028	9,972
Aging Service Outreach (new funding for Northeast HSC)	30,047	0	30,047
Staff Licenses	12,250	6,137	6,113
Essential Learning Training Service for staff of the Ruth Meiers PRTF	3,800	3,800	0
Crisis Line Answering Service	3,100	462	2,638
Foster Grandparent Recognition for Years of Service	11,550	0	11,550
Years of Service Awards	5,220	2,615	2,605
Total Operating Fees & Services Budget Account Code	**292,616**	**87,511**	**205,105**

Grants Summary

Department of Human Services
NE Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Adult Protective Services	General Funds	$20,952	$17,928	($3,024)
Protective Services for Vulnerable Adults -- $ 41,663	Federal Funds	$24,688	$25,632	$944
Provider Inflation -- $ 1,897		$45,640	$43,560	($2,080)
Care Coordination	General Funds	$712	$34,519	$33,807
Mentoring/Tracking/Visitation -- $35,000	Federal Funds	$199,242	$174,521	($24,721)
School Social Workers -- $144,118		$199,954	$209,040	$9,086
Nurturing Parent -- $20,836				
Provider Inflation -- $ 9,086				
Case Aide	General Funds			0
	Federal Funds			0
	Special Funds			0
		0	0	0
Crisis Care / Safe Beds	General Funds	501,513	730,322	228,809
Crisis Beds-- SMI Adult $ 705,202	Federal Funds	198,134	3,819	(194,315)
Provider Inflation -- $ 32,054	Special Funds	5,555	3,115	(2,440)
		705,202	737,256	32,054
DD Services	General Funds	0	3,420	3,420
Experienced Parent-- $ 75,000	Federal Funds	75,000	75,000	0
Provider Inflation-- $ 3,420		75,000	78,420	3,420
Detoxification	General Funds	152,768	159,708	6,940
Social Detox.-- $ 152,768	Federal Funds	0	0	0
Provider Inflation-- $ 6,940		152,768	159,708	6,940

Grants Summary

Department of Human Services
NE Human Service Center

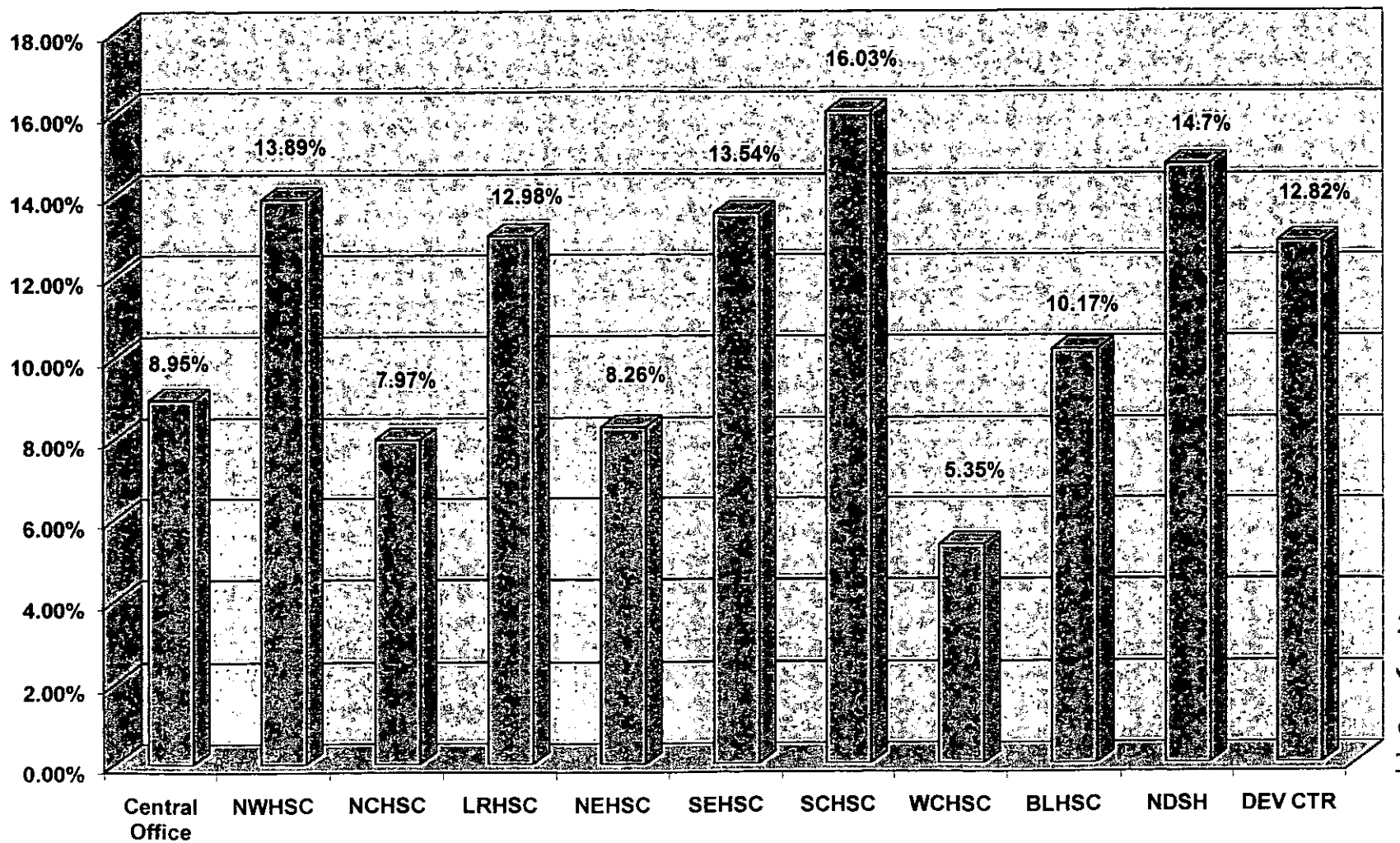
Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Inpatient Hospitalization	General Funds	165,400	172,908	7,508
SMI-- Altru Hospital -- $ 165,400		165,400	172,908	7,508
Provider Inflation-- $ 7,508				
Recovery Center	General Funds	290,000	303,180	13,180
Recovery Center -- $ 290,000		290,000	303,180	13,180
Provider Inflation-- $ 13,180				
Psychiatric / Psychological / Medical Services	General Funds	70,894	45,534	(25,360)
Psychiatric Services-- Altru Hospital $ 62,400	Federal Funds	68,026	14,466	(53,560)
Provider Inflation-- $ 2,832	Special Funds	17,938	5,232	(12,706)
		156,858	65,232	(91,626)
Residential Services	General Funds	2,535,492	2,708,487	172,995
CD Residential Adult -- $ 764,102	Federal Funds	1,532,926	1,516,611	(16,315)
CD Residential Adol -- $ 730,252	Special Funds	179,931	189,714	9,783
SMI Residential-- Prairie Harvest HSF $ 1,341,482		4,248,349	4,414,812	166,463
SMI Transitional Living-- Prairie Harvest HSF - Harvest Homes $ 434,928				
SMI Transitional Living-- Prairie Harvest HSF - Siewert Plains $ 662,658				
CD Residential Women & Children Specific - Growing Together, Inc. $ 289,451				
Provider Inflation-- $ 191,939				
Substance Abuse Treatment and Prevention	General Funds			0
	Federal Funds			0
	Special Funds			0
		0	0	0

Grants Summary

Department of Human Services
NE Human Service Center

Description		Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
TOTAL GRANTS			6,039,171	6,184,116	144,945

ND Department of Human Services
2010 Turnover



Prepared by DHS HR Division
January, 2011

-SB 2012
- Attachment + 5/X
- Brenda Weisz
- March 15, 2011

-Attachment SEVEN -Candace Fuglesten -March 15, 2011

- General fund was also increased by $1,421,236 due to decreased collections and a decrease in the federal medical assistance percentage (FMAP). - SB 2012

In summary, the general fund request increased by $7,950,684 with 24% of that increase ($1,928,425) related to the Governor's salary package for State employees and other salary increases. The grants line accounts for $4,570,994 of the increase which is 57% of the increase. The remaining increase of $1,451,265 is associated with the increase in the operating changes and the loss of federal and other funds described above.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

South Central Human Service Center (SCHSC)

SCHSC provides community services to individuals who live in Foster, Wells, Griggs, Barnes, Stutsman, LaMoure, Dickey, McIntosh and Logan counties. This region is comprised of 54,506 residents (8.4% of the state's population) as estimated by the 2009 U.S. Census Bureau and covers 10,441 square miles.

Caseload / Customer Base

- SCHSC continues to provide clinical services in Valley City, Oakes, Carrington, Cooperstown, LaMoure, Wishek and Fessenden. In addition, clinicians who work with individuals with serious mental illness, vocational rehabilitation needs and developmental disabilities travel to each of the nine counties in Region VI providing services.

- SCHSC provided behavioral health services to 3,074 individuals in SFY 2010 (2,313 adults and 761 children received services). This total includes 612 individuals within the developmental disabilities (DD) service area. This represents close to a four percent overall increase in numbers served from last biennium.
- In addition, 685 individuals received Vocational Rehabilitation Services and 124 individuals received Older Blind Services.
- Twenty-seven percent of those receiving services had no insurance. Forty-eight percent are covered by Medicare, Medicaid or other public payers.
- SCHSC has the only full-time community psychiatrist in Region VI.
- SCHSC accounted for 30% of the total admissions to the North Dakota State Hospital (NDSH) in FY 2010, averaging about 24 individuals hospitalized per month. As Region VI has no private inpatient mental health treatment facility, the NDSH is utilized for acute inpatient needs as well as for longer term hospitalization needs. Individuals from Region VI also access out-of-region private psychiatric hospitals.
- Admissions to the crisis residential unit for the past two years averaged 168 individuals per year with 66% of those admissions occurring outside of normal work hours.
- Requests for emergency service interventions continued to remain constant with SCHSC providing 510 emergent interventions in SFY 2010, which is the highest number in the State.
- Twelve percent of North Dakota's reported adult abuse and neglect incidents during FFY 2010 occurred within Region VI.
- SCHSC's Family Caregiver Support Program has consistently served the largest number of caregivers in the state, with an active caseload of 43 individuals. SCHSC utilizes both in-home

and inpatient respite for our caregivers. The Family Caregiver Support Program allows families to delay transitioning of a loved one to a care facility. We can anticipate with a growing population of adults age 60 and over within Region VI that program needs will continue to grow and be impacted by the availability of staffing resources and programmatic funds in the future.

- There was a decreasing rate of staff turnover which was 3.64% in CY 2009. SCHSC also saw the positive results of its efforts to "grow our own professionals" in the filling of all open licensed addiction counselor positions.
- A workforce analysis of staff at SCHSC was completed which indicated a labor force of skilled experienced individuals with a high number of years of service in their current positions. A significant percentage of individuals will reach the "rule of 85" within next few years and will be eligible for state retirement. For succession planning purposes, we have made administrative and supervisory training available to interested staff to minimize the impact of retirements and to prepare individuals to compete and perform in the near future in leadership roles.
- An essential new element in the south central region's recovery oriented mental health system has been the introduction and development of the peer support program. As a means to model recovery and resiliency in overcoming everyday obstacles common to those who live with serious mental illness (SMI), 3 trained peer support specialists (individuals who have experienced SMI) coordinate weekly peer support groups with 70-80 consumers actively participating in recovery-based activities.
- SCHSC participates in the Network for the Improvement of Addiction Treatment (NIATx) project, which utilizes a rapid change

process to look at program and process improvement. The Center reviewed barriers consumers face in attending assessments and follow-up appointments. As a result, we have implemented strategies which have resulted in no show rate for intakes at 21% and the no show rates for follow up appointments between 12.6% and 15%, both of which are well below industry standards.

Program Trends

- Citizens age 65 and older comprised 25% of the total population in Region VI. The south central region has the oldest average age in the state. The current estimate for individuals 65 and older in McIntosh County is 37.2% which makes it one of the highest in the country.
- The baby boomers, the large group of individuals born between 1946 and 1964, will continue to create a sizable bulge in the region's future age distribution. Projections indicate that between 2010 and 2015, 35% of the region's residents will be age 60 and over.
- The changing age profile of Region VI has implications for both the caregiver program and adult abuse and neglect reporting and interventions. Requests for interventions remain strong due to several factors including declining health status of older adults, poverty which hits certain old age subgroups the hardest, and other vulnerabilities associated with advanced age. These factors, in conjunction with Department's goal to assist this population to remain independent as long as possible, impacts referrals and workloads of SCHSC staff.
- During CY 2010, Stutsman County within Region VI has seen 40 Somali families move to the Jamestown area, with 27 of those families receiving housing assistance. Additionally Stutsman County Housing received housing assistance requests from 1,400

Somali families and received completed applications from 400 of these requests. They continue to receive about ten new applications monthly from Somali families. This has resulted in the housing assistance wait list being frozen with 123 households on the wait list. This means about a minimum of a one year wait for housing assistance in Jamestown and a three to four year wait for housing assistance in the outlying areas surrounding Jamestown. This has a significant impact on meeting the housing needs of the vulnerable consumers served by the Center.

- In the child welfare area, the region continues to increase in the number of full assessments done in response to reports of child abuse, completing 243 in SFY 2009 and 262 in SFY 2010. Region VI is also placing increased emphasize on the placement of children with relatives as well as county social services serving children who at one time were served in the juvenile justice system as they are not delinquent but impacted by abuse and neglect.
- SCHSC continued to strengthen consumer care through multiple collaborative efforts with local inpatient and outpatient facilities on such issues as social detoxification, transportation, consumer medication distribution efforts, homelessness, licensed addiction counselor development and recruitment, outpatient sex offender evaluations, and substance abuse prevention efforts.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
SCHSC	15,702,864	1,250,835	16,953,699	-	16,953,699
General Funds	8,464,433	879,114	9,343,547	-	9,343,547
Federal Funds	6,486,699	204,852	6,691,551	-	6,691,551
Other Funds	751,732	166,869	918,601	-	918,601
Total	15,702,864	1,250,835	16,953,699	-	16,953,699

FTE	85.50	-	85.50	-	85.50

Budget Changes from Current Budget to the Executive Budget:

The major changes can be explained as follows:

The salaries and fringe benefits portion of the budget increased $1,059,336.

- $636,693 in total funds of which $516,333 is general fund needed to fund the Governor's salary package for state employees.
- $243,504 in total funds of which $190,308 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $90,063 to cover an underfunding of salaries from the 2009 – 2011 budget.
- A decrease of $58,043 to underfund the 2011 – 2013 pay plan.
- The remaining increase of $147,119 in the salaries and fringe benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 85.50 FTEs in this area of the budget.

The operating portion of the budget increased by $87,222 and can be attributed to the following two items.

- Travel – The increase is made up of an increase in utilization for services to outreach areas and for staff training.
- Operating fees and services - The increase is due to the provision of Aging Outreach services at the HSC and is all federal funds.

The grants portion of the budget increased by $104,277. The net increase is a combination of the 3% inflationary increase for the contracted providers for each year of the biennium and a decrease in the contract cost for residential services. The net increase is all general funds.

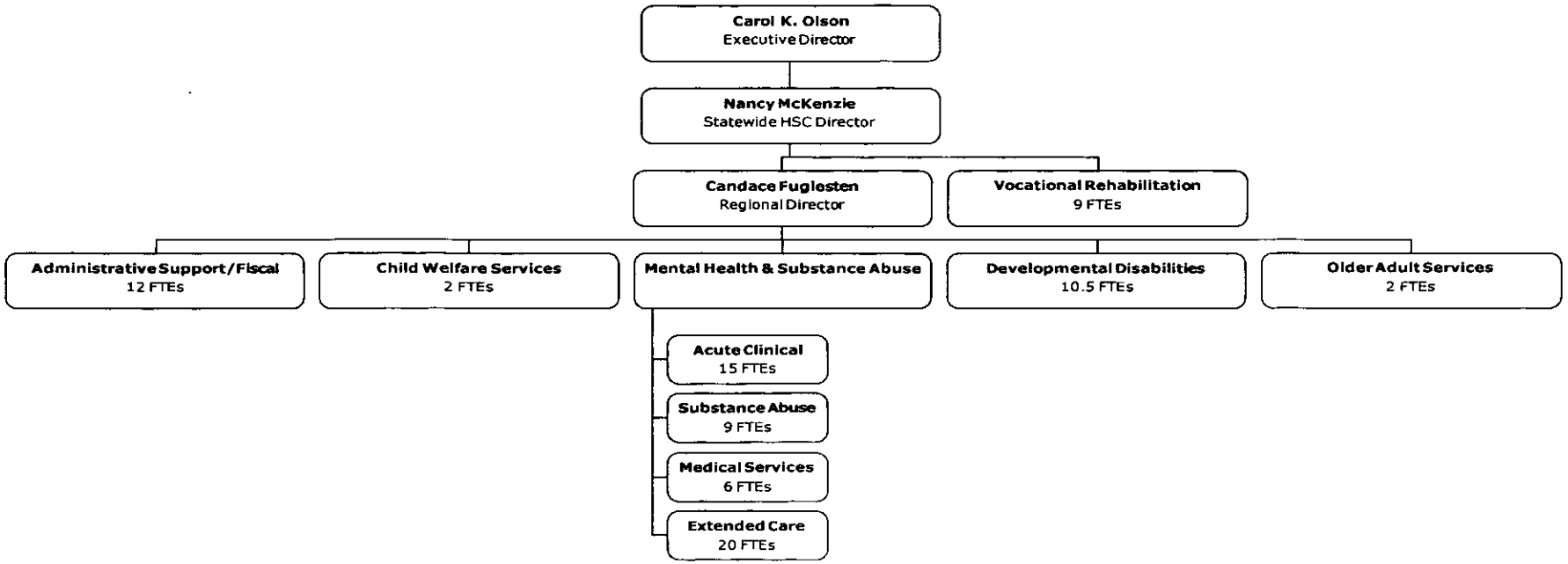
General fund also increased due to a substantial reduction in the federal medical assistance percentage (FMAP).

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for the SEHSC and SCHSC portions of the DHS budget. I would be happy to answer any questions.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SOUTH CENTRAL HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 85.5 FTEs

Revised 3/7/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-76 SOUTH CENTRAL HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	85.500	85.500	0.000	0.000	0.000	85.500	0.000	85.500
32570	B	511000 Salaries - Permanent	6,537,338	7,741,100	3,644,528	446,726	0	8,187,826	0	8,187,826
32570	B	512000 Salaries-Other	6,750	10,200	3,383	(1,199)	0	9,001	0	9,001
32570	B	513000 Temporary Salaries	144,711	177,602	84,417	(9,217)	0	168,385	0	168,385
32570	B	514000 Overtime	16,628	2,500	2,141	(2,500)	0	0	0	0
32570	B	516000 Fringe Benefits	2,424,648	3,058,035	1,465,562	46,876	0	3,104,911	0	3,104,911
32570	B	519100 Reduction in Salary - Budget	0	0	0	(58,043)	0	(58,043)	0	(58,043)
32570	B	521000 Travel	184,937	250,426	107,081	38,765	0	289,191	0	289,191
32570	B	531000 Supplies - IT Software	3,654	4,450	2,756	2,800	0	7,250	0	7,250
32570	B	532000 Supply/Material-Professional	17,773	44,547	10,465	(3,902)	0	40,645	0	40,645
32570	B	533000 Food and Clothing	22,514	25,998	13,910	5,402	0	31,400	0	31,400
32570	B	534000 Bldg, Grounds, Vehicle Supply	12,187	19,465	8,568	416	0	19,881	0	19,881
32570	B	535000 Miscellaneous Supplies	525	5,000	239	(1,000)	0	4,000	0	4,000
32570	B	536000 Office Supplies	28,178	25,754	8,724	(704)	0	25,050	0	25,050
32570	B	541000 Postage	27,912	36,026	15,420	3,701	0	39,727	0	39,727
32570	B	542000 Printing	11,457	11,850	4,813	(1,100)	0	10,750	0	10,750
32570	B	552000 Other Equip under $5,000	1,024	0	0	0	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	8,071	12,959	735	(959)	0	12,000	0	12,000
32570	B	581000 Rentals/Leases-Equip & Other	2,830	1,300	1,292	(1,300)	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	682,907	676,502	357,684	(3,381)	0	673,121	0	673,121
32570	B	591000 Repairs	12,471	17,775	4,337	0	0	17,775	0	17,775
32570	B	599110 Salary Increase	0	0	0	0	367,692	367,692	0	367,692
32570	B	599160 Benefit Increase	0	0	0	0	59,609	59,609	0	59,609
32570	B	599161 Health Increase	0	0	0	0	125,184	125,184	0	125,184
32570	B	599162 Retirement Increase	0	0	0	0	83,963	83,963	0	83,963
32570	B	599163 EAP Increase	0	0	0	0	245	245	0	245
32570	B	602000 IT-Communications	107,572	119,711	56,455	(206)	0	119,505	0	119,505
32570	B	611000 Professional Development	19,776	8,895	3,618	9,530	0	18,425	0	18,425
32570	B	621000 Operating Fees and Services	174,124	60,479	26,070	39,460	0	99,939	0	99,939
32570	B	623000 Fees - Professional Services	464	650	0	0	0	650	0	650
32570	B	625000 Medical, Dental and Optical	2,844	3,300	2,801	(300)	0	3,000	0	3,000
32570	B	712000 Grants, Benefits & Claims	2,828,267	3,388,340	1,510,417	104,277	0	3,492,617	0	3,492,617

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-76 SOUTH CENTRAL HSC										
		Subtotal:	13,279,562	15,702,864	7,335,416	614,142	636,693	16,953,699	0	16,953,699
32570	F	F_7091 HSCs & Institutions - Gen Fund	6,928,294	8,464,433	3,739,107	362,781	516,333	9,343,547	0	9,343,547
32570	F	F_7092 HSCs & Institutions - Fed Fnds	5,533,646	6,486,699	3,297,053	84,493	120,359	6,691,551	0	6,691,551
32570	F	F_7093 HSCs & Institutions - Oth Fnds	817,622	751,732	299,256	166,868	1	918,601	0	918,601
		Subtotal:	13,279,562	15,702,864	7,335,416	614,142	636,693	16,953,699	0	16,953,699
		Subdivision Budget Total:	13,279,562	15,702,864	7,335,416	614,142	636,693	16,953,699	0	16,953,699
410-76 SOUTH CENTRAL HSC		**General Funds:**	6,928,294	8,464,433	3,739,107	362,781	516,333	9,343,547	0	9,343,547
		Federal Funds:	5,533,646	6,486,699	3,297,053	84,493	120,359	6,691,551	0	6,691,551
		Other Funds:	817,622	751,732	299,256	166,868	1	918,601	0	918,601
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	13,279,562	15,702,864	7,335,416	614,142	636,693	16,953,699	0	16,953,699

South Central Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	11.88	625,121	356,512	268,609
Transitional Living Facility Rent		48,000		48,000
Total Rentals & Leases Budget Account Code		**673,121**	**356,512**	**316,609**

South Central Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Bus Transportation and Gas Vouchers for clients	11,600	6,257	5,343
Cable Television at Transitional Living Home	950	0	950
Client Record Requests to Other Agencies	775	492	283
Flexible Funding for Partnership Children	4,125	2,235	1,890
Freight Costs for Purchased Goods	3,261	2,404	857
Job Announcements and Yearly Civil Rights Legal Notices	11,700	10,232	1,468
Aging Service Outreach	36,663	0	36,663
Rent Assistance for Homeless clients	8,000	3,482	4,518
Respite Care for Families	5,000	5,000	0
Staff Licenses	9,165	5,142	4,023
Years of Service Awards	8,700	7,608	1,092
Total Operating Fees & Services Budget Account Code	**99,939**	**42,852**	**57,087**

Grants Summary

Department of Human Services
South Central Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Case Aide	General Funds	13,632	7,966	(5,666)
Partnership-- $13,632	Federal Funds	0	6,285	6,285
Inflation - $619	Special Funds	0		0
		13,632	14,251	619
DD Services	Federal Funds	34,000	35,000	1,000
Experienced Parent-- $35,000		34,000	35,000	1,000
Recovery Center	General Funds	254,364	272,905	18,541
Recovery Center -- $261,040	Federal Funds	0	0	0
Inflation - $11,865		254,364	272,905	18,541
Residential Services	General Funds	1,827,944	1,973,451	145,507
Social Detox-- $36,784	Federal Funds	1,253,400	1,191,783	(61,617)
CD Residential -- $621,785	Special Funds	0	0	0
SMI Residential-- $403,479		3,081,344	3,165,234	83,890
SMI Transitional Living--				
Semi-Structured-- $1,014,528				
TL facility - 14 bed -- $951,312				
Inflation - $137,346				
Respite Care	General Funds	5,000	5,227	227
Inflation - $227		5,000	5,227	227
TOTAL GRANTS		**3,388,340**	**3,492,617**	**104,277**

- Attachment ONE

Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 15, 2011

Chairman Pollert, members of the House Appropriations Committee - Human Resources Division, I am Candace Fuglesten, Director of Southeast Human Service Center (SEHSC) and South Central Human Service Center (SCHSC) for the Department of Human Services (DHS). I am here today to provide you an overview of the budgets for both Centers.

Southeast Human Service Center (SEHSC)

SEHSC provides community behavioral health and safety net services to individuals who live in Steele, Traill, Cass, Ransom, Sargent and Richland counties, in Region V of our State. The region is comprised of 178,472 residents (27.6% of the state's population) as estimated by the 2009 U.S. Census Bureau.

Caseload / Customer Base

- SEHSC provided behavioral health services to 5,102 individuals in State Fiscal Year (SFY) 2010 (4,003 adults and 1,099 children 17 years of age or younger). This total includes 1,247 individuals within the developmental disability (DD) service area. Thirty-seven percent of those individuals have no insurance and 45% are covered by Medicare, Medicaid or another public funding source.
- SEHSC also provided Vocational Rehabilitation (VR) services to 1,451 individuals.

- Due to demand issues and capacity limitations, SEHSC provides all of the established human service center core services, but prioritizes serving the most vulnerable individuals who cannot access services elsewhere in the community/region. Our Admission staff assists individuals requesting non-urgent services, who have the potential to access other community providers, by discussing alternative resources with the caller. Many of these individuals with acute needs then seek those services from other local providers.
- Due to the high demand for case management services for individuals with serious mental illness and/or chronic addiction, we provide those services to those individuals most often accessing higher level of care such as hospitalization, repeat law enforcement encounters, social detox and/or harm to self or others. Individuals who receive case management services require multiple and generally more intensive services.
- Thirty-three percent of all admissions to the North Dakota State Hospital (NDSH) in SFY 2010 came from this region. This is a significant increase from last biennium and a reversal in the trend of decreasing admissions for the region. When MeritCare partnered to become Sanford Medical Center, the mission and purpose of their psychiatric services changed to focus more on acute admissions. This has resulted in decreased local hospital options for SEHSC consumers with severe mental illness; and increased the number of individual with severe mental illness referred by Sanford to SEHSC for services. Hence, local short-term inpatient hospitalization for indigent clients is less available and consumers with severe mental illness referred to SEHSC for outpatient care is growing. Prairie St. John's has stepped up to provide more hospital services to adult individuals with severe

mental illness, but as they are a standalone psychiatric hospital they are unable to collect payment from Medical Assistance adult clients due to the federal institutions for mental disease (IMD) exclusion. All of this has played a role in the increased admissions to the NDSH. Prairie St. John's at this time is also restricting new admissions to their outpatient services, referring many of those individuals to SEHSC.

- We have one 15 bed crisis unit which continues to have high utilization. A triage process is used for admission access.
- We also contract for crisis beds for children with severe emotional disorders and crisis/social detox beds for adolescents with substance abuse issues. The addiction crisis beds provide an intensive level of substance abuse residential care in a family setting. Outcomes in this area have been very positive with increased school attendance, reduction in substance use, and successful reintegration into the parental home.
- Many of our clients are involved in the correctional system either at the local jail and court system or after release from prison and under the supervision of Probation and Parole. The SEHSC regional intervention staff works with the jail to triage and identify new individuals that need immediate psychiatric evaluations that are completed by SEHSC staff at the jail. SEHSC most recently completed a formal contract with Cass County Jail, who was awarded a Department of Justice grant to work with community partners in a pilot project of a post-booking diversion program for eligible offenders with mental health diagnoses. As a result of the demonstration project, called the Jail Intervention Coordinating Committee (JICC), Cass County Jail has recognized the benefit and funded a mental health professional to work in the jail and SEHSC has an expedited process in providing case

management services to offenders whose mental illness contributed to their commitment of a crime when the court feel that is an appropriate piece of their sentence. A positive unintended outcome of the project was an increase in getting individuals at the jail who were identified as having mental illness connected with services at SEHSC and with other area providers without the court ordering requirement. Both the jail and the prison work with us to plan for aftercare as much as possible with appointments made as often as possible for the day of release.

- The demand for addiction treatment services for both adults and adolescents in our region continues to grow. During this biennium, we became newly licensed to provide 3.1 American Society of Addiction Medicine (ASAM) level of residential care treatment at both our crisis residential unit and for an additional eight beds at Dakota Pioneer, which is an apartment building housing vulnerable adults. We have also expanded outreach hours in both Lisbon and Wahpeton to meet rural demand. This increased demand occurs at a time that SEHSC is experiencing a difficult time recruiting qualified licensed addiction counselors. SEHSC has implemented a "grow our own" addiction counselor program providing education support and training to current employees to help them obtain an addiction counselor license. Due to the continued expected labor shortage in this area, and expected retirement of a large number of current licensed addiction counselors in the State, this will be an on-going effort for the foreseeable future.
- The turnover rate for all employees at SEHSC during Calendar Year 2009 was 10.84%.

- We have just finished our third full year of implementing the evidence-based practice of Integrated Dual Disorder Treatment (IDDT) which has proven to improve the quality of life for individuals with co-occurring mental and chronic substance use disorders. IDDT outcomes include **reduced** rates of relapse, hospitalization, arrest, incarceration, and utilization of high cost services while **increasing** continuity of care, quality of life outcomes, stable housing, employment, and independent living. This model provides staff with very specific strategies for delivering service. Fidelity reviews led by Ohio Case Western University have been very positive and local outcomes good.
- In conjunction with the University of North Dakota Medical School, SEHSC continues to provide a psychiatric residency training site for a number of doctors each year. This has assisted with recruitment of psychiatrists both at our Center and within the State.
- SEHSC was granted a five year accreditation by the American Psychological Association (APA) in November 2009 as an approved internship site. This is the first approved APA accredited site in North Dakota to our knowledge. We believe this will assist in our recruitment efforts of psychologists for the Department, especially those completing their education at the University of North Dakota where they are required to participate in an APA approved intern site. This will provide them a North Dakota State option which has not been available to them before.

Program Trends

- The demographics of the region are shifting. Individuals 85 and older increased by 32% from 2000 to 2008. Fargo-Moorhead continues to have a culturally diverse population which requires interpreters and other special services from the center.
- Area minority groups continue to experience high levels of poverty. The largest increase in poverty since 2000 is among single mothers regardless of ethnic background.
- Seventy-six percent of children under the age of six have both parents working.
- Region V has 40% (111 individuals) of the long term homeless population in North Dakota according to the latest point in time study conducted in January 2010. "That definition is used to describe individuals or families with disabling conditions who have been homeless continuously for at least one year, or more than four times in the last three years (ND Interagency Council on Homelessness)."
- As of December 1, 2010, there were 90 children from Region V in the custody of the Department of Human Services, which is a slight increase from last biennium.
- There are between 300-350 children in foster homes in the region during a year which mirrors the State trend of declining numbers.
- There is a trend statewide and locally of placing more children with relatives instead of existing foster homes, if it can be done safely. Cass County is part of a pilot project of convening a meeting of the extended family when children are taken into custody so the family can help decide if there are family members able and willing to provide care for the children.

- There is also a trend statewide that shows children once placed with the Division of Juvenile Services are now being referred to county social services. The philosophy is that some of the children that entered the juvenile correction system were neglected and abused children and the social service system could better meet their needs.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
SEHSC	30,339,652	8,125,068	38,464,720	-	38,464,720
General Funds	14,235,049	7,950,684	22,185,733	-	22,185,733
Federal Funds	14,748,761	396,283	15,145,044	-	15,145,044
Other Funds	1,355,842	(221,899)	1,133,943	-	1,133,943
Total	30,339,652	8,125,068	38,464,720	-	38,464,720
FTE	182.35	(.20)	182.15	-	182.15

Budget Changes from Current Budget to the Executive Budget:

The salary and wages line item increased by $2,525,038 which is primarily attributed to the following:

- $1,319,916 in total funds of which $1,064,086 is general fund to fund the Governor's salary package;
- $476,950 in total funds of which $339,351 is general funds to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget;
- An increase of $115,044 to cover an underfunding of salaries from the 2009 – 2011 budget;
- A decrease of $99,079 to underfund the 2011 – 2013 pay plan;

- $70,299 to provide for the annual and sick leave lump sum payouts for 11 FTE's expected to retire;
- $92,059 in total funds of which $88,790 is general fund to maintain our current temporary employees;
- A decrease of $32,278 in the budget for overtime; and
- During the current biennium, $503,146 was transferred from the salaries – permanent budget account code to the temporary salaries budget account code to meet the increased demand for services and to prevent waiting lists. The increase is included as part of the continuing program changes in the salaries – permanent budget account code.
- The remaining increase of $78,981 in the salaries and fringe benefits portion of the budget is a combination of increases and decreases needed to sustain the salary of the 182.15 FTEs and temporary employees in this area of the budget.

The operating line item increased by $65,636 and is a combination of increases and decreases expected next biennium. The majority of changes can be explained as follows:

- increased rent of $12,803 for the Off Main (dual diagnosis mental health/substance abuse) facility;
- $62,289 of federal funds, in operating fees, for vulnerable adults ombudsman program to fund local point of contact and outreach services;
- $10,981 inflation and demand increase for janitorial, drug testing and interpreter services;
- increase of $21,441 in professional service fees for the cost of the accreditation survey for our sheltered workshop during the 2011-2013 biennium;

- $7,330 decrease in motor pool costs due to removing budgets for federal part C programs from the Center budget.
- a decrease of $33,211 for staff training due to making the amount uniform for each staff in the department;
- The operating increases have a total increase of $37,857 of general fund.

Grants increased by $5,534,394 primarily based on the following:

- Inflationary increases of 3% each year for providers for a total of $265,241;
- An increase of $201,203 to continue an eight bed short term substance abuse residential facility that was established in August 2010 based upon need;
- $498,502 for an additional 24 hour contracted staff program coverage for the Cooper Apartments to ensure safety;
- $939,159 for a 15 bed substance abuse residential facility;
- $25,000 for peer support services at the Recovery Center
- A decrease of $206,339 in the medical detox contract due to the discontinuance of medical detox services for the chemically dependent population by the provider;
- $384,000 for continuing a supported employment project for individuals with mental illness;
- $3,431,017 for the increased need of inpatient hospital services for indigent HSC clients across the State. One contract for all human service centers will apply a uniform Medical Assistance equivalent rate and consistent contract specifications for all providers of the hospital service;
- These grant line increases/decreases account for $4,570,994 of general funds.

- General fund was also increased by $1,421,236 due to decreased collections and a decrease in the federal medical assistance percentage (FMAP).

In summary, the general fund request increased by $7,950,684 with 24% of that increase ($1,928,425) related to the Governor's salary package for State employees and other salary increases. The grants line accounts for $4,570,994 of the increase which is 57% of the increase. The remaining increase of $1,451,265 is associated with the increase in the operating changes and the loss of federal and other funds described above.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

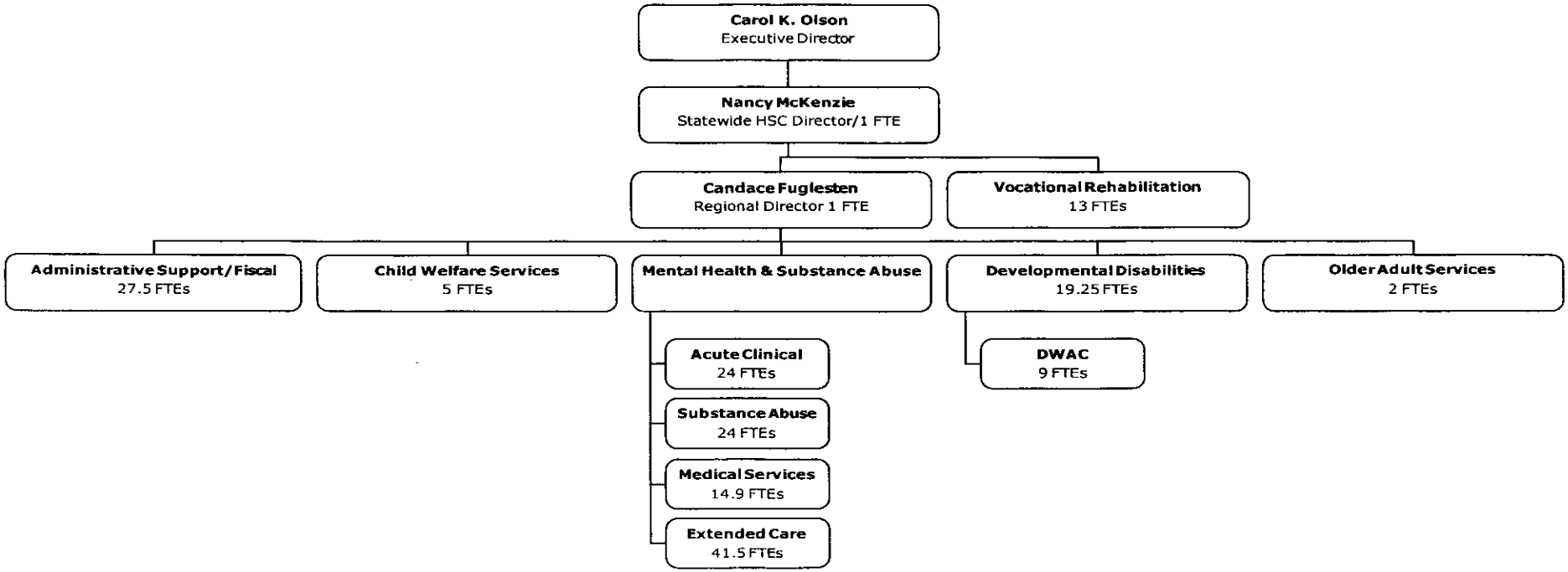
South Central Human Service Center (SCHSC)

SCHSC provides community services to individuals who live in Foster, Wells, Griggs, Barnes, Stutsman, LaMoure, Dickey, McIntosh and Logan counties. This region is comprised of 54,506 residents (8.4% of the state's population) as estimated by the 2009 U.S. Census Bureau and covers 10,441 square miles.

Caseload / Customer Base

- SCHSC continues to provide clinical services in Valley City, Oakes, Carrington, Cooperstown, LaMoure, Wishek and Fessenden. In addition, clinicians who work with individuals with serious mental illness, vocational rehabilitation needs and developmental disabilities travel to each of the nine counties in Region VI providing services.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
SOUTHEAST HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 182.15 FTEs

Revised 3/4/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-75 SOUTHEAST HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	182.350	182.350	0.000	(0.200)	0.000	182.150	0.000	182.150
32570	B	511000 Salaries - Permanent	14,529,919	15,811,340	7,851,725	1,030,811	0	16,842,151	0	16,842,151
32570	B	513000 Temporary Salaries	580,491	1,235,477	524,204	92,059	0	1,327,536	0	1,327,536
32570	B	514000 Overtime	28,401	32,278	20,670	(32,278)	0	0	0	0
32570	B	516000 Fringe Benefits	5,272,398	6,333,199	3,196,261	213,609	0	6,546,808	0	6,546,808
32570	B	519100 Reduction in Salary - Budget	0	0	0	(99,079)	0	(99,079)	0	(99,079)
32570	B	521000 Travel	450,978	464,026	240,696	(7,330)	0	456,696	0	456,696
32570	B	531000 Supplies - IT Software	18,469	27,286	12,758	0	0	27,286	0	27,286
32570	B	532000 Supply/Material-Professional	34,694	46,571	22,115	0	0	46,571	0	46,571
32570	B	533000 Food and Clothing	4,716	6,764	3,343	0	0	6,764	0	6,764
32570	B	534000 Bldg, Grounds, Vehicle Supply	28,303	19,930	8,271	0	0	19,930	0	19,930
32570	B	535000 Miscellaneous Supplies	55,372	41,983	27,496	0	0	41,983	0	41,983
32570	B	536000 Office Supplies	45,523	45,534	31,903	0	0	45,534	0	45,534
32570	B	541000 Postage	42,198	44,350	22,676	0	0	44,350	0	44,350
32570	B	542000 Printing	27,949	26,196	11,912	0	0	26,196	0	26,196
32570	B	552000 Other Equip under $5,000	3,801	9,405	777	0	0	9,405	0	9,405
32570	B	553000 Office Equip & Furniture-Under	42,032	16,918	14,030	0	0	16,918	0	16,918
32570	B	561000 Utilities	153,670	162,730	61,296	0	0	162,730	0	162,730
32570	B	571000 Insurance	416	736	325	0	0	736	0	736
32570	B	581000 Rentals/Leases-Equip & Other	12,868	15,328	8,010	50	0	15,378	0	15,378
32570	B	582000 Rentals/Leases - Bldg/Land	197,288	209,320	106,085	12,803	0	222,123	0	222,123
32570	B	591000 Repairs	381,299	250,051	118,509	(28,383)	0	221,668	0	221,668
32570	B	599110 Salary Increase	0	0	0	0	762,071	762,071	0	762,071
32570	B	599160 Benefit Increase	0	0	0	0	122,818	122,818	0	122,818
32570	B	599161 Health Increase	0	0	0	0	260,551	260,551	0	260,551
32570	B	599162 Retirement Increase	0	0	0	0	173,927	173,927	0	173,927
32570	B	599163 EAP Increase	0	0	0	0	549	549	0	549
32570	B	601000 IT - Data Processing	119	1,860	1,200	0	0	1,860	0	1,860
32570	B	602000 IT-Communications	237,216	257,531	124,127	(2,483)	0	255,048	0	255,048
32570	B	611000 Professional Development	49,270	78,716	28,846	(35,810)	0	42,906	0	42,906
32570	B	621000 Operating Fees and Services	114,289	84,512	57,661	62,473	0	146,985	0	146,985
32570	B	623000 Fees - Professional Services	37,382	58,383	30,960	28,645	0	87,028	0	87,028

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-75 SOUTHEAST HSC										
32570	B	625000 Medical, Dental and Optical	11,689	28,301	12,196	0	0	28,301	0	28,301
32570	B	683000 Other Capital Payments	55,762	0	0	0	0	0	0	0
32570	B	684000 Extraordinary Repairs	0	0	0	35,671	0	35,671	0	35,671
32570	B	691000 Equipment Over $5000	12,762	19,000	6,000	0	0	19,000	0	19,000
32570	B	712000 Grants, Benefits & Claims	3,634,045	5,011,927	2,020,207	5,534,394	0	10,546,321	0	10,546,321
		Subtotal:	26,063,319	30,339,652	14,564,259	6,805,152	1,319,916	38,464,720	0	38,464,720
32570	F	F_7091 HSCs & Institutions - Gen Fund	11,490,333	14,235,049	6,299,883	6,886,598	1,064,086	22,185,733	0	22,185,733
32570	F	F_7092 HSCs & Institutions - Fed Fnds	13,210,375	14,748,761	7,829,578	140,453	255,830	15,145,044	0	15,145,044
32570	F	F_7093 HSCs & Institutions - Oth Fnds	1,362,611	1,355,842	434,798	(221,899)	0	1,133,943	0	1,133,943
		Subtotal:	26,063,319	30,339,652	14,564,259	6,805,152	1,319,916	38,464,720	0	38,464,720
		Subdivision Budget Total:	26,063,319	30,339,652	14,564,259	6,805,152	1,319,916	38,464,720	0	38,464,720
		General Funds:	11,490,333	14,235,049	6,299,883	6,886,598	1,064,086	22,185,733	0	22,185,733
		Federal Funds:	13,210,375	14,748,761	7,829,578	140,453	255,830	15,145,044	0	15,145,044
410-75 SOUTHEAST HSC		**Other Funds:**	1,362,611	1,355,842	434,798	(221,899)	0	1,133,943	0	1,133,943
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	26,063,319	30,339,652	14,564,259	6,805,152	1,319,916	38,464,720	0	38,464,720

SE Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/4/2011

Rentals & Leases	Rate per Sq Ft.	Amount	General	Fed/Other
Human Service Center Building Rent				
Off- Main Facility Rent	12.12	190,985	108,100	82,885
Off- Main Facility Rent	10.21	25,607	14,493	11,114
Rent of Rooms for Off Site Meetings		5,532	5,315	217
Total Rentals & Leases Budget Account Code		**222,123**	**127,908**	**94,215**

SE Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Background checks employee	2,541	1,438	1,103
Client Incentive Programs	597	271	326
Drug tests for addiction clients	15,682	7,918	7,764
Film Processing	357	111	246
Freight Costs for Purchased Goods	3,448	1,952	1,496
Job Announcements and Yearly Civil Rights Legal Notices	30,970	17,529	13,441
Aging Outreach	62,829		62,829
Rent Assistance for Homeless clients	100		100
Special Assessments - Property Taxes	4,097	2,318	1,779
Staff Licenses	11,964	6,772	5,192
Years of Service Awards	14,400	8,151	6,249
Total Operating Fees & Services Budget Account Code	**146,985**	**46,460**	**100,525**

Grants Summary

Department of Human Services
SE Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Adult Protective Services	General Funds	$12,200	$15,836	$3,636
Protective services - $92,200	Federal Funds	$80,000	$80,554	$554
Adult Outreach -		$92,200	$96,390	$4,190
Provider Inflation--$4,190				
Care Coordination	General Funds	$9,223	$18,679	$9,456
Wrap Around $19,274	Federal Funds	$67,809	$61,857	($5,952)
West Fargo $65,040	Special Funds	$7,282	$7,610	$328
Provider Inflation-- $3,832		$84,314	$88,146	$3,832
Case Aide	General Funds	$665,929	$859,773	$193,844
SMI adult--797,596	Federal Funds	$648,063	$922,212	$274,149
CD adult--340,644	Special Funds	$53,067	$43,303	($9,764)
Partnership-- $123,741		$1,367,059	$1,825,288	$458,229
Supported Employment $484,000				
Provider Inflation-- $79,307				
Crisis Care / Safe Beds	General Funds	$297,691	$331,948	$34,257
Partnership Safe Beds--$258,805	Federal Funds	$151,022	$123,142	($27,880)
Crisis Beds-- $161,587	Special Funds	$20,430	$21,830	$1,400
Crises Line $35,748		$469,143	$476,920	$7,777
Provider Inflation--$20,780				
DD Services	General Funds		$0	$0
Behavioral Therapy	Federal Funds	$60,308	$75,000	$14,692
Experienced Parent--$75,000		$60,308	$75,000	$14,692

Grants Summary

Department of Human Services

SE Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Detoxification	General Funds	$35,000	$36,591	$1,591
Social Detox.-- $35,000	Federal Funds	$0		$0
Provider Inflation--$1,591		$35,000	$36,591	$1,591
Flex Funds - Partnership	General Funds	$6,109	$12,368	$6,259
Flex Funds $43,080	Federal Funds	$32,148	$27,627	($4,521)
Provider Inflation--$1,957	Special Funds	$4,823	$5,042	$219
		$43,080	$45,037	$1,957
Inpatient Hospitalization	General Funds	$440,182	$3,675,488	$3,235,306
SMI-- $233,843	Federal Funds		$0	$0
Addiction-- $3,431,017		$440,182	$3,675,488	$3,235,306
Provider Inflation-- $10,628				
Recovery Centers	General Funds	$250,601	$288,127	$37,526
Recovery Center--$275,601	Federal Funds			$0
Provider Inflation--$12,526		$250,601	$288,127	$37,526
Psychiatric / Psychological / Medical Services	General Funds	$15,545	$36,270	$20,725
Psychiatric Services-- $45,000	Federal Funds	$18,152	$7,467	($10,685)
Provider Inflation--$2,046	Special Funds	$11,303	$3,309	($7,994)
		$45,000	$47,046	$2,046
Residential Services	General Funds	$1,073,699	$3,012,524	$1,938,825
CD Residential -- $1,937,358	Federal Funds	$521,626	$308,237	($213,389)
SMI Residential-- $990,800	Special Funds	$8,749	$26,883	$18,134
Supportive Living-- $139,580		$1,604,074	$3,347,644	$1,743,570
Provider Inflation--$104,706				

Grants Summary

Department of Human Services

SE Human Service Center

Description		Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Respite Care		General Funds	$210,958	$220,546	$9,588
Respite Care - $210,958		Federal Funds		$0	$0
Provider Inflation--$9,588			$210,958	$220,546	$9,588
Substance Abuse Treatment and Prevention		General Funds	$154,146	$160,918	$6,772
Native American Access--		Federal Funds	$142,734	$149,777	$7,043
CD Adolescent Recreational/Occupation Therapy--		Special Funds	$13,128	$13,403	$275
Drug Court Contract-- $310,008			$310,008	$324,098	$14,090
Provider Inflation--$14,090					
TOTAL GRANTS			**5,011,927**	**10,546,321**	**5,534,394**

- Attachment TWO

Testimony
SB 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
March 15, 2011

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Tim Sauter, Director of West Central Human Service Center(WCHSC) and Badlands Human Service Center (BHSC) for the Department of Human Services (DHS). I am submitting this testimony to provide you an overview of the budget for both of these centers.

West Central Human Service Center

West Central Human Service Center serves the residents of Burleigh, Emmons, Grant, Kidder, McLean, Mercer, Morton, Oliver, Sheridan, and Sioux counties.

Caseload/Customer Base

- 5,348 individuals received service in Fiscal Year 2010 (4,059 adults and 1,289 children).
- 1,719 individuals received vocational rehabilitation services.
- A high percentage of adults who receive services (92%) and parents whose children receive services (86%) report satisfaction.
- 94% of Vocational Rehabilitation Service clients report satisfaction.
- 91% of the WCHSC Vocational Rehabilitation clients placed on jobs remain employed after 6 months.

Program Trends

- The number of individuals with developmental disabilities receiving services has stabilized over the past two years, serving 1,131 in SFY 2010.
- Alcohol remains the biggest drug problem, there continues to be decrease in methamphetamine numbers, but an increasing number of adult clients who abuse prescription drugs, and adolescents abusing marijuana.
- Continues to be a significant number of referrals from the Department of Corrections and Rehabilitation (DOCR); a point in time review, reveals a decline in the percent of WCHSC adult addiction clients, from 72% in 2008 to 51% in 2010, who were referred for the DOCR.
- The WCHSC Region is seeing an increase in the number of foster home placements.
- The WCHSC Aging Services Unit was selected in October 2009 as the 3 year pilot region for the federally funded Aging and Disability Resource Center project.
- WCHSC is a member of the Standing Rock Sioux Tribe Psychology Internship Training Program.
- We continue to have a minimal number of residents from Region VII enter the North Dakota State Hospital or the Developmental Center.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
WCHSC	24,883,525	1,856,968	26,740,493		26,740,493
General Funds	11,918,377	2,191,155	14,109,532		14,109,532
Federal Funds	11,756,689	(325,728)	11,430,961		11,430,961
Other Funds	1,208,459	(8,459)	1,200,000		1,200,000
Total	24,883,525	1,856,968	26,740,493		26,740,493
FTE	135.30	0.00	135.30		135.30

Budget Changes from Current Budget to Executive Budget:

The Budget increased by $1,856,968 which can be primarily attributed to the following:

- $979,454 for the Governor's salary package of which $737,567 are general funds.
- $348,402 in total funds of which $249,992 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $94,610 to cover an underfunding of salaries from the 2009-2011 budget.
- A decrease of ($81,909) to underfund the 2011-2013 Payplan.
- A decrease of ($25,095) for a part-time Support Services student trainee.
- $26,262 to provide for the annual and sick leave lump sum payouts for five FTE expected to retire.
- The remaining decrease in salaries and benefits, totaling ($121,586), is a combination of increases and decreases needed to sustain the salary of the 135.30 FTE's.
- Decrease of ($29,834) for travel based on motor pool rental rates and our projected utilization.

- Increase in postage of $9,070 based on utilization and rate increases.
- Decrease of ($8,605) in IT Equipment under $5,000. Any purchases made for the VR Technology Lab will be made by the DHS Central Office VR Division.
- Increase of $7,579 for Office Equipment and Furniture under $5,000. Funding would be used to replace aging office furniture with more functional modular furniture and desk chairs.
- Increase of $84,237, for office building rent, as a result of an increase in the projected rental rate.
- Increase in IT-Communications of $7,565 based on utilization and rate changes.
- Reduction of Professional Development by ($19,461) based on Department guidelines.
- Increase in Operating Fees and Services of $67,538 as a result of additional federal funding for Aging Outreach Services.
- Increase of $8,500 for client medication purchases based on utilization and cost.
- Decrease of ($16,500) for Equipment over $5,000. No major equipment purchases are planned.
- Increase in Grants of $539,588 which includes $309,128 to increase the bed capacity, from 10 beds to 14 beds, for our contracted Adult Crisis Residential facility and $231,378 for provider inflationary increases. The remaining decrease in grants, totaling ($918), is a combination of increases and decreases needed to sustain our existing contracts.
- The remaining decrease of ($12,847) is a combination of expenditure increases and decreases needed to sustain the budget for West Central Human Service Center.

The general fund request increased by $2,191,155 and can be primarily attributed to the following:

- An increase of $737,567 for the Governor's salary package.
- An increase of $249,992 to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- An increase of $537,481 to fund the capacity expansion of the Adult Crisis Residential facility and provider inflationary increases.
- The remaining increase of $666,115 is related to ongoing cost to continue operations and the reduction in the Federal Medical Assistance Percentage (FMAP).

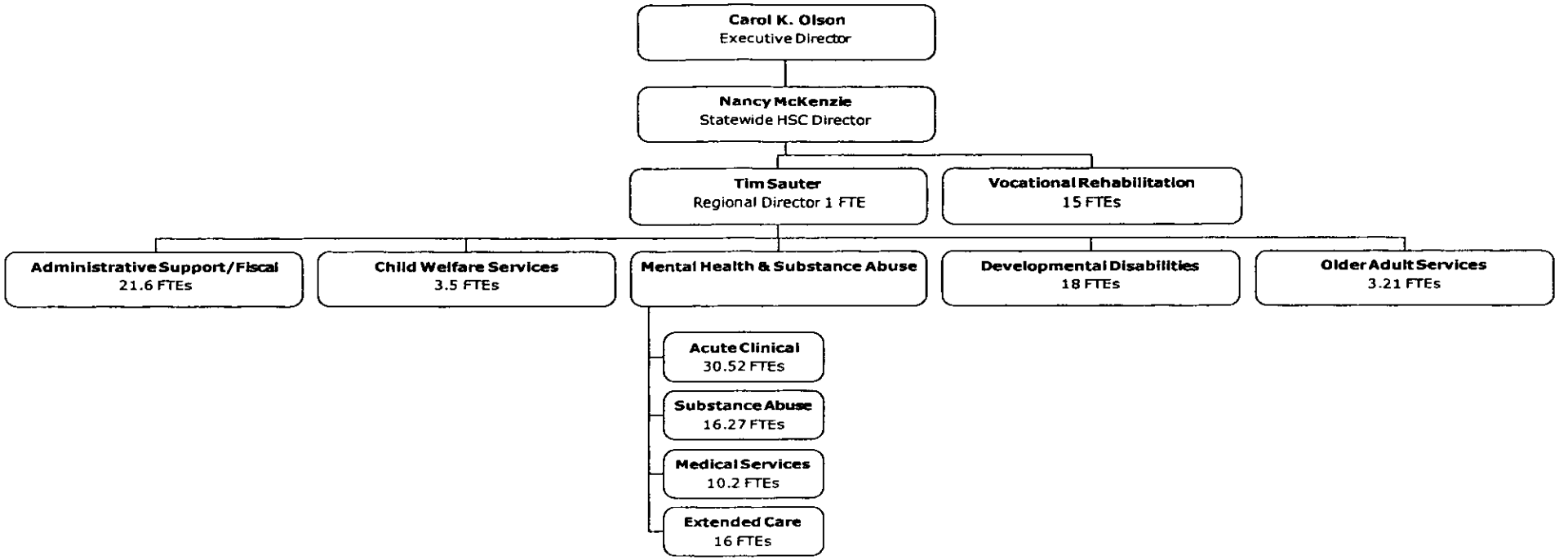
The net change in federal and other funds is primarily the result of a decrease in projected Medical Assistance collections and other changes mentioned previously.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 - 2013 budget request for West Center Human Service Center of the Department. I would be happy to answer any questions.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
WEST CENTRAL HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 135.3 FTEs

Revised 3/4/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-77 WEST CENTRAL HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	135.300	135.300	0.000	0.000	0.000	135.300	0.000	135.300
32570	B	511000 Salaries - Permanent	10,424,905	12,226,344	5,691,342	340,119	0	12,566,463	0	12,566,463
32570	B	513000 Temporary Salaries	63,385	98,943	35,973	(25,095)	0	73,848	0	73,848
32570	B	514000 Overtime	17,171	9,601	8,052	(1)	0	9,600	0	9,600
32570	B	516000 Fringe Benefits	3,761,454	4,678,988	2,233,018	7,570	0	4,686,558	0	4,686,558
32570	B	519100 Reduction in Salary - Budget	0	0	0	(81,909)	0	(81,909)	0	(81,909)
32570	B	521000 Travel	360,432	466,975	163,797	(29,834)	0	437,141	0	437,141
32570	B	531000 Supplies - IT Software	29,900	32,372	12,690	28	0	32,400	0	32,400
32570	B	532000 Supply/Material-Professional	49,612	48,692	30,748	327	0	49,019	0	49,019
32570	B	533000 Food and Clothing	5,223	6,500	1,646	0	0	6,500	0	6,500
32570	B	534000 Bldg, Grounds, Vehicle Supply	3,361	3,200	2,282	0	0	3,200	0	3,200
32570	B	535000 Miscellaneous Supplies	5,004	400	157	0	0	400	0	400
32570	B	536000 Office Supplies	49,236	50,000	11,886	(4,000)	0	46,000	0	46,000
32570	B	541000 Postage	45,126	44,330	25,485	9,070	0	53,400	0	53,400
32570	B	542000 Printing	30,286	31,000	9,567	(4,000)	0	27,000	0	27,000
32570	B	551000 IT Equip under $5,000	1,659	8,605	549	(8,605)	0	0	0	0
32570	B	552000 Other Equip under $5,000	520	0	0	0	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	127,498	22,671	7,718	7,579	0	30,250	0	30,250
32570	B	561000 Utilities	129	0	0	0	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	1,040,627	1,212,580	591,811	84,237	0	1,296,817	0	1,296,817
32570	B	591000 Repairs	10,710	11,500	4,104	(1,400)	0	10,100	0	10,100
32570	B	599110 Salary Increase	0	0	0	0	569,690	569,690	0	569,690
32570	B	599160 Benefit Increase	0	0	0	0	92,688	92,688	0	92,688
32570	B	599161 Health Increase	0	0	0	0	186,323	186,323	0	186,323
32570	B	599162 Retirement Increase	0	0	0	0	130,356	130,356	0	130,356
32570	B	599163 EAP Increase	0	0	0	0	397	397	0	397
32570	B	601000 IT - Data Processing	172	0	0	0	0	0	0	0
32570	B	602000 IT-Communications	150,441	154,596	79,042	7,565	0	162,161	0	162,161
32570	B	611000 Professional Development	21,861	42,317	14,036	(19,461)	0	22,856	0	22,856
32570	B	621000 Operating Fees and Services	63,404	126,455	39,814	67,538	0	193,993	0	193,993
32570	B	623000 Fees - Professional Services	7,980	3,802	2,376	(3,802)	0	0	0	0
32570	B	625000 Medical, Dental and Optical	25,246	20,000	14,245	8,500	0	28,500	0	28,500

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-77 WEST CENTRAL HSC										
32570	B	691000 Equipment Over $5000	0	16,500	0	(16,500)	0	0	0	0
32570	B	712000 Grants, Benefits & Claims	4,584,824	5,567,154	2,678,109	539,588	0	6,106,742	0	6,106,742
		Subtotal:	20,880,166	24,883,525	11,658,447	877,514	979,454	26,740,493	0	26,740,493
32570	F	F_7091 HSCs & Institutions - Gen Fund	9,647,776	11,918,377	5,079,115	1,453,588	737,567	14,109,532	0	14,109,532
32570	F	F_7092 HSCs & Institutions - Fed Fnds	10,199,678	11,756,689	6,132,421	(567,615)	241,887	11,430,961	0	11,430,961
32570	F	F_7093 HSCs & Institutions - Oth Fnds	1,032,712	1,208,459	446,911	(8,459)	0	1,200,000	0	1,200,000
		Subtotal:	20,880,166	24,883,525	11,658,447	877,514	979,454	26,740,493	0	26,740,493
		Subdivision Budget Total:	20,880,166	24,883,525	11,658,447	877,514	979,454	26,740,493	0	26,740,493
		General Funds:	9,647,776	11,918,377	5,079,115	1,453,588	737,567	14,109,532	0	14,109,532
		Federal Funds:	10,199,678	11,756,689	6,132,421	(567,615)	241,887	11,430,961	0	11,430,961
410-77 WEST CENTRAL HSC		**Other Funds:**	1,032,712	1,208,459	446,911	(8,459)	0	1,200,000	0	1,200,000
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	20,880,166	24,883,525	11,658,447	877,514	979,454	26,740,493	0	26,740,493

WC Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/9/2011

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent	15.34	1,075,185	517,786	557,399
Human Service Center Building Rent_VR	16.48	170,132	34,270	135,862
Residential Apartments_DD	N/A	11,500	6,043	5,457
Residential Apartments_Alcohol & Drug	N/A	40,000	6,934	33,066
Total Rentals & Leases Budget Account Code		**1,296,817**	**565,033**	**731,784**

WC Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

Operating Fees & Services	Amount	General	Fed/Other
Aging Outreach Services	87,628		87,628
Respite Care Services	25,000		25,000
Wrap Around Services	25,000		25,000
Flexible Funding_Homeless and SMI	20,000	12,000	8,000
Staff License/Certification Renewal	11,865	4,118	7,747
Staff Service Awards	9,950	4,489	5,461
Program Fees for Client Activities	8,200	2,251	5,949
Client Record Storgage	2,200	1,871	329
Freight and Shipping on purchases	1,550	501	1,049
Shredding Services	1,500	1,275	225
Attorney General Research Fees	1,100	935	165
Total Operating Fees & Services Budget Account Code	**193,993**	**27,440**	**166,553**

Grants Summary

Department of Human Services
WC Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Adult Protective Services	General Funds	$38	$0	($38)
Adult Protective Service--$0	Federal Funds	$0	$0	$0
		$38	$0	($38)
Care Coordination	General Funds	$25,321	$24,766	($555)
Care Coordination--$38,912	Federal Funds	$12,833	$15,798	$2,965
Inflation--$1,769	Special Funds	$38	$117	$79
		$38,192	$40,681	$2,489
Case Aide	General Funds	$743,819	$750,457	$6,638
SMI adult--$641,619	Federal Funds	$590,833	$626,256	$35,423
Partnership--$683,760	Special Funds	$21,447	$40,268	$18,821
CD--$30,000		$1,356,099	$1,416,981	$60,882
Inflation--$61,602				
Crisis Care / Safe Beds	General Funds	$49,725	$50,916	$1,191
Partnership Safe Beds--$80,000	Federal Funds	$25,200	$32,480	$7,280
Inflation--$3,636	Special Funds	$75	$240	$165
		$75,000	$83,636	$8,636
DD Services	Federal Funds	$80,000	$80,000	$0
Experienced Parent--$80,000		$80,000	$80,000	$0
Detoxification	General Funds	$32,518	$47,045	$14,527
Social Detox--$32,518	Federal Funds	$0	$0	$0
Inflation--$2,045		$32,518	$47,045	$14,527
Evaluation Services - VR	General Funds	$1,704	$1,704	$0
Psychological Consultation--$8,000	Federal Funds	$6,296	$6,296	$0
		$8,000	$8,000	$0

Grants Summary

Department of Human Services
WC Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Flex Funds - Partnership	General Funds	$39,780	$35,460	($4,320)
Flexible Funding--$60,000	Federal Funds	$20,160	$24,360	$4,200
	Special Funds	$60	$180	$120
		$60,000	$60,000	$0
Inpatient Hospitalization	General Funds	$150,000	$150,000	$0
SMI--$67,500	Federal Funds	$0	$0	$0
Addiction--$82,500	Special Funds	$0	$0	$0
		$150,000	$150,000	$0
Recovery Center	General Funds	$222,604	$284,994	$62,390
Recovery Center - $272,604	Federal Funds		$0	$0
Inflation--$12,390		$222,604	$284,994	$62,390
Psychiatric / Psychological / Medical Services	General Funds	$113,023	$255,897	$142,874
Medication Monitor--$174,000	Federal Funds	$148,662	$64,091	($84,571)
Title XIX evaluations--$116,000	Special Funds	$47,463	$27,652	($19,811)
CD medical assessments--$5,000		$309,148	$347,640	$38,492
CD acupuncture--$34,960				
Medical Consultation-VR--$4,500				
Inflation--$13,180				
Residential Services	General Funds	$2,037,302	$2,404,789	$367,487
CD Residential Adult--$1,063,450	Federal Funds	$944,599	$871,434	($73,165)
CD Residential Adolescent--$578,500	Special Funds	$131,654	$189,542	$57,888
SMI Residential--$1,373,567		$3,113,555	$3,465,765	$352,210
Clinical Services Residential--$4,364				
Crisis Residential Expansion from 10 to 14 Beds--$309,128				
Inflation--$136,756				

Grants Summary

Department of Human Services
WC Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Respite Care	Federal Funds	$22,000	$22,000	$0
Respite Care--$22,000		$22,000	$22,000	$0
Substance Abuse Treatment and Prevention	General Funds	$17,100	$17,330	$230
Native American Access Program--$100,000	Federal Funds	$69,300	$69,060	($240)
	Special Funds	$13,600	$13,610	$10
		$100,000	$100,000	$0
TOTAL GRANTS		**$5,567,154**	**$6,106,742**	**$539,588**

- Attachment THREE
- Tim Sauter
- March 15, 2011
- SB 2012

Badlands Human Service Center

Badlands Human Service Center (BHSC) serves the people of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties.

Caseload/Customer Base

- Badlands served 1,860 individuals (1,322 adults and 538 children) in SFY 2010.
- 308 individuals received vocational rehabilitation services.
- 89% of adults receiving services, and 94% of the parents whose children receive services, report satisfaction with those services.
- 91% of clients receiving vocational rehabilitation services report satisfaction.
- 93% of BLHSC clients remain employed 6 months after being placed in a job.

Service Trends

- The number of individuals receiving developmental disabilities services had remained stable from SFY 2006 to SFY 2008, but increased in SFY 2010 by 18%.
- The number of referrals from the Department of Corrections and Rehabilitation comprises 48% of the individuals in adult addiction programs in this region.
- Due to oil impact on housing in Dickinson, finding and maintaining housing has become a bigger issue for the people we serve.
- Following the closure of the inpatient mental health unit at St. Joseph's Hospital there was an increase in admission to the North Dakota State Hospital, and the numbers have remained consistent.

Overview of Budget Changes

Description	2009 - 2011 Budget	Increase / Decrease	2011 - 2013 Executive Budget	Senate Changes	To House
BLHSC	10,975,282	814,372	11,789,654		11,789,654
General Funds	5,511,630	1,017,662	6,529,292		6,529,292
Federal Funds	4,648,886	(222,764)	4,426,122		4,426,122
Other Funds	814,766	19,474	834,240		834,240
Total	10,975,282	814,372	11,789,654		11,789,654
FTE	72.70	0.00	72.70		72.70

Budget Changes from Current Budget to Executive Budget:

The Budget increased by $814,372 which can be primarily attributed to the following:

- $503,605 in total funds of which $416,095 is general fund needed to fund the Governor's salary package for state employees.
- $185,410 in total funds of which $141,559 is general fund needed to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $491,554 increase in salaries needed to convert a support services position to medical services. This position will be filled by a full-time Psychiatrist.
- A decrease of ($38,080) to underfund the 2011-2013 Payplan.
- $31,853 to provide for the annual and sick leave lump sum payouts for six FTE expected to retire.
- An increase of $28,097 to cover an underfunding of salaries from the 2009-2011 budget.

- The remaining decrease in salaries and benefits, totaling ($79,552), is a combination of increases and decreases needed to sustain the salary of the 72.70 FTE's.
- $132,798 increase in building rent based primarily on a rent increase from $12 to $15 per square foot.
- $41,960 increase in IT-Data Processing needed for the wiring costs associated with the new Human Service Center facility.
- Professional Development was increased by $5,091 based on Department guidelines.
- $79,051 increase in Operating Fees and Services of which $53,675 is tied to additional federal funds for Aging Outreach Services and $30,000 for moving costs associated with relocating the Human Service Center. The remaining decrease of ($4,624) is related to miscellaneous operating fees.
- The net decrease in grants of ($563,222) relates primarily to the shifting of the psychiatric services budget to salaries and $10,808 for provider inflationary increases.
- The remaining decrease of ($4,193) is a combination of expenditure increases and decreases needed to sustain the budget for Badlands Human Service Center.

The general fund request increased by $1,017,662 which can be primarily attributed to the following:

- $416,095 to fund the Governor's salary package.
- $141,559 to fund the second year employee increase for 24 months versus the 12 months that are contained in the current budget.
- $174,111 for increased building rent and one-time costs associated with relocating the Human Service Center office facility.

- The remaining increase of $285,897 is related to ongoing costs to continue operations and the reduction in Federal Medical Assistance Percentage (FMAP).

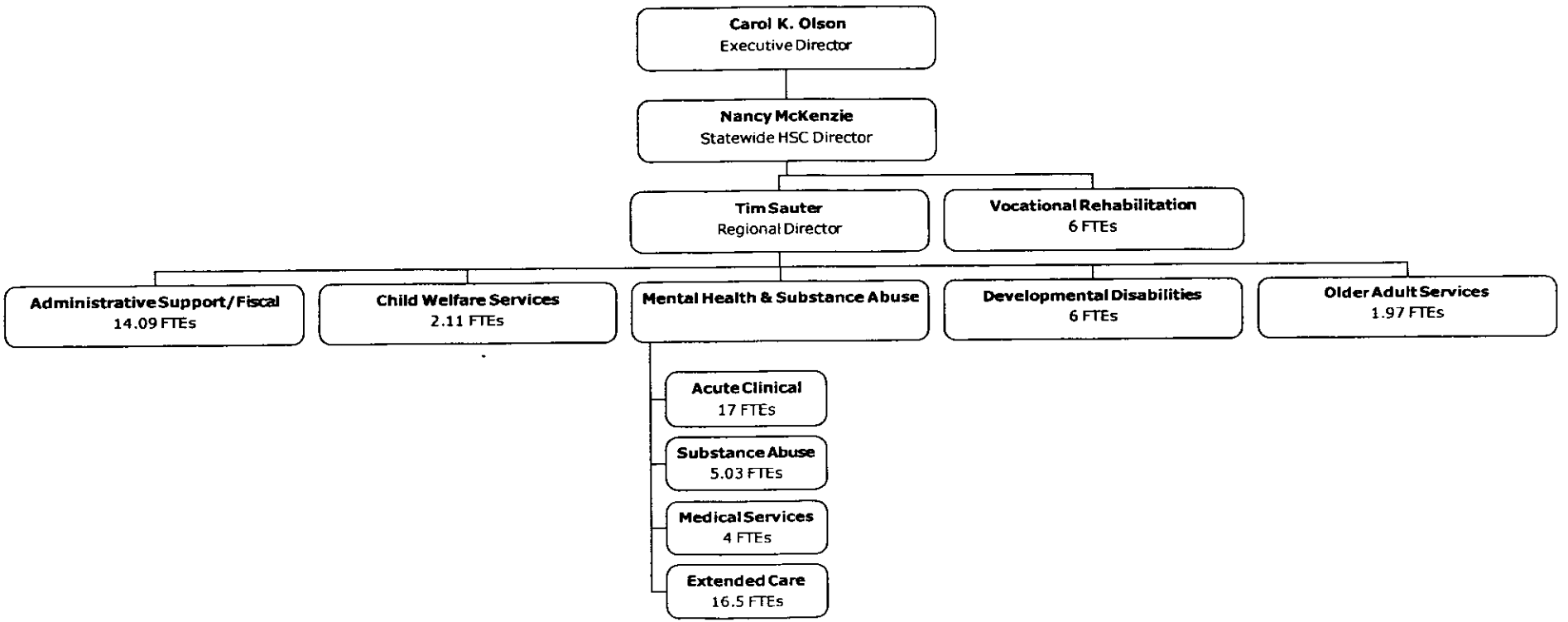
The net change in federal and other funds is a result of the decrease in projected Medical Assistance collections and other changes mentioned previously.

Senate Changes:

The Senate made no changes to this section of the Department's budget.

This concludes my testimony on the 2011 – 2013 budget request for Badlands Human Service Center of the Department. I would be happy to answer any questions.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
BADLANDS HUMAN SERVICE CENTER



2011-2013 Budget
Authorized 72.7 FTEs

Revised 3/4/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-78 BADLANDS HSC										
S101		FULL-TIME EQUIVALENTS (FTEs)	72.700	72.700	0.000	0.000	0.000	72.700	0.000	72.700
32570	B	511000 Salaries - Permanent	4,968,685	5,817,080	2,816,998	564,424	0	6,381,504	0	6,381,504
32570	B	512000 Salaries-Other	6,371	7,008	2,891	1	0	7,009	0	7,009
32570	B	513000 Temporary Salaries	196,326	293,420	120,241	22,108	0	315,528	0	315,528
32570	B	514000 Overtime	3,144	0	0	0	0	0	0	0
32570	B	516000 Fringe Benefits	1,956,522	2,443,369	1,177,295	70,829	0	2,514,198	0	2,514,198
32570	B	519100 Reduction in Salary - Budget	0	0	0	(38,080)	0	(38,080)	0	(38,080)
32570	B	521000 Travel	181,223	216,187	100,709	503	0	216,690	0	216,690
32570	B	531000 Supplies - IT Software	13,769	11,905	3,358	(405)	0	11,500	0	11,500
32570	B	532000 Supply/Material-Professional	25,569	35,182	15,486	407	0	35,589	0	35,589
32570	B	533000 Food and Clothing	43,412	51,225	27,503	500	0	51,725	0	51,725
32570	B	535000 Miscellaneous Supplies	20,548	31,410	11,024	(4,359)	0	27,051	0	27,051
32570	B	536000 Office Supplies	18,111	15,378	7,501	(3,728)	0	11,650	0	11,650
32570	B	541000 Postage	20,116	21,331	10,667	3,069	0	24,400	0	24,400
32570	B	542000 Printing	4,032	13,100	1,772	0	0	13,100	0	13,100
32570	B	552000 Other Equip under $5,000	2,349	0	0	0	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under	44,356	6,250	4,750	2,750	0	9,000	0	9,000
32570	B	561000 Utilities	32,929	35,725	13,274	(4,350)	0	31,375	0	31,375
32570	B	581000 Rentals/Leases-Equip & Other	0	500	0	(500)	0	0	0	0
32570	B	582000 Rentals/Leases - Bldg/Land	614,014	721,339	378,564	132,798	0	854,137	0	854,137
32570	B	591000 Repairs	16,949	13,930	7,164	(1,402)	0	12,528	0	12,528
32570	B	599110 Salary Increase	0	0	0	0	288,151	288,151	0	288,151
32570	B	599160 Benefit Increase	0	0	0	0	47,410	47,410	0	47,410
32570	B	599161 Health Increase	0	0	0	0	101,888	101,888	0	101,888
32570	B	599162 Retirement Increase	0	0	0	0	65,937	65,937	0	65,937
32570	B	599163 EAP Increase	0	0	0	0	219	219	0	219
32570	B	601000 IT - Data Processing	50	0	0	41,960	0	41,960	0	41,960
32570	B	602000 IT-Communications	86,944	89,799	45,348	3,407	0	93,206	0	93,206
32570	B	611000 Professional Development	11,617	9,600	4,855	5,091	0	14,691	0	14,691
32570	B	621000 Operating Fees and Services	54,178	88,595	35,265	79,051	0	167,646	0	167,646
32570	B	625000 Medical, Dental and Optical	449	12,085	65	(85)	0	12,000	0	12,000
32570	B	632000 Other Expenses	150	0	0	0	0	0	0	0

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 410-78 BADLANDS HSC										
32570	B	712000 Grants, Benefits & Claims	831,893	1,040,864	525,114	(563,222)	0	477,642	0	477,642
		Subtotal:	9,153,706	10,975,282	5,309,844	310,767	503,605	11,789,654	0	11,789,654
32570	F	F_7091 HSCs & Institutions - Gen Fund	4,744,544	5,511,630	2,473,490	601,567	416,095	6,529,292	0	6,529,292
32570	F	F_7092 HSCs & Institutions - Fed Fnds	3,650,036	4,648,886	2,447,840	(310,274)	87,510	4,426,122	0	4,426,122
32570	F	F_7093 HSCs & Institutions - Oth Fnds	759,126	814,766	388,514	19,474	0	834,240	0	834,240
		Subtotal:	9,153,706	10,975,282	5,309,844	310,767	503,605	11,789,654	0	11,789,654
		Subdivision Budget Total:	9,153,706	10,975,282	5,309,844	310,767	503,605	11,789,654	0	11,789,654
410-78 BADLANDS HSC		**General Funds:**	4,744,544	5,511,630	2,473,490	601,567	416,095	6,529,292	0	6,529,292
		Federal Funds:	3,650,036	4,648,886	2,447,840	(310,274)	87,510	4,426,122	0	4,426,122
		Other Funds:	759,126	814,766	388,514	19,474	0	834,240	0	834,240
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	9,153,706	10,975,282	5,309,844	310,767	503,605	11,789,654	0	11,789,654

BL Human Service Center
Detail of Budget Account Code 582000
For the 2011 - 2013 Biennium Budget

3/10/2011

Rentals & Leases	Rate per Sq.Ft.	Amount	General	Fed/Other
Human Service Center Building Rent_Main Office	12.75	431,970	251,609	180,361
Human Service Center Building Rent_Main Office Basement	5.00	13,260	11,700	1,560
Additional Rent for New Human Service Center Office Building	15.00	118,255	108,203	10,052
Outreach Offices_Bowman	7.50	6,000	2,151	3,849
Outreach Offices_Beach	9.14	1,920	688	1,232
Human Service Center_Supported Living Office	9.19	5,880	5,880	0
Human Service Center Building Rent_VR Office	10.30	70,452	14,418	56,034
Human Service Center_Transitional Living Facility	21.72	206,400	53,413	152,987
Total Rentals & Leases Budget Account Code		**854,137**	**448,062**	**406,075**

BL Human Service Center
Detail of Budget Account Code 621000 - Operating Fees & Services
For the 2011 - 2013 Biennium

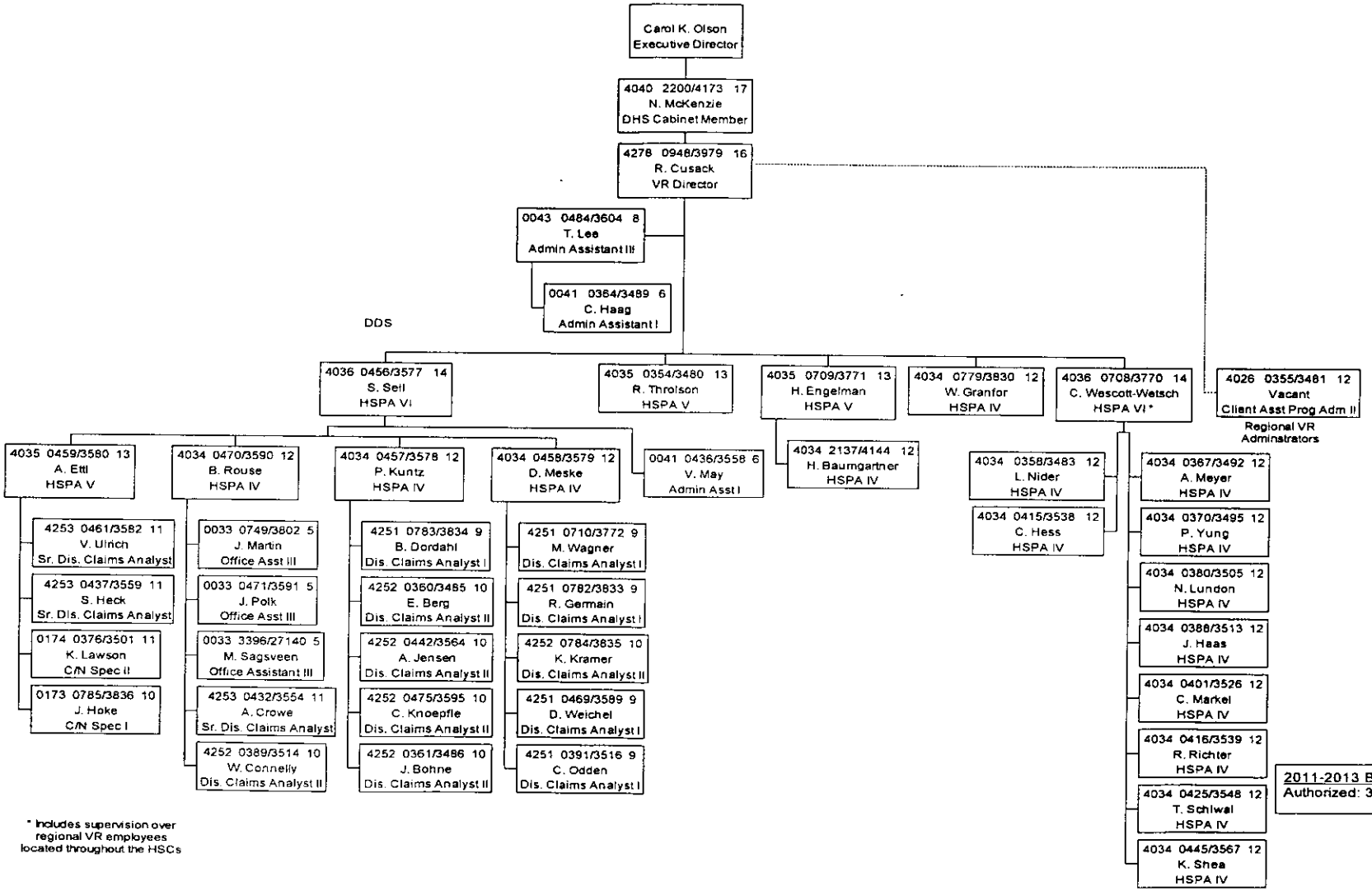
Operating Fees & Services	Amount	General	Fed/Other
Aging Outreach Services	53,675		53,675
Moving Expenses to New Office Facility	30,000	27,450	2,550
Wrap Around Services	18,000	18,000	
Respite Care Services	12,000	12,000	
Flexible Funding_Homeless	8,000		8,000
Staff License/Certification Renewal	7,555	3,038	4,517
Service Awards	7,550	4,139	3,411
Program fees for client activities	7,000	2,370	4,630
Cleaning/Janitorial service	6,543	1,320	5,223
Misc. fees related to vehicle maintenance and shredding services	5,723	5,050	673
Snow Removal_VR Office	4,650	878	3,772
Radio - TV- Newspaper Services--Advertising	3,000	2,510	490
Snow Removal, Cleaning and yard work--Bowman Outreach	2,000	730	1,270
Cable TV for Residential Services	1,200	199	1,001
Attorney General Research Fees	600	529	71
Background Checks	150	23	127
Total Operating Fees & Services Budget Account Code	**167,646**	**78,236**	**89,410**

Grants Summary

Department of Human Services
BL Human Service Center

Description	Funding	2009-2011 Appropriation	2011-2013 Budget Recommendation	Total Changes
Care Coordination	General Funds	14,400	0	(14,400)
Care Coordination - $0	Federal Funds	600	0	(600)
	Special Funds	0	0	0
		15,000	0	(15,000)
DD Services	General Funds	3,830	0	(3,830)
Experienced Parent - $35,000	Federal Funds	40,000	35,000	(5,000)
	Special Funds	0	0	0
		43,830	35,000	(8,830)
Inpatient Hospitalization	General Funds	130,000	130,000	0
Inpatient Hospitalization - $130,000	Federal Funds	0	0	0
	Special Funds	0	0	0
		130,000	130,000	0
Psychiatric / Psychological / Medical Services	General Funds	307,006	19,444	(287,562)
Medical Consultation (VR) - $1,250	Federal Funds	279,200	28,874	(250,326)
Outreach Services - $22,000	Special Funds	51,844	4,932	(46,912)
CD Acupuncture - $30,000		638,050	53,250	(584,800)
Recovery Center	General Funds	212,784	248,592	35,808
Recovery Center - $237,784	Federal Funds	0		0
Inflation--$10,808	Special Funds	0		0
		212,784	248,592	35,808
Residential Services				
Residential Adult Transportation Services - $10,800	General Funds	1,200	7,158	5,958
	Federal Funds	0	3,642	3,642
	Special Funds	0		0
		1,200	10,800	9,600
TOTAL GRANTS		**1,040,864**	**477,642**	**(563,222)**

North Dakota Department of Human Services
Vocational Rehabilitation and Disability Determination Services



* Includes supervision over regional VR employees located throughout the HSCs

- March 15, 2011
- Russell Cusack
- Attachment Four
- SB 2012

Revised 3/7/11

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-51 VOC REHAB											
		S101 FULL-TIME EQUIVALENTS (FTEs)		34.000	35.000	0.000	0.000	0.000	35.000	0.000	35.000
32510	B	511000 Salaries - Permanent		2,395,846	2,940,186	1,340,410	184,427	0	3,124,613	0	3,124,613
32510	B	513000 Temporary Salaries		49,414	96,557	94,924	(65,525)	0	31,032	0	31,032
32510	B	514000 Overtime		7,131	31,008	27,875	192	0	31,200	0	31,200
32510	B	516000 Fringe Benefits		935,637	1,176,372	572,504	61,964	0	1,238,336	0	1,238,336
32510	B	599110 Salary Increase		0	0	0	0	140,416	140,416	0	140,416
32510	B	599160 Benefit Increase		0	0	0	0	23,755	23,755	0	23,755
32510	B	599161 Health Increase		0	0	0	0	50,944	50,944	0	50,944
32510	B	599162 Retirement Increase		0	0	0	0	32,131	32,131	0	32,131
32510	B	599163 EAP Increase		0	0	0	0	105	105	0	105
			Subtotal:	3,388,028	4,244,123	2,035,713	181,058	247,351	4,672,532	0	4,672,532
32510	F	F_1991 Salary - General Fund		303,489	400,036	105,200	(84,491)	17,614	333,159	0	333,159
32510	F	F_1992 Salary - Federal Funds		3,078,008	3,844,087	1,930,513	265,549	229,738	4,339,374	0	4,339,374
32510	F	F_1993 Salary - Other Funds		6,531	0	0	0	(1)	(1)	0	(1)
			Subtotal:	3,388,028	4,244,123	2,035,713	181,058	247,351	4,672,532	0	4,672,532
32530	B	521000 Travel		196,678	232,011	110,228	56,797	0	288,808	0	288,808
32530	B	531000 Supplies - IT Software		33,488	29,051	26,801	3,599	0	32,650	0	32,650
32530	B	532000 Supply/Material-Professional		4,445	8,540	4,483	(8,350)	0	190	0	190
32530	B	535000 Miscellaneous Supplies		25,738	8,358	6,178	(8,200)	0	158	0	158
32530	B	536000 Office Supplies		20,039	16,850	11,668	17,750	0	34,600	0	34,600
32530	B	541000 Postage		16,511	10,430	1,900	(5,200)	0	5,230	0	5,230
32530	B	542000 Printing		70,130	66,196	43,101	(5,304)	0	60,892	0	60,892
32530	B	551000 IT Equip under $5,000		436	14,626	11,284	(14,626)	0	0	0	0
32530	B	552000 Other Equip under $5,000		22,068	32,164	32,042	(32,164)	0	0	0	0
32530	B	553000 Office Equip & Furniture-Under		23,472	17,638	17,322	(16,638)	0	1,000	0	1,000
32530	B	561000 Utilities		0	20	0	(20)	0	0	0	0
32530	B	581000 Rentals/Leases-Equip & Other		21,207	32,584	9,114	(14,584)	0	18,000	0	18,000
32530	B	582000 Rentals/Leases - Bldg/Land		364,940	373,370	192,187	50,191	0	423,561	0	423,561
32530	B	591000 Repairs		9,702	4,725	4,663	2,515	0	7,240	0	7,240

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 300-51 VOC REHAB										
32530	B	601000 IT - Data Processing	753	2,804	66	(984)	0	1,820	0	1,820
32530	B	602000 IT-Communications	922	2,550	422	(1,600)	0	950	0	950
32530	B	603000 IT Contractual Services and Re	94	0	0	0	0	0	0	0
32530	B	611000 Professional Development	69,349	95,250	63,843	15,185	0	110,435	0	110,435
32530	B	621000 Operating Fees and Services	445,758	537,115	287,167	(95,019)	0	442,096	0	442,096
32530	B	623000 Fees - Professional Services	643,718	581,624	312,349	39,976	0	621,600	0	621,600
		Subtotal:	1,969,448	2,065,906	1,134,818	(16,676)	0	2,049,230	0	2,049,230
32530	F	F_3991 Operating - General Fund	241,496	215,233	112,211	(4,437)	0	210,796	0	210,796
32530	F	F_3992 Operating - Federal Funds	1,718,571	1,849,211	1,021,586	(10,777)	0	1,838,434	0	1,838,434
32530	F	F_3993 Operating - Other Funds	9,381	1,462	1,021	(1,462)	0	0	0	0
		Subtotal:	1,969,448	2,065,906	1,134,818	(16,676)	0	2,049,230	0	2,049,230
32560	B	712000 Grants, Benefits & Claims	16,376,586	21,396,891	9,538,846	(838,260)	0	20,558,631	0	20,558,631
		Subtotal:	16,376,586	21,396,891	9,538,846	(838,260)	0	20,558,631	0	20,558,631
32560	F	F_6991 Grants - General Fund	3,665,329	4,229,636	1,869,217	85,535	0	4,315,171	0	4,315,171
32560	F	F_6992 Grants - Federal Funds	12,628,944	17,077,255	7,627,980	(928,795)	0	16,148,460	0	16,148,460
32560	F	F_6993 Grants - Other Funds	82,313	90,000	41,649	5,000	0	95,000	0	95,000
		Subtotal:	16,376,586	21,396,891	9,538,846	(838,260)	0	20,558,631	0	20,558,631
		Subdivision Budget Total:	21,734,062	27,706,920	12,709,377	(673,878)	247,351	27,280,393	0	27,280,393
300-51 VOC REHAB		**General Funds:**	4,210,314	4,844,905	2,086,628	(3,393)	17,614	4,859,126	0	4,859,126
		Federal Funds:	17,425,523	22,770,553	10,580,079	(674,023)	229,738	22,326,268	0	22,326,268
		Other Funds:	98,225	91,462	42,670	3,538	(1)	94,999	0	94,999
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	21,734,062	27,706,920	12,709,377	(673,878)	247,351	27,280,393	0	27,280,393

Vocational Rehabilitation - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Prairie Hills Plaza office space	13,153.21	15.34	16,517	387,024		403,541
Prairie Hills Plaza storage space	500.00	6.12	1,343	4,777		6,120
Miscellaneous rent (booth & room rentals)			2,872	11,028		13,900
			$ 20,732	**$ 402,829**	**$ -**	**$ 423,561**

Vocational Rehabilitation - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Advertising services for public notices	704	1,521		2,225
Storage and handling cost of VR files	51	189		240
Research fees	344	1,270		1,614
CAP underwriting of conferences	-	9,000	-	9,000
VR conference underwriting and purchase of service contracts	3,195	11,805	-	15,000
Purchase of service for Central Office program costs	878	3,122	-	4,000
Speakers & presenters for VR annual conferences	2,169	19,521		21,690
Media contracts for VR business services	80,940	299,060	-	380,000
Contracts for Independent Living Council	1,499	1,328		2,827
Purchase of service for DDS evaluations provided out of town	-	4,670	-	4,670
Freight and shipping costs	106	724	-	830
	$ 89,886	**$ 352,210**	**$ -**	**$ 442,096**

Vocational Rehabilitation - 2011-13 Biennium Budget

Budget Account Code 712000 - Grants, Benefits & Claims

Description	General Fund	Federal Funds	Other Funds	Total
Older Blind client purchases	-	61,326	-	61,326
Randolph Sheppard program	-	-	95,000	95,000
Technical assistance for individuals with disabilities - IPAT	500,000	888,504	-	1,388,504
Services to groups contracts	55,380	273,795	-	329,175
Transition services contract	106,500	393,500	-	500,000
Client services grants	2,506,333	11,568,481	-	14,074,814
Centers for Independent Living contracts	924,785	819,754	-	1,744,539
Disability Determination Services claiment grants	-	1,583,100	-	1,583,100
Extended Services grants	222,173	-	-	222,173
Supported Employment grants	-	560,000	-	560,000
	$ 4,315,171	**$ 16,148,460**	**$ 95,000**	**$ 20,558,631**

- Brenda Weisz
- Attachment FIVE
- March 21, 2011
- SB 2012

Cost of 6 Prevention Coordinator Compared to Contract

Prevention Coordinator FTES

Salary	$ 612,432	
Fringe	$ 225,205	
Total Salary		$ 837,637
Travel		$ 90,376
Supplies		$ 4,000
Rent		$ 24,190
IT Communications		$ 9,600
Total for 6 FTES		$ 965,803

Contracted Prevention Coordination

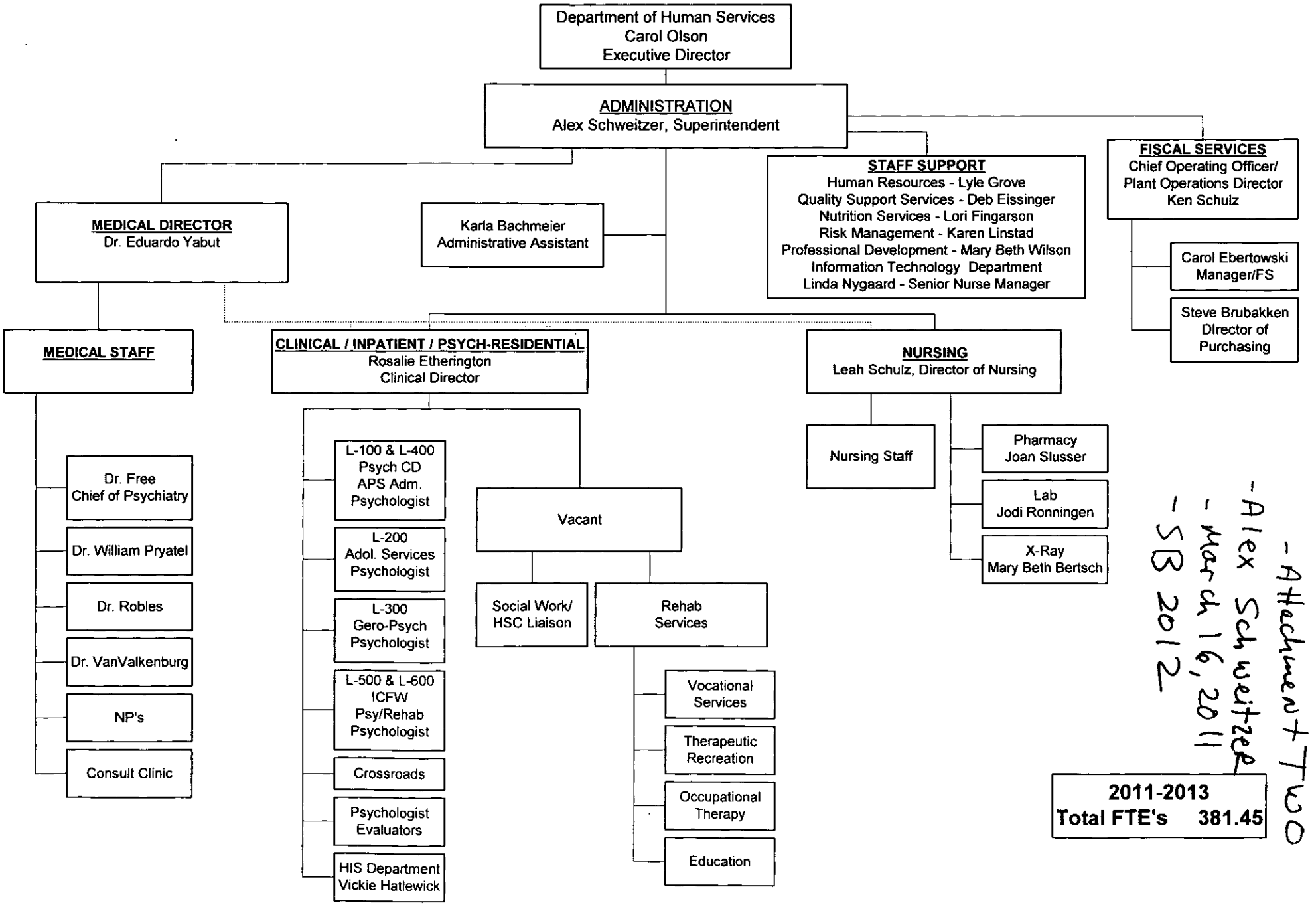
8 regions @ $130,000/region	$ 1,040,000
Savings from change to FTES	$ 74,197

- Attachment ONE
- Alex Schweitzer
- March 16, 2011
- SB 2012

Department of Human Services
SB 2012
Added Residential Services

North Central - SMI Crisis Unit - 10 beds (July 1, 2011 start date)	$197.90	per day
Southeast Human Service Center - CD Residential Facility - 15 bed (January 1, 2012 start date)	$114.46	per day
West Central Human Service Center - additional 4 crisis beds (July 1, 2011 start date)	$105.87	per day

North Dakota State Hospital - Traditional Services
March 2011



2011-2013
Total FTE's 381.45

- Attachment Two
- Alex Schweitzer
- March 16, 2011
- SB 2012

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 420-00 STATE HOSPITAL											
S101		FULL-TIME EQUIVALENTS (FTEs)		381.060	380.960	0.000	0.490	0.000	381.450	0.000	381.450
32550	B	684000 Extraordinary Repairs		0	1,179,625	758,185	(1,179,625)	0	0	0	0
			Subtotal:	0	1,179,625	758,185	(1,179,625)	0	0	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		0	1,179,625	758,185	(1,179,625)	0	0	0	0
			Subtotal:	0	1,179,625	758,185	(1,179,625)	0	0	0	0
32570	B	511000 Salaries - Permanent		26,966,559	30,345,350	14,805,749	2,209,680	0	32,555,030	0	32,555,030
32570	B	512000 Salaries-Other		567,349	645,766	284,400	2	0	645,768	0	645,768
32570	B	513000 Temporary Salaries		840,302	763,194	437,530	(282,860)	0	480,334	0	480,334
32570	B	514000 Overtime		243,367	229,574	139,734	37,330	0	266,904	0	266,904
32570	B	516000 Fringe Benefits		10,370,569	13,157,093	6,204,338	228,019	0	13,385,112	0	13,385,112
32570	B	519100 Reduction in Salary - Budget		0	0	0	(796,986)	0	(796,986)	0	(796,986)
32570	B	521000 Travel		334,232	352,100	156,251	67,166	0	419,266	0	419,266
32570	B	531000 Supplies - IT Software		46,126	43,122	15,346	(4,388)	0	38,734	0	38,734
32570	B	532000 Supply/Material-Professional		177,006	186,250	96,069	25,756	0	212,006	0	212,006
32570	B	533000 Food and Clothing		1,016,578	1,088,598	413,314	37,799	0	1,126,397	0	1,126,397
32570	B	534000 Bldg, Grounds, Vehicle Supply		551,424	552,754	313,632	10,200	0	562,954	0	562,954
32570	B	535000 Miscellaneous Supplies		202,231	200,212	134,696	1,416	0	201,628	0	201,628
32570	B	536000 Office Supplies		301,960	270,115	168,992	44,526	0	314,641	0	314,641
32570	B	541000 Postage		23,511	13,146	7,787	5,260	0	18,406	0	18,406
32570	B	542000 Printing		46,850	43,718	19,362	(3,696)	0	40,022	0	40,022
32570	B	552000 Other Equip under $5,000		23,114	162,250	85,135	(129,850)	0	32,400	0	32,400
32570	B	553000 Office Equip & Furniture-Under		203	13,000	3,657	58,876	0	71,876	0	71,876
32570	B	561000 Utilities		1,224,467	1,432,237	740,321	117,160	0	1,549,397	0	1,549,397
32570	B	571000 Insurance		98,218	116,498	57,621	18,671	0	135,169	0	135,169
32570	B	581000 Rentals/Leases-Equip & Other		27,713	43,330	16,656	99,035	0	142,365	0	142,365
32570	B	582000 Rentals/Leases - Bldg/Land		678	600	480	0	0	600	0	600
32570	B	591000 Repairs		273,157	293,639	233,015	11,253	0	304,892	0	304,892
32570	B	599110 Salary Increase		0	0	0	0	1,452,315	1,452,315	0	1,452,315
32570	B	599160 Benefit Increase		0	0	0	0	235,204	235,204	0	235,204

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class FB	Budget Account Code	Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 420-00 STATE HOSPITAL									
32570 B	599161 Health Increase	0	0	0	0	540,008	540,008	0	540,008
32570 B	599162 Retirement Increase	0	0	0	0	329,535	329,535	0	329,535
32570 B	599163 EAP Increase	0	0	0	0	1,127	1,127	0	1,127
32570 B	602000 IT-Communications	285,005	268,541	122,798	(50)	0	268,491	0	268,491
32570 B	603000 IT Contractual Services and Re	0	20	13	(20)	0	0	0	0
32570 B	611000 Professional Development	122,469	108,923	52,641	84,404	0	193,327	0	193,327
32570 B	621000 Operating Fees and Services	203,588	219,269	114,403	7,599	0	226,868	0	226,868
32570 B	623000 Fees - Professional Services	1,483,262	1,588,442	934,770	87,498	0	1,675,940	0	1,675,940
32570 B	625000 Medical, Dental and Optical	3,162,334	3,048,006	1,444,634	(3,101)	0	3,044,905	0	3,044,905
32570 B	682000 Land and Buildings	0	0	0	1,800,000	0	1,800,000	0	1,800,000
32570 B	683000 Other Capital Payments	453,025	437,729	424,537	(437,729)	0	0	0	0
32570 B	684000 Extraordinary Repairs	3,812,180	3,001,017	983,754	(2,267,367)	0	733,650	161,840	895,490
32570 B	691000 Equipment Over $5000	122,000	246,220	160,511	(246,220)	0	0	0	0
	Subtotal:	52,979,477	58,870,713	28,572,146	779,383	2,558,189	62,208,285	161,840	62,370,125
32570 F	F_7091 HSCs & Institutions - Gen Fund	34,948,657	38,934,572	20,198,892	569,121	2,558,189	42,061,882	161,840	42,223,722
32570 F	F_7092 HSCs & Institutions - Fed Fnds	2,616,977	4,803,599	3,308,925	(2,193,816)	0	2,609,783	0	2,609,783
32570 F	F_7093 HSCs & Institutions - Oth Fnds	15,413,843	15,132,542	5,064,329	2,404,078	0	17,536,620	0	17,536,620
	Subtotal:	52,979,477	58,870,713	28,572,146	779,383	2,558,189	62,208,285	161,840	62,370,125
	Subdivision Budget Total:	52,979,477	60,050,338	29,330,331	(400,242)	2,558,189	62,208,285	161,840	62,370,125
	General Funds:	34,948,657	40,114,197	20,957,077	(610,504)	2,558,189	42,061,882	161,840	42,223,722
	Federal Funds:	2,616,977	4,803,599	3,308,925	(2,193,816)	0	2,609,783	0	2,609,783
420-00 STATE HOSPITAL	**Other Funds:**	15,413,843	15,132,542	5,064,329	2,404,078	0	17,536,620	0	17,536,620
	SWAP Funds:	0	0	0	0	0	0	0	0
	County Funds:	0	0	0	0	0	0	0	0
	IGT Funds:	0	0	0	0	0	0	0	0
	Subdivision Funding Total:	52,979,477	60,050,338	29,330,331	(400,242)	2,558,189	62,208,285	161,840	62,370,125

State Hospital Traditional - 2011-13 Biennium Budget

Budget Account Code 582000 - Rental / Leases

Description	Square Footage	Rate per Square Foot	General Fund	Federal Funds	Other Funds	Total
Booth Rental for Human Resources attending career fairs etc.			600			600
TOTAL --->			600	-	-	600

State Hospital Traditional - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

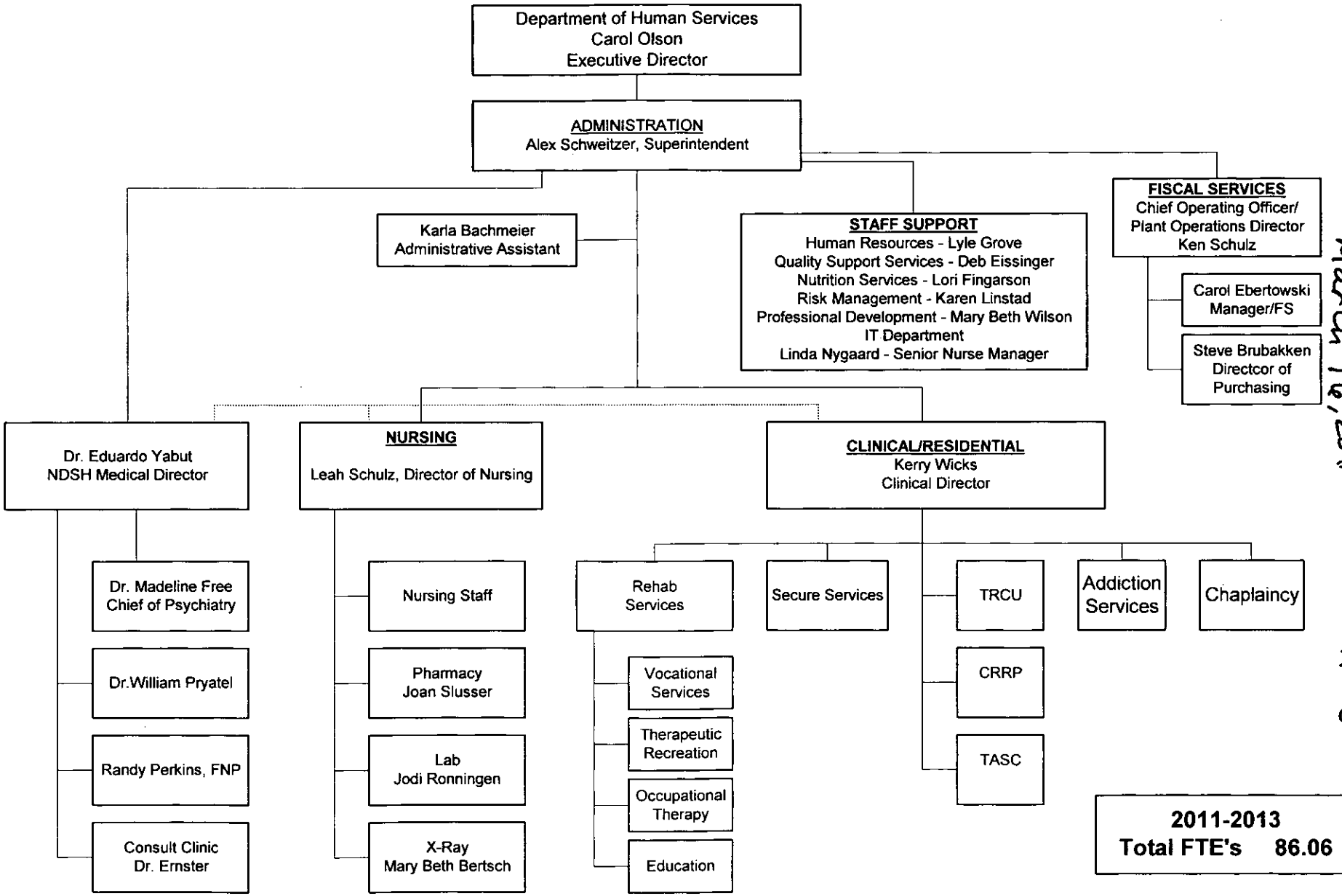
Description	General Fund	Federal Funds	Other Funds	Total
Vehicle Licenses	64			64
Professional Licenses	10,886	319	13,265	24,470
Specials	6,171		40,231	46,402
Advertising - Staff Recruitment	36,698			36,698
Extermination Service - Pest Control	8,828			8,828
Fingerprinting Fee	227		173	400
Freight and Express	32,377	193	3,090	35,660
Awards, Rewards - Retirees and years of service awards	34,251			34,251
Research Fees - Background Checks	8,155			8,155
Miscellaneous Refunds - Sales Tax for the Gobbler	13,376		2,682	16,058
Hazardous Waste Collection - Medical waste	11,189			11,189
Other Operating Fees - Radiation hazard survey	722			722
Patient Allowances - Adolescent patients	72	1,636	2,263	3,971
TOTAL -->	163,016	2,148	61,704	226,868

State Hospital Traditional - 2011-13 Biennium Budget

Budget Account Code 623000 - Professional Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Legal Services - Attorney fees for patient hearings	6,581		42,898	49,479
Management/Consulting - Medical equipment testing	6,500			6,500
Management/Consulting - Pharmacy contract for TL patients	2,026	2,515	259	4,800
Outside Doctor & Hosp - Drug Tests	4,078			4,078
Outside Doctor & Hosp - Reference lab	60,000			60,000
Outside Doctor & Hosp - Pathology Services	10,000			10,000
Outside Doctor & Hosp - EEGs	2,176		179	2,355
Outside Doctor & Hosp - Radiologist	47,010		3,867	50,877
Outside Doctor & Hosp - Physical Therapist	12,000			12,000
Outside Doctor & Hosp - Essentia Health - Consult Clinic	361,380	9,120	9,500	380,000
Outside Doctor & Hosp - Podiatrist	20,351	514	535	21,400
Outside Doctor & Hosp - Patient medical services	567,516	14,322	14,919	596,757
Professionals Not Classified - Joint Commission Certification	50,000			50,000
Professionals Not Classified - Chaplaincy Intern	58,000			58,000
Professionals Not Classified - Psychological Evaluations	2,490		16,230	18,720
Professionals Not Classified - Med Tox Lab - Med Side Effects	17,924			17,924
Professionals Not Classified - HIV Testing	81			81
Professionals Not Classified - ND Public Health - AMP Probe	2,969			2,969
Professionals Not Classified - Peer Support Services	19,920	1,020	9,060	30,000
Professionals Not Classified - Work Activity Contract	300,000			300,000
TOTAL --->	**1,551,002**	**27,491**	**97,447**	**1,675,940**

North Dakota State Hospital - Secure Services
March 2011



- Alex Schweitzer
- SB 2012
- March 16, 2011
- Attachment THREE

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Biennium Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 421-00 SH SECURED SERVICES											
S101		FULL-TIME EQUIVALENTS (FTEs)		85.450	85.550	0.000	0.510	0.000	86.060	0.000	86.060
32550	B	684000 Extraordinary Repairs		1,802,054	0	0	0	0	0	0	0
			Subtotal:	1,802,054	0	0	0	0	0	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		1,802,054	0	0	0	0	0	0	0
			Subtotal:	1,802,054	0	0	0	0	0	0	0
32570	B	511000 Salaries - Permanent		4,544,330	5,452,101	2,712,581	624,357	0	6,076,458	0	6,076,458
32570	B	512000 Salaries-Other		143,123	173,440	82,485	8	0	173,448	0	173,448
32570	B	513000 Temporary Salaries		11,433	3,800	3,080	187,432	0	191,232	0	191,232
32570	B	514000 Overtime		92,496	106,458	93,408	122,238	0	228,696	0	228,696
32570	B	516000 Fringe Benefits		1,912,554	2,741,409	1,298,472	87,457	(1)	2,828,865	0	2,828,865
32570	B	519100 Reduction in Salary - Budget		0	0	0	(900,000)	0	(900,000)	0	(900,000)
32570	B	521000 Travel		12,520	12,299	6,440	76	0	12,375	0	12,375
32570	B	531000 Supplies - IT Software		285	4,564	4,374	3,932	0	8,496	0	8,496
32570	B	532000 Supply/Material-Professional		603	3,066	2,805	10,799	0	13,865	0	13,865
32570	B	533000 Food and Clothing		383,191	520,426	153,817	22,356	0	542,782	0	542,782
32570	B	534000 Bldg, Grounds, Vehicle Supply		35,006	31,908	20,351	28,694	0	60,602	0	60,602
32570	B	535000 Miscellaneous Supplies		20,000	24,035	23,039	8,621	0	32,656	0	32,656
32570	B	536000 Office Supplies		8,978	8,800	7,537	11,170	0	19,970	0	19,970
32570	B	541000 Postage		6,543	8,954	2,264	(3,360)	0	5,594	0	5,594
32570	B	542000 Printing		3,045	4,500	4,016	6,043	0	10,543	0	10,543
32570	B	552000 Other Equip under $5,000		13,976	14,000	11,955	(14,000)	0	0	0	0
32570	B	553000 Office Equip & Furniture-Under		6,958	12,000	0	6,550	0	18,550	0	18,550
32570	B	561000 Utilities		305,399	250,016	127,649	(8,693)	0	241,323	0	241,323
32570	B	571000 Insurance		7,133	22,577	11,541	3,056	0	25,633	0	25,633
32570	B	581000 Rentals/Leases-Equip & Other		112	100	37	0	0	100	0	100
32570	B	591000 Repairs		9,195	28,317	4,666	18,305	0	46,622	0	46,622
32570	B	599110 Salary Increase		0	0	0	0	303,376	303,376	0	303,376
32570	B	599160 Benefit Increase		0	0	0	0	51,213	51,213	0	51,213
32570	B	599161 Health Increase		0	0	0	0	129,563	129,563	0	129,563

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 421-00 SH SECURED SERVICES										
32570	B	599162 Retirement Increase	0	0	0	0	69,422	69,422	0	69,422
32570	B	599163 EAP Increase	0	0	0	0	264	264	0	264
32570	B	602000 IT-Communications	67,586	50,275	29,206	(17,201)	0	33,074	0	33,074
32570	B	611000 Professional Development	0	29,979	2,099	12,093	0	42,072	0	42,072
32570	B	621000 Operating Fees and Services	7,980	39,402	5,488	(2,586)	0	36,816	0	36,816
32570	B	623000 Fees - Professional Services	377,656	412,819	146,949	153,608	0	566,427	0	566,427
32570	B	625000 Medical, Dental and Optical	425,336	524,878	132,744	(130,000)	0	394,878	0	394,878
32570	B	684000 Extraordinary Repairs	498,358	0	0	0	0	0	0	0
		Subtotal:	8,893,796	10,480,123	4,887,003	230,955	553,837	11,264,915	0	11,264,915
32570	F	F_7091 HSCs & Institutions - Gen Fund	8,862,836	10,429,000	4,879,204	282,078	553,837	11,264,915	0	11,264,915
32570	F	F_7092 HSCs & Institutions - Fed Fnds	0	17,824	0	(17,824)	0	0	0	0
32570	F	F_7093 HSCs & Institutions - Oth Fnds	30,960	33,299	7,799	(33,299)	0	0	0	0
		Subtotal:	8,893,796	10,480,123	4,887,003	230,955	553,837	11,264,915	0	11,264,915
		Subdivision Budget Total:	10,695,850	10,480,123	4,887,003	230,955	553,837	11,264,915	0	11,264,915
		General Funds:	10,664,890	10,429,000	4,879,204	282,078	553,837	11,264,915	0	11,264,915
		Federal Funds:	0	17,824	0	(17,824)	0	0	0	0
421-00 SH SECURED SERVICES		**Other Funds:**	30,960	33,299	7,799	(33,299)	0	0	0	0
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	10,695,850	10,480,123	4,887,003	230,955	553,837	11,264,915	0	11,264,915

SH SECURED SERVICES - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Professional Licenses	2,705			2,705
Specials	7,211			7,211
Advertising - Staff Recruitment	8,303			8,303
Extermination Services - Pest Control	1,372			1,372
Fingerprinting Fee	100			100
Freight and Express	5,000			5,000
Awards, Rewards - Retirees and longevity awards	7,749			7,749
Research Fees - Background Checks	1,845			1,845
Hazardous Waste Collection - Medical waste	2,531			2,531
TOTAL -->	36,816	-	-	36,816

SH SECURED SERVICES - 2011-13 Biennium Budget

Budget Account Code 623000 - Professional Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Legal Services - Attorney fees for patient hearings	21,205			21,205
Management Consulting - Sex offender treatment consultant	18,000			18,000
Outside Doctor & Hosp - Drug tests	923			923
Outside Doctor & Hosp - Radiologist	1,299			1,299
Outside Doctor & Hosp - Medical services for patients	25,000			25,000
Professionals Not Classified - Psychological Evaluations	500,000			500,000
TOTAL -->	566,427			566,427

- Alex Schweitzer - Attachment Four -SB 2012 - March 16, 2011

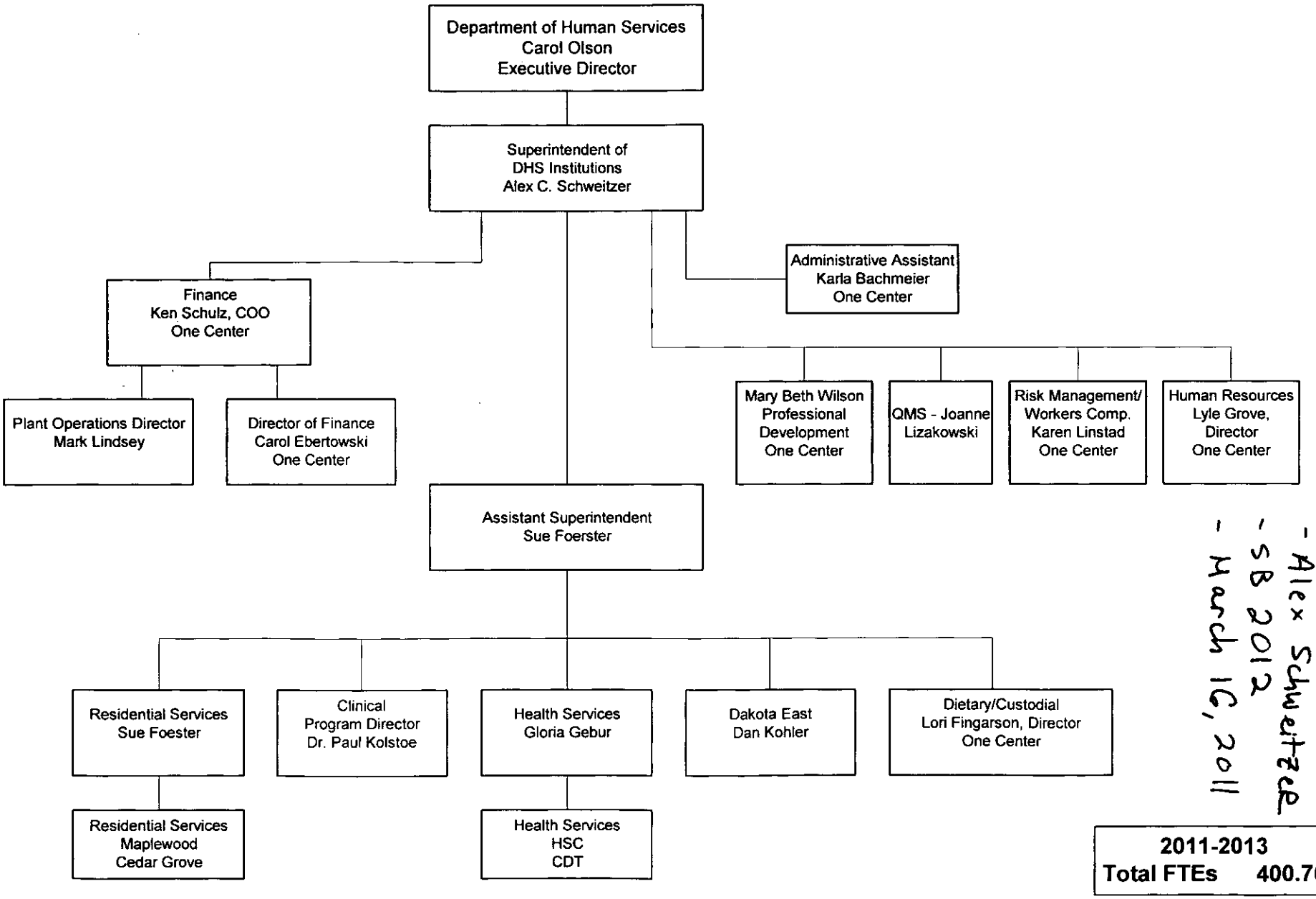
North Dakota State Hospital & Transitional Living Center

Daily Rates
Effective February 1, 2010

ADULT PSYCHIATRIC SERVICES (L100 - APSA) – Admissions	481.50
CHILDREN & ADOLSECENT SERVICES (L200-ROSE) Prairie Rose	633.32
ADULT PSYCHIATRIC EXTENDED TREATMENT SERVICES (L300-GRPS)	353.96
CHEMICAL DEPENDENCY SERVICES (L400-PSCD) Inpatient	375.09
ADULT PSYCHIATRIC SERVICES (L500-ICFW) Intensive Care For Women	494.55
ADULT PSYCHIATRIC EXTENDED TREATMENT SERVICES (L600—PSRH)	366.93
ADULT PSYCHIATRIC SERVICES – FORENSIC RESIDENTIAL (SECR, SCR2, SCR3 & SCR4) – Sex Offenders	236.56
CROSSROADS RESIDENTAL	252.40
TOMPKINS RESIDENTIAL CENTER SERVICES #25 (CRRP, TRC1, TRC2)	[redacted] $82.49
TRANSITIONAL LIVING SERVICES (TLTR) #22 Rent	197.50 9.54

North Dakota State Hospital care and treatment charges are the above fixed daily rates. Additional charges are incurred for pharmacy & professional services. No further breakdown of charges is available. Rates are subject to change.

North Dakota Developmental Center
March 2011



2011-2013
Total FTEs 400.76

- Attachment FIVE
- Alex Schweitzer
- SB 2012
- March 16, 2011

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code		Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 430-00 DEVELOPMENTAL CENTER											
S101		FULL-TIME EQUIVALENTS (FTEs)		445.540	441.290	0.000	(40.530)	0.000	400.760	0.000	400.760
32550	B	684000 Extraordinary Repairs		0	20,100	11,192	(20,100)	0	0	0	0
			Subtotal:	0	20,100	11,192	(20,100)	0	0	0	0
32550	F	F_5991 Land & Cptl Imprv - Gen Fund		0	20,100	11,192	(20,100)	0	0	0	0
			Subtotal:	0	20,100	11,192	(20,100)	0	0	0	0
32570	B	511000 Salaries - Permanent		24,459,206	28,170,576	13,250,384	(1,938,664)	0	26,231,912	0	26,231,912
32570	B	512000 Salaries-Other		286,636	253,860	145,280	(44,990)	0	208,870	0	208,870
32570	B	513000 Temporary Salaries		480,508	516,690	280,099	27,632	0	544,322	0	544,322
32570	B	514000 Overtime		160,562	345,724	195,593	(100,420)	0	245,304	0	245,304
32570	B	516000 Fringe Benefits		11,188,492	14,311,953	6,768,555	(1,065,435)	2	13,246,520	0	13,246,520
32570	B	519100 Reduction in Salary - Budget		0	0	0	(738,694)	0	(738,694)	0	(738,694)
32570	B	521000 Travel		411,832	364,961	248,814	55,736	0	420,697	0	420,697
32570	B	531000 Supplies - IT Software		23,599	35,565	8,933	(20,366)	0	15,199	0	15,199
32570	B	532000 Supply/Material-Professional		49,090	52,366	13,652	(21,351)	0	31,015	0	31,015
32570	B	533000 Food and Clothing		1,192,446	1,155,010	640,306	(24,868)	0	1,130,142	0	1,130,142
32570	B	534000 Bldg, Grounds, Vehicle Supply		401,427	273,233	188,969	51,738	0	324,971	0	324,971
32570	B	535000 Miscellaneous Supplies		250,327	199,649	110,902	(22,984)	0	176,665	0	176,665
32570	B	536000 Office Supplies		135,743	92,476	62,400	(44,822)	0	47,654	0	47,654
32570	B	541000 Postage		18,126	21,130	8,159	(294)	0	20,836	0	20,836
32570	B	542000 Printing		16,931	14,879	6,098	(351)	0	14,528	0	14,528
32570	B	551000 IT Equip under $5,000		600	0	0	0	0	0	0	0
32570	B	552000 Other Equip under $5,000		108,643	15,400	15,061	(2,500)	0	12,900	0	12,900
32570	B	553000 Office Equip & Furniture-Under		39,234	1,500	1,464	(1,500)	0	0	0	0
32570	B	561000 Utilities		2,426,917	2,082,507	1,076,158	5,200	0	2,087,707	0	2,087,707
32570	B	571000 Insurance		67,386	106,900	51,055	8,573	0	115,473	0	115,473
32570	B	581000 Rentals/Leases-Equip & Other		54,206	52,216	26,129	(3,758)	0	48,458	0	48,458
32570	B	582000 Rentals/Leases - Bldg/Land		90	200	0	(200)	0	0	0	0
32570	B	591000 Repairs		439,797	300,808	208,671	82,904	0	383,712	0	383,712
32570	B	599110 Salary Increase		0	0	0	0	1,192,253	1,192,253	0	1,192,253

DEPARTMENT OF HUMAN SERVICES
Summary by Subdivision and Bgt_Acct with Funding Sources
2011 - 2013

Class	FB	Budget Account Code	Prior Bien Exp 2007-2009	Current Budget 2009-2011	Year 1	Total Budget Changes	Exec Salary Recmndtn	To the Senate 2011-2013	Senate Adj	To the House 2011-2013
Subdivision: 430-00 DEVELOPMENTAL CENTER										
32570	B	599160 Benefit Increase	0	0	0	0	204,943	204,943	0	204,943
32570	B	599161 Health Increase	0	0	0	0	609,895	609,895	0	609,895
32570	B	599162 Retirement Increase	0	0	0	0	268,957	268,957	0	268,957
32570	B	599163 EAP Increase	0	0	0	0	1,291	1,291	0	1,291
32570	B	602000 IT-Communications	240,796	207,578	123,731	8,247	0	215,825	0	215,825
32570	B	603000 IT Contractual Services and Re	5,920	0	0	0	0	0	0	0
32570	B	611000 Professional Development	30,952	41,196	19,856	(263)	0	40,933	0	40,933
32570	B	621000 Operating Fees and Services	2,345,838	2,378,305	1,317,401	448,066	0	2,826,371	0	2,826,371
32570	B	623000 Fees - Professional Services	182,416	251,391	76,722	(85,579)	0	165,812	0	165,812
32570	B	625000 Medical, Dental and Optical	1,470,824	1,546,835	550,369	(411,528)	0	1,135,307	0	1,135,307
32570	B	683000 Other Capital Payments	519,187	501,657	435,538	(501,657)	0	0	0	0
32570	B	684000 Extraordinary Repairs	705,954	712,675	356,081	(133,206)	0	579,469	0	579,469
32570	B	691000 Equipment Over $5000	67,583	75,000	62,950	(75,000)	0	0	0	0
		Subtotal:	47,781,268	54,082,240	26,249,330	(4,550,334)	2,277,341	51,809,247	0	51,809,247
32570	F	F_7091 HSCs & Institutions - Gen Fund	13,469,303	14,575,629	9,645,654	4,781,470	1,060,331	20,417,430	0	20,417,430
32570	F	F_7092 HSCs & Institutions - Fed Fnds	30,057,162	35,363,271	14,873,235	(8,756,820)	1,217,009	27,823,460	0	27,823,460
32570	F	F_7093 HSCs & Institutions - Oth Fnds	4,254,803	4,143,340	1,730,441	(574,984)	1	3,568,357	0	3,568,357
		Subtotal:	47,781,268	54,082,240	26,249,330	(4,550,334)	2,277,341	51,809,247	0	51,809,247
		Subdivision Budget Total:	47,781,268	54,102,340	26,260,522	(4,570,434)	2,277,341	51,809,247	0	51,809,247
430-00 DEVELOPMENTAL CENTER		**General Funds:**	13,469,303	14,595,729	9,656,846	4,761,370	1,060,331	20,417,430	0	20,417,430
		Federal Funds:	30,057,162	35,363,271	14,873,235	(8,756,820)	1,217,009	27,823,460	0	27,823,460
		Other Funds:	4,254,803	4,143,340	1,730,441	(574,984)	1	3,568,357	0	3,568,357
		SWAP Funds:	0	0	0	0	0	0	0	0
		County Funds:	0	0	0	0	0	0	0	0
		IGT Funds:	0	0	0	0	0	0	0	0
		Subdivision Funding Total:	47,781,268	54,102,340	26,260,522	(4,570,434)	2,277,341	51,809,247	0	51,809,247

Developmental Center - 2011-13 Biennium Budget

Budget Account Code 621000 - Operating Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Provider Tax ($1,870 * 175)	1,023,117	1,406,280	188,603	2,618,000
Advertising $16,500	6,448	8,863	1,189	16,500
Pest Extermination $7,500	2,931	4,029	540	7,500
Freight and Express $29,900	11,685	16,061	2,154	29,900
Other Miscellaneous (film proc, dry cleaning, radios) $36,128	14,083	19,356	2,596	36,035
Licenses and Taxes $65,000	25,402	34,915	4,683	65,000
Years of Service Awards $26,000	10,161	13,966	1,873	26,000
Background Checks $ 27,436	10,722	14,737	1,977	27,436
TOTALS	**$ 1,104,549**	**$ 1,518,207**	**$ 203,615**	**$ 2,826,371**

Developmental Center - 2011-13 Biennium Budget

Budget Account Code 623000 - Professional Fees and Services

Description	General Fund	Federal Funds	Other Funds	Total
Neurological Consultation	1,563	2,149	288	4,000
Practioner Supervision	16,257	22,346	2,997	41,600
Physician on-call Services	4,690	6,446	864	12,000
Laboratory & Pathology Consult	2,814	3,868	518	7,200
On-site painting service	4,690	6,446	864	12,000
Catholic Support Services	1,913	2,630	353	4,896
Protestant Support Services	769	1,057	142	1,968
Protestant Clergy Services	3,826	5,259	705	9,790
Catholic Clergy Services	2,194	3,016	404	5,614
Respiratory Therapy	26,084	35,852	4,808	66,744
TOTALS	**$ 64,800**	**$ 89,069**	**$ 11,943**	**$ 165,812**

Outcomes of Dementia Care Services Program (provided by the UND Center for Rural Health - independent evaluator)

Outcomes of the Dementia Care Services Program

Contacts with Caregivers	*N = 907 Contacts in North Dakota*
Type of Contact	**Care Consultations in Person**
Care Consultations: 360	In Person: 206
Information Helpline: 342	By Phone: 154
Follow-Up Care Consultation: 150	
Follow-Up Information Helpline: 55	
Total Care Consultations: 510	

Caregiver Demographics *N = 471 caregivers in North Dakota*

Age (Avg = 62.54)	**Gender**	**Rurality of Residence**	**Relationship to PWD**
<50 yrs: 45	Female: 362	Isolated Rural: 112	Spouse: 113
50-64 yrs: 70	Male: 104	Small Rural: 28	Wife: 74
65-74 yrs: 39		Large Rural: 84	Family: 239
75-84 yrs: 44		Urban: 233	Child: 182
85+ yrs: 17			Female Child: 146
			Self: 28
			Professional: 69
			Other: 22

Persons with Dementia (PWD) Demographics *N = 320 PWDs in North Dakota*

Age (Avg = 78.45)	**Gender**	**Veteran**	**Living Arrangement**
<50 yrs: 4	Female: 168	Yes: 49	Home Alone: 107
50-64 yrs: 17	Male: 139	No: 254	Home with Spouse: 71
65-74 yrs: 39			Home with Other: 30
75-84 yrs: 105			Assisted Living: 33
85+ yrs: 65			Long Term Care Facility: 40
			Other: 39

Estimated Long-Term Care Costs Avoided

based on 32 caregivers with two or more reports that showed a decrease of either estimated time to placement or estimated liklihood to place in LTC

	Cost Avoided
Median	**$1,664,071**
Low	$1,248,498
High	$3,353,935

Estimated Health Care Costs Avoided

based on comparison of incidence reports of 200 caregivers after 1-3 months to 55 after 4 or more months

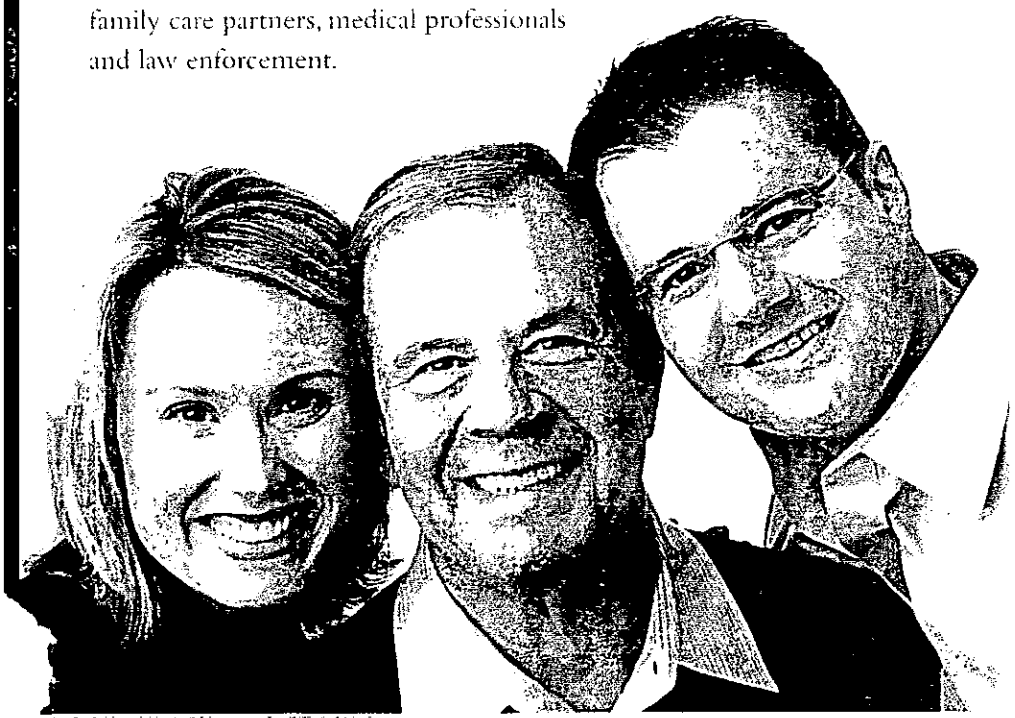
Hospital	$31,955	*(three month savings)*
Emergency Room	None	
Ambulance	Urb $1,048; Rur $626	**Total 3 Month Savings**
911 Calls	$213	**$33,842**

- SB 2012
- March 21, 2011
- Attachment ONE
- Dementia Care Services Program

No matter where you are, the Alzheimer's Association is here for you.

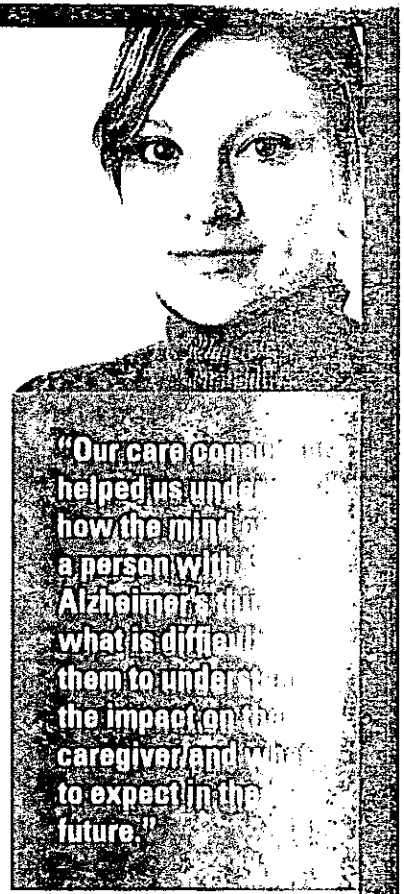
Individualized assistance, problem solving and identification of resources are available to individuals with memory loss and care partners through care consultation. Individuals with dementia and their care partners will receive valuable one-on-one assistance that will enable them to better manage care and make more informed decisions regarding services and treatments, including clinical trials. Care consultation can be provided in the location most convenient for the people accessing it.

We offer workshops on disease-related topics, such as understanding memory loss, partnering with your doctor and understanding communication. Classes available for the general public, professional and family care partners, medical professionals and law enforcement.



Our 24/7 Information Helpline is available to provide information, support, printed materials and referrals to area resources. This service is available for anyone with Alzheimer's or related disorders and their family and professional care partners. Interpreters are available in more than 60 languages.

We offer a 24-hour nationwide emergency response service for individuals with Alzheimer's or a related dementia who wander or have a medical emergency. We provide 24-hour, nationwide assistance, no matter when or where the person is reported missing.



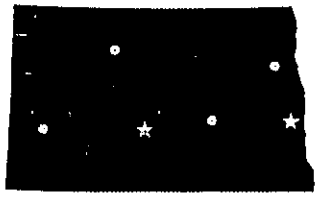
We have many affiliated support groups led by trained facilitators for individuals and their care partners affected by Alzheimer's disease and related disorders. These groups provide support, assistance and encouragement to help manage and cope with the disease.

These groups provide a way for care partners of people with dementia to interact, learn and gain valuable support from others. There are various locations throughout the state.

Care partners of people with dementia can call in from any location by telephone. Calls are toll-free and participants may remain anonymous. Pre-registration is required.

alzheimer's association

Minnesota-North Dakota Chapter
4550 W 77th Street, Ste 200
Minneapolis, MN 55435



Eastern North Dakota Office
4357 13th Avenue SW, Ste 203
Fargo, ND 58103

701-277-9757 **p**
701-277-9785 **f**

Western North Dakota Office
1110 College Drive, Ste 216
Bismarck, ND 58501

701-258-4933 **p**
701-258-4914 **f**

ALZHEIMER'S ASSOCIATION NORTH DAKOTA

Dickinson Staff Office
235 Sims Street, Ste 26B
Dickinson, ND 58601

701-225-7988 **p**
701-225-9172 **f**

Jamestown Staff Office
114 1st Ave S. Ste 160
Jamestown, ND 58401

701-952-0800 **p**
701-322-4939 **f**

Grand Forks Staff Office
311 S 4th Street, Ste 202
Grand Forks, ND 58201

701-775-8544 **p**
701-775-8612 **f**

Minot Staff Office
P.O. Box 2234
Minot, ND 58702

701-837-0062 **p**
701-837-0811 **f**



North Dakota Dementia Care Services Program

- Brenda Weisz
- Attachment TWO
- SB 2012
- March 21, 2011

North Dakota Department of Human Services
Health Care Reform FTEs
Cost to Continue Salaries for the 2013 - 2015 Biennium

	Salaries Included in the 2011 - 2013 Executive Budget (Amounts do not Include Governor's Salary Package)		
Position	**Total Funds**	**General Funds**	**Start Date**
Economic Assistance Policy Trainer	17,058	17,058	April 1, 2013
Child Support Enforcement Attorney	174,612	59,368	July 1, 2011
Medical Services			
Eligibility Policy	110,919	55,460	July 1, 2011
Program Integrity	103,961	51,980	January 1, 2012
Nurse	52,896	13,224	October 1, 2012
SURS Analyst *	24,221	5,888	January 1, 2013
Administrative Support	20,612	11,145	January 1, 2013
Total	**$ 504,279**	**$ 214,123**	

- Brenda Weisz
- Attachment THREE
- March 21, 2011
- SB 2012

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

LONG-TERM CARE COMMITTEE

Tuesday, September 28, 2010
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Gary Kreidt, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives Gary Kreidt, Tom Conklin, Richard Holman, Robert Kilichowski, Joyce M. Kingsbury, Vonnie Pietsch, Chet Pollert, Louise Potter, Gerry Uglem, Alon C. Wieland; Senators JoNell A. Bakke, Dick Dever, Tom Fiebiger, Joan Heckaman, Terryl L. Jacobs, Judy Lee, Jim Pomeroy

Member absent: Representative Robin Weisz

Others present: See Appendix A

It was moved by Representative Wieland, seconded by Representative Uglem, and carried on a voice vote that the minutes of the July 14, 2010, meeting be approved as distributed.

OTHER RESPONSIBILITIES

Ms. JoAnne Hoesel, Cabinet Lead for Program and Policy, Department of Human Services, provided testimony (Appendix B) and distributed a copy of the final report (Appendix C) from the study of the methodology and calculations for the ratesetting structure for developmental disabilities and home and community-based service providers pursuant to 2009 House Bill No. 1556. She said the department contracted with Burns and Associates, Inc., to complete the study directed by House Bill No. 1556. She said Burns and Associates, Inc., has offered four options for consideration by the state--two options for adults and two options for children. She said one of the options for children and one of the options for adults retain the current cost-based, retrospective reimbursement system. She said the others involve the development of a prospective reimbursement process. The following is a summary of the four options:

Adults	Option A - Revise and shorten the progress assessment review and continue the cost-based, retrospective reimbursement process
	Option B - Adopt a new assessment tool and move to a prospective reimbursement process. The supports intensity scale is recommended.
Children	Option C - Pilot the child supports intensity scale and move to a prospective reimbursement process
	Option D - Continue the Oregon medical tool and add the child and adolescent level of care utilization system or other similar tools and continue the cost-based, retrospective reimbursement process

Ms. Hoesel said the department agrees with the recommendation to move to a prospective reimbursement process using an independent ratesetting model and a resource allocation for the entire development disability client base. She said the department recommends hiring a consultant to guide the ratesetting and assessment implementation process and to begin implementation with a pilot project.

Dr. Gretchen Engquist, CEO, Burns and Associates, Inc., Phoenix, Arizona, provided information regarding the outcomes and recommendations from the study of the methodology and calculations for the ratesetting structure for developmental disabilities and home and community-based service providers. She said replacing the progress assessment review with the supports intensity scale would be more costly initially both in terms of time and dollars as it requires new assessments to be performed on all clients and the results of those assessments to subsequently be used to develop a resource allocation model and prospective rates.

In response to a question from Representative Holman, Dr. Engquist said most providers support the development of a prospective reimbursement process.

In response to a question from Representative Pollert, Dr. Engquist said the estimated costs for the prospective reimbursement process are less in later years because audits are conducted once every five years instead of every year.

In response to a question from Representative Kreidt, Dr. Engquist said adults would need to be reassessed every three years and children reassessed every year under the prospective reimbursement process. She said procedures would need to be in place for emergency reassessments.

In response to a question from Senator Lee, Dr. Engquist said continuation of the 95 percent occupancy rule would be a policy decision.

Mr. Eric Monson, CEO, Anne Carlsen Center, Jamestown, provided comments (Appendix D) regarding the outcomes and recommendations from the study of the ratesetting structure for developmental disabilities and home and community-based service providers. He said a different assessment method should be implemented to determine the resources needed to adequately support an individual. He said a prospective

reimbursement process would be the most effective and efficient method for both the state and providers.

In response to a question from Senator Lee, Mr. Monson said the Anne Carlsen Center would support a pilot project.

Ms. Borgi Beeler, President and CEO, Minot Vocational Adjustment Workshop, Minot, provided comments (Appendix E) regarding the outcomes and recommendations from the study of the ratesetting structure for developmental disabilities and home and community-based service providers. She said the state needs to ensure that sufficient funding is available to provide quality services. If the reimbursement process is changed, she said, the incentives that affect providers' decisionmaking may also change. She said a new reimbursement system may require different safeguards.

In response to a question from Representative Kreidt, Ms. Beeler said the state should proceed cautiously as it considers implementation of a new reimbursement system.

In response to a question from Representative Pollert, Ms. Hoesel said the department believes additional staff would be needed if a prospective reimbursement process is to be implemented.

Ms. Hoesel provided information (Appendix F) regarding the review of the audit and reimbursement process and the review and reconsideration of the 95 percent occupancy rule directed by 2009 Senate Bill No. 2423. She said the department established a workgroup comprised of members from developmental disabilities providers, the department, and the North Dakota Association of Community Providers. She said the workgroup issued a request for information to gain an understanding of the available services that could address the timing of the audits and the costs associated with an independent audit firm completing the audits of the cost reports rather than provider audit. The following is a summary of cost information received through the request for information:

	Biennial Cost
Department of Human Services - Provider audit (1.5 full-time equivalent positions)	$171,447
Public Consulting Group	$298,020
Clifton Gunderson LLP	$320,000
Myers and Stauffer, LC	$471,600

Ms. Hoesel said the workgroup also reviewed the 95 percent occupancy rule, including potential changes relating to calculating the 95 percent rule. She said the department believes the only method that would allow the elimination of the 95 percent occupancy limitation would be to no longer use the retrospective reimbursement process.

In response to a question from Representative Kreidt, Ms. Hoesel said the 95 percent occupancy rule is a major concern for a small number of providers.

It was moved by Senator Heckaman, seconded by Representative Potter, and carried on a roll call vote that the Legislative Council staff be requested to prepare a bill draft to require the Department of Human Services to implement a prospective reimbursement pilot project for developmental disabilities and home and community-based service providers during the 2011-13 biennium and that the bill draft be approved and recommended to the Legislative Management. Representatives Kreidt, Conklin, Holman, Kilichowski, Kingsbury, Pietsch, Pollert, Potter, Uglem, and Wieland and Senators Bakke, Dever, Fiebiger, Heckaman, Jacobs, Lee, and Pomeroy voted "aye." No negative votes were cast.

It was moved by Senator Lee, seconded by Senator Heckaman, and carried on a roll call vote that the committee recommend the Department of Human Services maintain the 95 percent occupancy rule while proceeding with the prospective reimbursement pilot project for developmental disabilities and home and community-based service providers. Representatives Kreidt, Conklin, Holman, Kilichowski, Kingsbury, Pietsch, Pollert, Potter, Uglem, and Wieland and Senators Bakke, Dever, Fiebiger, Heckaman, Jacobs, Lee, and Pomeroy voted "aye." No negative votes were cast.

Mr. Brad Gibbens, Associate Director, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, Grand Forks, provided information (Appendix G) regarding the outcomes of the dementia care services program. He said implementation of the dementia care services program began in January 2010. He said preliminary outcomes include:

- The number of citizens completing intake into the program continues to grow each month.
- Services are being provided in all eight Department of Human Services regional service areas.
- Fifty-six percent of those living with Alzheimer's disease remain in their own home.
- Families caring for the family member in their own home are those needing the greatest assistance.

In response to a question from Senator Dever, Ms. Brenda Weisz, Chief Financial Officer, Department of Human Services, said the department will be requesting funding of $1.2 million from the general fund for the dementia care services program in its 2011-13 biennium base budget request. She said this is the same level of funding as provided for the 2009-11 biennium.

STUDY OF LONG-TERM CARE SERVICES

Ms. Maggie Anderson, Director, Medical Services Division, Department of Human Services, provided information (Appendix H) regarding long-term care expenditures for the 2009-11 biennium. She said actual long-term care expenditures for the 2009-11 biennium through June 30, 2010, total $208,610,640.

Testimony to the North Dakota Long Term Care Committee
Submitted by Brad Gibbens, Associate Director
Center for Rural Health
UND School of Medicine and Health Sciences
September 28, 2010

Good morning, Chairman Kreidt and members of the committee. My name is Brad Gibbens and I am the Associate Director of the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. Thank you for allowing me to appear before you today.

In 2009, the North Dakota Legislature passed the Dementia Care Services bill (House Bill 1043) to provide resources, assistance, and support for citizens across the state of North Dakota, including all geographic areas, large and small, urban, and rural.

The Aging Services Division of the North Dakota Department of Human Services issued a Request for Proposal (RFP) for these services and awarded the contract to the Alzheimer's Association of MN/ND.

The Alzheimer's Association selected the Center for Rural Health to conduct the study and report the outcomes of the dementia care services program; including estimated long-term care, and health care costs avoided, and the improvement in disease management and caregiver assistance. The Center's research staff led by Dr Marilyn Klug, Dr. Kyle Muus, and Dr. Boris Volkov are responsible for the research.

Implementation of the Dementia Care Services project began in January 2010 and we now have preliminary data to share here today. From the perspective of the Alzheimer's Association and the Center for Rural Health, I must emphasize this program is still in the early stages of its implementation; however, the data is indicative of an overall positive trend.

As you see from Slide 1, the number of citizens completing intake into the program continues to grow larger with each successive month. With Slide 2, we are able to confirm services in every geographical area, including 25% of services provided to caregivers living in isolated rural areas. (Slide 3)The caregiver is most generally the adult child (40%) which is usually a daughter or the wife (20%).

Slide 4 shows where persons with Alzheimer's disease who have received services currently reside. The Alzheimer's Association provides service delivery in all 8 DHS regional service areas. The DHS region that has the highest number of Alzheimer cases seeking care is Region V, the Southeast with 33%. This includes the counties of Steele, Trail, Cass, Ransom, Sargent, and Richland. This followed by Region VII. The West Central with 23% and includes the counties of McLean, Sheridan, Mercer, Oliver, Burleigh, Kidder, Morton, Grant, Sioux, and Emmons. The region most challenging at the moment is found in the Devils Lake area (Region 3), where cultural barriers may exist requiring a longer time to build tribal relationships and develop trust.

Slide 5 demonstrates that most of those living with Alzheimer's disease remain in their own home, as do national statistics that show up to 70% of those with dementia in the U.S. continue to live at home. In North Dakota we are seeing a majority, 56%, are residing in their home setting, The next closest living arrangements are LTC (11%), family (11%) and simply unknown (11%).

Slides 6-9 provide a breakout of veterans who have received services from the Alzheimer's Association. The veteran population is a distinct group and an important part of our society. This is particularly true in a rural state like North Dakota. Nationally, about 36% of veterans come from rural areas when only about 20% of the entire U.S. population is rural. In North Dakota, about 48% of our veterans are rural so access to health services are compounded by geographical factors. For a rural veteran and his or her family dealing with Alzheimer's, access to important services can be a struggle. To date, our study shows (slide 6) that 14% of those served to date have been veterans. Those veterans served thus far are more likely to live in the country (slide 7). By country, we mean rural but outside of the city limits. There is also a greater percentage of veterans than non-veteran with Alzheimer's living in urban and large rural. Slide 8 shows the living arrangement for veteran's with Alzheimer's and we see that they tend to remain in their own home (over 50%) although the rate of non-veterans living in their own home is slightly greater. This slide also shows that the veteran is more likely than the non-veteran to live with family or live in a group home or live in a long term care setting. The part of the state with the highest percentage of people with Alzheimer's and to be a veteran is in the southeastern region (Region V and shown in slide 9).

Slide 10 is included to indicate the geographical breakdown of multiple service users. The highest number of users is in the urban centers, where awareness of the disease may be higher, and in the isolated rural area, where access may be more difficult leading to multiple requests to assist the same family.

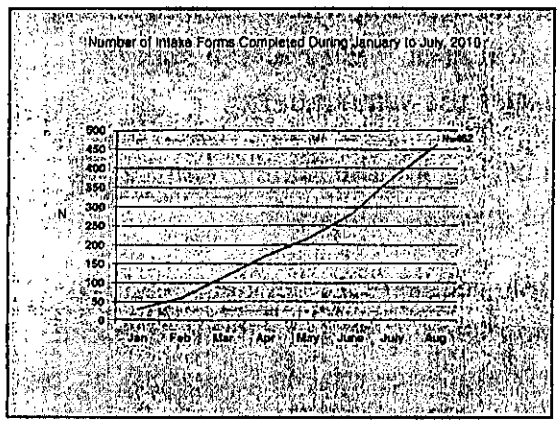
Slide 11 confirms our supposition that families caring for the family member in their own home remain the families needing the greatest assistance.

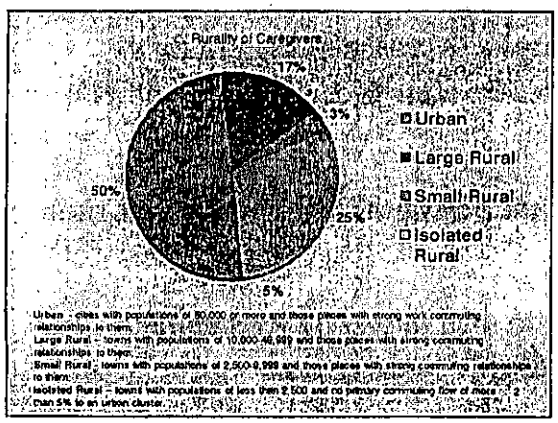
Slide 12 provides a visual demonstrating multiple requests for services leads to families putting in place important legal planning such as power of attorney and health care directives. In a way this data is likely evidence that as time goes by, as the complexity of the health and family situation builds, and as the stress mounts families contend with more extensive and formal decision making.

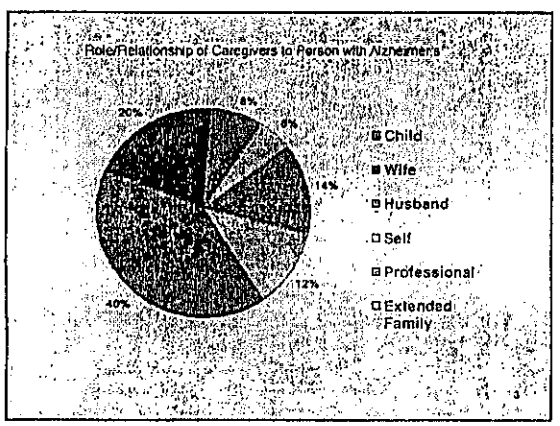
The final slide (Slide 13) proves the importance of services delivery provided in person versus on the telephone and demonstrates a decrease in the family's likelihood to place their loved one in long term care after receiving Alzheimer's Association services delivered in person.

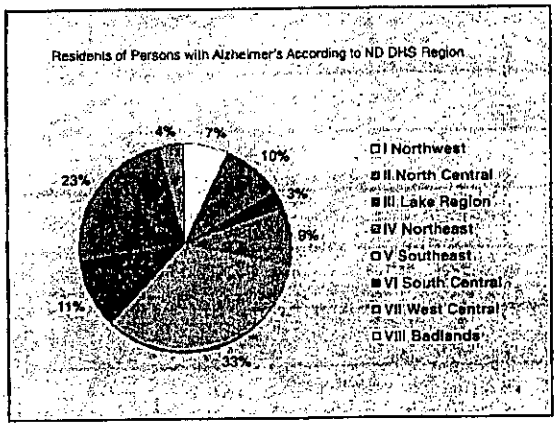
This project continues through June 30, 2011 and the data collected by that time will provide additional valuable information.

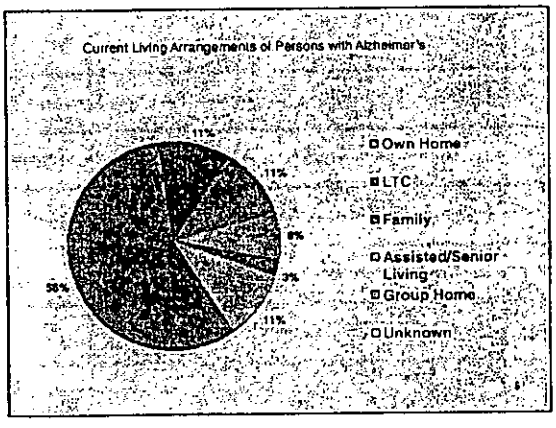
I am happy to respond to any questions and I am also joined by Alzheimer's Association staff to assist in providing clarity to this presentation.

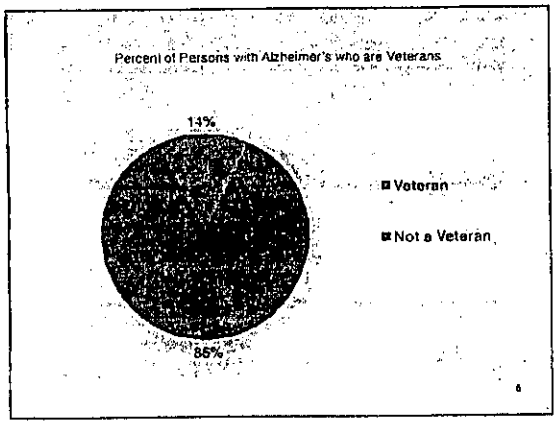

Number of Intake Forms Completed During January to July, 2010
N
Jan
Feb
Mar
Apr
May
June
July
Aug

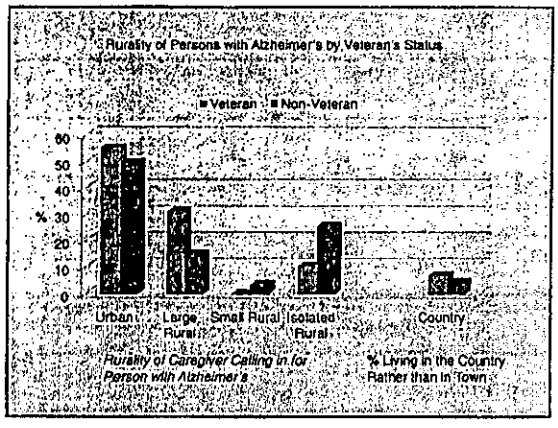

Rurality of Caregivers
17%
3%
50%
25%
5%
Urban
Large Rural
Small Rural
Isolated Rural
Urban – cities with populations of 50,000 or more and those places with strong work commuting relationships to them
Large Rural – towns with populations of 10,000-49,999 and those places with strong commuting relationships to them
Small Rural – towns with populations of 2,500-9,999 and those places with strong commuting relationships to them
Isolated Rural – towns with populations of less than 2,500 and no primary commuting flow of more than 5% to an urban cluster

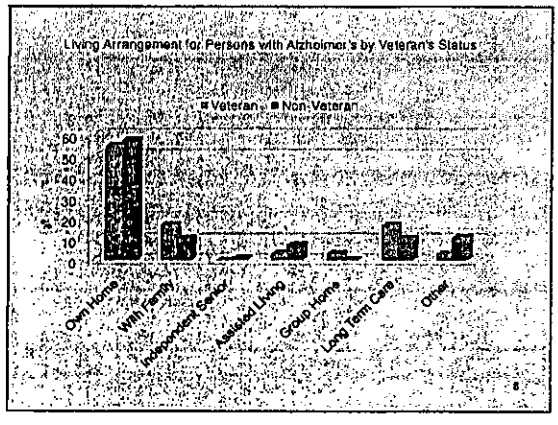

Role/Relationship of Caregivers to Person with Alzheimers
20%
8%
0%
14%
12%
40%
Child
Wife
Husband
Self
Professional
Extended Family

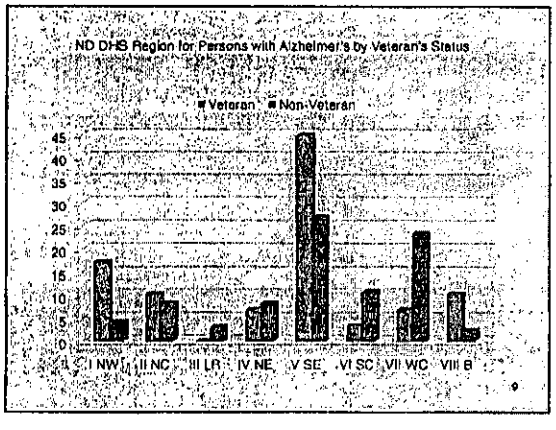

Residents of Persons with Alzheimer's According to ND DHS Region
4%
7%
10%
3%
9%
33%
11%
23%
I Northwest
II North Central
III Lake Region
IV Northeast
V Southeast
VI South Central
VII West Central
VIII Badlands

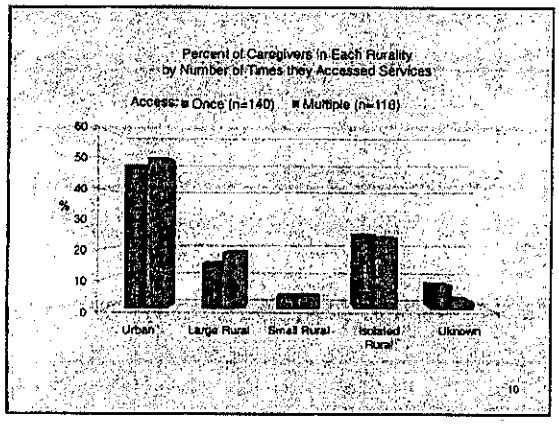

Current Living Arrangements of Persons with Alzheimer's
11%
11%
8%
3%
11%
56%
Own Home
LTC
Family
Assisted/Senior Living
Group Home
Unknown

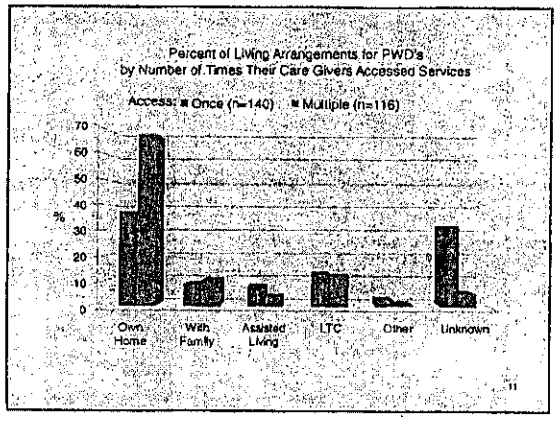

Percent of Persons with Alzheimer's who are Veterans
14%
86%
Veteran
Not a Veteran

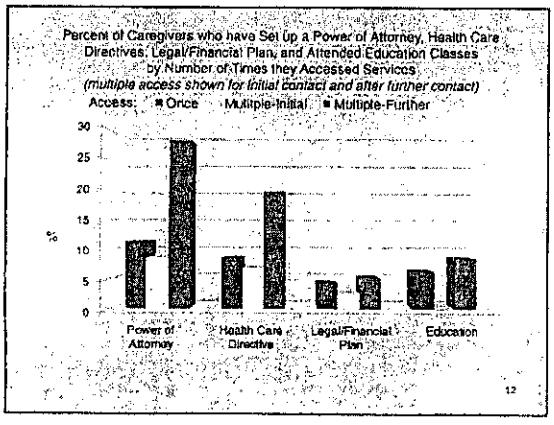

Rurality of Persons with Alzheimer's by Veteran's Status
Veteran
Non-Veteran
%
Urban
Large Rural
Small Rural
Isolated Rural
Country
Rurality of Caregiver Calling in for Person with Alzheimer's
% Living in the Country Rather than in Town

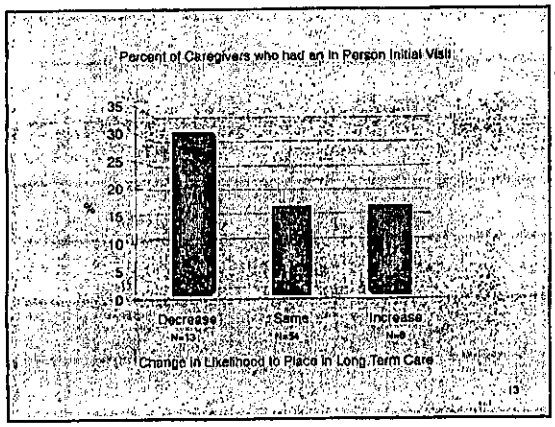

Living Arrangement for Persons with Alzheimer's by Veteran's Status
Veteran
Non-Veteran
%
Own Home
With Family
Independent Senior
Assisted Living
Group Home
Long Term Care
Other


ND DHS Region for Persons with Alzheimer's by Veteran's Status
Veteran
Non-Veteran
I NW
II NC
III LR
IV NE
V SE
VI SC
VII WC
VIII S


Percent of Caregivers in Each Rurality
by Number of Times they Accessed Services
Access: Once (n=140) Multiple (n=116)
%
Urban
Large Rural
Small Rural
Isolated Rural
Unknown
10


Percent of Living Arrangements for PWD's
by Number of Times Their Care Givers Accessed Services
Access: Once (n=140) Multiple (n=116)
%
Own Home
With Family
Assisted Living
LTC
Other
Unknown
11


Percent of Caregivers who have Set Up a Power of Attorney, Health Care Directives, Legal/Financial Plan, and Attended Education Classes
by Number of Times they Accessed Services
(multiple access shown for initial contact and after further contact)
Access: Once Multiple-Initial Multiple-Further
%
Power of Attorney
Health Care Directive
Legal/Financial Plan
Education
12


Percent of Caregivers who had an In Person Initial Visit
35
30
25
20
%
15
10
5
0
Decrease
N=13
Same
N=54
Increase
N=8
Change in Likelihood to Place in Long Term Care
13

-SB 2012
-March 21, 2011
-Attachment Four
-Jan Engan

FACT SHEET: aging & disability resource LINK

Partnering to help people find the services and supports they need **March 2011**

Linking people to the services they need to stay in their homes longer as their abilities and needs change

How it works:

- **Is not** an agency, **but is a new approach** to serving people
- **Retrains existing staff** and partners to more effectively connect people to services
- **Makes it easier** for older adults, adults with physical disabilities, and their families **to learn about choices** if they need long-term supportive services
- **Helps** people live independently longer
- **Does more than provide** information, phone numbers, and referrals
- **Is a resource for people** – not just those who qualify for publicly-funded services
- **Enhances the ND Aging & Disability Resource LINK Web site** so people can search for services and programs online, or talk to someone if they prefer.

Background:

- The N.D. Dept. of Human Services (DHS) – Aging Services Division received a **3-year grant** in late 2009 to develop a pilot Aging and Disability Resource Center (ADRC). N.D. was one of the last states funded.
- The **pilot is based at DHS' West Central Human Service Center and serves Region VII**. It serves Burleigh County and is expanding to Morton, Oliver, Emmons, and Kidder counties (2011), and Grant, McLean, Mercer, Sheridan, and Sioux counties (2012).
- North Dakota is developing a "**No Wrong Door**" model.
- A **network of partnering agencies** and entities who serve seniors and adults with physical disabilities are involved.
- DHS is **realigning existing "infra-structure"** and services to build stronger collaboration and **address gaps, avoid duplication and improve access** to service options and information.
- **Changing federal requirements related to long-term care services are reshaping aging services in North Dakota.**
- The DHS Aging Services Division is guiding the roll-out of the "ADRC service delivery model" into other regions.
- The ADRC pilot project has conducted ADRC services training at **North Central Human Service Center** in Minot so that their Aging Services Unit can provide options counseling services and consistent information.

Key Partners:

- N.D. Dept. of Human Services (DHS) – Aging Services Division
- DHS West Central Regional Human Service Center (Bismarck)
- Burleigh County Social Services (*fiscal agent for two pilot grant-funded positions*) and other county social service offices in Region VII.
- Dakota Center for Independent Living and other CILs
- Burleigh County Senior Adults Program and other Title III Older Americans Act Providers
- Community Elder Service Network Members
- N.D. Insurance Department
- Other organizations serving older persons and adults with disabilities

OVER >

Funding/Sustainability:

- The Federal Administration on Aging approved $202,771 for the first year.
- *Additional grant funding is subject to availability of federal funding.*
- Aging and Disability Resource LINK **services will be rolled out to other regions over the next two years using existing federal Older Americans Act funds and Aging Services Unit staffs** in the department's eight regional human service centers.

  Trained staff will provide options counseling services for people who need long term support and services and will continue strengthening collaboration and coordination with county social service offices and other entities that serve older persons and adults with disabilities.

Goals & Outcomes:

- Partnering organizations will **work more cohesively** to meet the needs of their shared clients.
- People will be aware of ADRC services and will contact the Aging and Disability Resource-LINK (phone and Web site www.carechoice.nd.gov), and partners for help finding and accessing services.
- N.D. will replicate aspects of the pilot in other regions starting with Minot.
- People will be able to research program and service options, to find out if they may qualify, and to find out how to access and apply for services.
- **Uniform intake, information, and options** counseling guidelines and protocols will be adopted by partnering organizations.
- Seamless referrals and support will occur.

north dakota department of human services

Next Steps:

- Continue to develop a network of partnering organizations and to engage them in simplifying access
- Roll-out ADRC model and services statewide
- Raise awareness about services
- Assess and revise efforts as appropriate

CONTACTS:

Bismarck Region:

West Central Human Service Center
Regional Aging Services Unit
1237 W Divide Avenue, Suite 5
Bismarck ND 58501

Cherry Schmidt, WCHSC Regional Aging Services Program Administrator:
701-328-8787 / cschmidt@nd.gov

Lynette Hinckley, ADRC: **701-328-8605**
Lhinckley@nd.gov

Katie Halloran, ADRC options counselor:
701-328-8606 / khalloran@nd.gov

Minot Region:

North Central Human Service Center
Regional Aging Services Unit
1015 S. Broadway, Suite 18
Minot ND 58701

Mari Don Sorum, NCHSC Regional Aging Services Program Administrator:
701-857-8627 / msorum@nd.gov

Statewide Information:

ND Aging & Disability Resource-LINK
1-800-451-8693
www.carechoice.nd.gov
Relay ND 1-800-366-6888 (TTY) for people with hearing impairments

March 2011

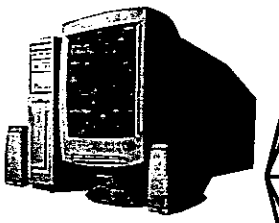
Seeking Services with "No Wrong Door"



Phone-in

Customer Concerns:

- Driving
- Meal Preparation
- Difficulty with Medications
- Forgetfulness
- Vision Impairment
- Hard of Hearing
- Incontinence
- Mental Health Concerns
- Other…



LINK Portal



Face-to-Face

Options Counseling

Agency Screening

- OAA Aging Services
- Hospitals, Nursing Homes
- Community Services
- Transportation Providers
- Senior Centers
- State County Social Services
- Home Health
- Centers for Independent Living

Care/Service Options:

- Transportation
- Home Delivered Meals
- In-Home Assistance
- Home Health
- Vision /Hearing Assist
- Personal Care
- Mental Health Services
- Other…

Service Providers

Referral

DHS
Shared Client Database and Resource LINK Service Provider Database

CHILD WELFARE GRANT EXPENDITURES		
	COUNTY RESPONSIBILITY	
Foster Care (Room & Board)		
IV-E		
Non-Native American	25.00%	of Nonfederal Share (federal share at FMAP)
Native American	0.00%	
Emergency Assistance (EA)/Regular	25.00%	
Foster Care (Therapy & Case Management)		
Therapy*	13.11%	of Nonfederal Share (federal share at FMAP)
Case Management		
IV-E	25.00%	of Nonfederal Share (federal share at 50%)
EA/Reg	25.00%	
Subsidized Guardianship	0.00%	
Other Foster Care Grants		
Intensive In-Home Medicaid*	13.11%	of Nonfederal Share (federal share at FMAP)
Subsidized Adoption		
IV-E		
Non-Native American	25.00%	of Nonfederal Share (federal share at FMAP)
Native American	0.00%	
Regular	25.00%	

* These services are Medicaid allowable services for children in Foster Care. Counties are billed a fixed percentage. This percentage was established in 1983 based upon each county's medicaid costs for SFY1983.

- Debra McDermott
- Attachment FIVE
- SB 2012
- March 21, 2011

- Maggie Anderson
- Attachment SIX
- SB 2012
- March 21, 2011

North Dakota Department of Human Services
Medical Services Division

Adult Family Foster Care Information

March 2011

Adult Family Foster Home

An occupied private residence in which Adult Family Foster Care is regularly provided by the owner or lessee thereof, to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation.

As of March 10, 2011:

Number of Individuals in Home and Community Based Services Adult Family Foster Care and the average cost:

Eighteen individuals are currently being served in Adult Family Foster Care through ExSPED, HCBS Waiver and SPED.

Total average annual cost per person is $5,955.20.

Summary:

- There is a monthly rate worksheet that is filled out by the county case managers to determine the level of services each client needs. The rate is formulated in accordance with the needs that are determined on the worksheet.
- Adult Family Foster Care Providers can charge up to $525 per month for room and board for public pay clients. This would be for meals, rent, etc.
- For clients receiving Adult Family Foster Care on the SPED program, the monthly cap for services is $1930 per month or $62.25 per day.
- For clients receiving Adult Family foster Care in the HCBS waiver, the monthly cap is $2,172 per month or $70.07 per day.
- Respite care is also available with a cap of $873 per month. This allows the AFFC caregiver to take time away from the job up to 8 hours per day and the provider can still bill for that day.

North Dakota Department of Human Services
Medical Services Division

Comparison of Medicaid Eligibles

North Dakota

	Number Eligible
July 2008	51,061
January 2011	63,924
Total Difference	**12,863**
Difference - Children	**9,629**

75% of growth has been children

South Dakota

	Number Eligible
FY 2009	104,520
FFY 2012 (budget)	119,452
Total Difference	**14,932**
Difference - Children	**10,810**

72% of growth has been children

Montana

	Number Eligible
November 2009	88,420
December 2010	102,913
Total Difference	**14,493**
Difference - Children	**13,214**

91% of growth has been children

INCOME LEVELS EFFE TIVE * JANUARY 1, 2011

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/09)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 750	$674	$ 903	$1,083	$1,201	$1,219	$1,444	$1,670	$1,805	$2,031
2	417	1008	1011	1,215	1,457	1,615	1,640	1,943	2,247	2,429	2,732
3	523	1267		1,526	1,831	2,030	2,060	2,442	2,823	3,052	3,434
4	629	1526		1,838	2,205	2,444	2,481	2,940	3,400	3,675	4,135
5	735	1784		2,150	2,579	2,859	2,902	3,439	3,976	4,299	4,836
6	841	2,043		2,461	2,953	3,273	3,323	3,938	4,553	4,922	5,537
7	947	2,302		2,773	3,327	3,688	3,743	4,436	5,130	5,545	6,239
8	1,053	2,560		3,085	3,701	4,102	4,164	4,935	5,706	6,169	6,940
9	1,159	2,819		3,396	4,075	4,517	4,585	5,435	6,283	6,792	7,641
10	1,265	3,078		3,708	4,449	4,931	5,006	5,935	6,859	7,415	8,342
+1*	107	259		312	374	415	421	500	577	624	702

Spousal Impoverishment Levels			
Community Spouse Minimum Asset Allowance (Effective 01/01/09)	Community Spouse Maximum Asset Allowance (Effective 01/01/09)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/09)
$21,912	$109,560	$2,267	$607

Average Cost of Nursing Care	
Average Monthly Cost of Care (Effective 01/01/11)	Average Daily Cost of Care (Effective 01/01/11)
$6,238	$205.07

Note: LTC income level increased from $40 to $50 effective with the benefit month of 01/01/02

*Caring for Children eligibility guidelines changed from 141-170% FPL to 151-200% FPL as of 11/01/08

(Due to Healthy Steps eligibility guidelines change to 160% as of 07/01/09) There has been no change in income levels since 07-01-09.

Rev 01/2011

North Dakota Department of Human Services

Medicaid and CHIP Income Disregards and Deductions

(As of January 2011)

Disregarded Income - ***disregards are not considered an income source***

The following types of income are disregarded in determining eligibility for Medicaid/CHIP:

1. State or tribal money payments for foster care, subsidized guardianship, the subsidized adoption program, or the State LTC Subsidy Program ;
2. Temporary Assistance for Needy Families (TANF) benefit and support services payments;
3. Benefits received through the Low Income Home Energy Assistance Program;
4. Refugee cash assistance payments;
5. County general assistance payments;
6. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;
7. Family subsidy program payments;
8. Housing assistance payments;
9. Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property. This includes distributions of per capita judgment funds;
10. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;
11. Income earned by a child who is a full-time student, or a part-time student who is not employed one hundred hours or more per month;
12. Supplemental Security Income (SSI) - *CHIP disregards all SSI. Medicaid disregards lump sum SSI payments. Medicaid counts SSI if the client chooses to be eligible under the children and family category. If they choose to be eligible under the aged and disabled category, they get an income level equal to the level that established SSI eligibility.*
13. Compensation received by volunteers participating in certain federal volunteer programs;

14. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
15. All income, allowances, and bonuses received as a result of participation in the Job Corps Program;
16. Occasional small gifts;
17. In-kind income except in-kind income received in lieu of wages;
18. Income tax refunds and earned income credits;
19. Homestead tax credits;
20. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, and work-study received by a student.
21. Any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution;
22. Training funds received from Vocational Rehabilitation;
23. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;
24. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act (WIA), and through the Job Opportunities and Basic Skills program;
25. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs;
26. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act;
27. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act;
28. Agent Orange payments;
29. Crime Victims Reparation payments;
30. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
31. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a presidentially declared major disaster (but not disaster assistance unemployment compensation);

32. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects;
33. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286;
34. Radiation Exposure Compensation, Public Law 101-426;
35. Interest or dividend income earned on liquid assets;
36. Additional pay received by military personnel as a result of deployment to a combat zone;
37. Fifty dollars per month of current child support, received on behalf of children in the SCHIP unit;
38. All wages paid by the Census Bureau for temporary employment related to census activities;
39. Reimbursements from an employer, training agency or other organization for past or future training, or volunteer related expenses

Income Deductions - ***deductions are subtracted after the income is calculated***

The following income deductions are allowed in determining Medicaid/CHIP eligibility:

1. Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
2. Mandatory retirement plan deductions;
3. Expenses of a blind person reasonably attributed to earning income;
4. Reasonable child care expenses, not otherwise reimbursed, that the Medicaid/CHIP Unit is responsible to pay, if necessary to engage in employment or training;
5. Non-voluntary child and spousal support payments if actually paid;
6. For individuals who are employed or in training, thirty dollars may be deducted as a work or training allowance (does not apply to children in school);
7. The cost of premiums for health insurance for members of the unit who are not eligible for Medicaid/CHIP; and
8. Medical expenses for necessary medical or remedial care for members of the unit who are not eligible for Medicaid/CHIP.

Additional Income Deductions allowed for Medicaid

The following additional income deductions are allowed in determining Medicaid eligibility

1. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.
2. Premiums for long term care insurance.
3. Transportation expenses necessary to secure medical care.
4. Reasonable adult dependent care expenses.
5. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.
6. A disregard of $20 per month for aged, blind and disabled applicants or recipients.
7. Guardian or conservator fees, up to a maximum of five percent of countable gross monthly income.
8. For all aged, blind, or disabled applicants or recipients, sixty-five dollars plus one-half of the remaining monthly gross earned income.

North Dakota Department of Human Services
Medical Services Division
Children's Health Insurance Program (CHIP)
Surrounding State Comparison Information
January 2011

South Dakota

Information provided by Larry Iverson, South Dakota Department of Social Services.

South Dakota looks at gross income, but has the following allowable deductions:

1. Less than 140% - there is a 20% earning disregard or $90, whichever is higher.
2. Childcare expenses
3. First $50 in child support payment received
4. Child support payments made

SD has two CHIP programs. One is the Medicaid "look-alike" that goes to 140% FPL. The other is an expansion from 141% to 200%. All CHIP kids receive all of the services the Medicaid kids do, including dental and vision services.

Minnesota

Information provided by Patricia Callaghan, Minnesota Department of Human Services.

Minnesota CHIP covers the noncitizen pregnant women (through the unborn child group) up to 275% FPL. Effective July 1, 2010, Minnesota adopted Medicaid coverage for noncitizen pregnant women and children lawfully residing in the U.S. This meant that coverage for some lawfully residing pregnant women shifted from the CHIP unborn group into Medicaid pregnant woman coverage (e.g. pregnant women within the 5-year bar period).

Effective January 31, 2009, Minnesota terminated (as required by CMS) its CHIP section 1115 waiver for parents with income between 100 and 200% FPL. The coverage for this population has been switched to the MinnesotaCare program.

Minnesota CHIP continues to cover a Medicaid expansion group of infants under age 2 with income between 275 and 280% FPL.

Minnesota's regular Medicaid program (State Plan) covers children between ages 2 and 19 with net income up to 150% FPL. Under a Medicaid section 1115 waiver program known as MinnesotaCare, the state covers families and children under age 21 up to 275% FPL based on family gross income and household size.

Note: Parents and children whose income levels overlap with MinnesotaCare are permitted to choose between the two programs, in other words they may choose to pay a premium under the MinnesotaCare program.

~ OVER ~

Montana

Information provided by Katherine Buckley-Patton from the Montana Health Kids Program

July 2007 MT CHIP eligibility level went to 175%. (Was previously 150%)
Effective October 1, 2009, the income eligibility level was raised to 250% FPL
Effective Oct 1, 2009, Montana CHIP became part of the Healthy Montana Kids (HMK) Program, the result of a ballot initiative passed in November 2008. The HMK Program combines under one 'umbrella' the Healthy Montana Kids *Plus* coverage group (formerly children's Medicaid) and the Healthy Montana Kids coverage group (formerly CHIP).

Montana allows these deductions in the HMK coverage group:

1. $1,440 per year for each family member with earned income.
2. $2,400 per year for dependent care expenses for each individual who has dependent care expenses. (Parents have to be working or going to school.)

Montana CHIP covers dental and vision. Dental services are limited to $350 per child per year. Effective 10/1/2010 (and in compliance with CHIPRA) MT's "Basic Dental Benefit" available to all enrolled members is $1200 in reimbursable services with a benefit year (Oct 1-Sept 30). MT's basic dental is now benchmarked on the state employee benefit plan. The Extended Dental Plan is in addition to the Basic Dental Plan and dentists can apply for additional funding (up to $1000 per child) for children with extensive needs.

As requested during the Hearings on Senate Bill 2264 and House Bill 1377

~ OVER ~

-Nancy McKenzie
-Attachment SEVEN
-March 21, 2011
-SB2012

Department of Human Services
March 21, 2011

Psychiatrists

- Badlands HSC/Dickinson-1 (vacant)
- Lake Region HSC/Devils Lake-1 (filled)
- Northeast HSC/Grand Forks-3 (filled)
- South Central HSC/Jamestown-2 (1 vacant, 1 filled)
- Southeast HSC/Fargo-6 (6 filled)
- West Central HSC/Bismarck-3 (1 vacant, 2 filled)

Clinical Nurse Specialists

- North Central HSC/Minot-4 (2 vacant, 2 filled)
- Northeast HSC/Grand Forks-1 (filled)
- Northwest HSC/Williston-2 (filled)
- South Central HSC/Jamestown-1 (filled)

COOPER HOUSE
MENTAL HEALTH TECHNICIAN

(Note: Formula to provide one staff for 24/7 coverage is 4.58 FTE)

A. SKILLS, KNOWLEDGE, AND ABILITIES REQUIRED:

1. Working knowledge of the general nature of rules, procedures, and methods related to the care and well-being of people with mental illness and/or chemical dependency.
2. Knowledge and/or skills required will generally be gained through training, both formal and informal, and/or related experience.
3. High degree of interpersonal skill required to be able to communicate with, motivate, and/or facilitate.
4. Be available (on-call) for times agreed upon with employer.
5. Good verbal and written communication skills.

B. ESSENTIAL DUTIES:

1. Monitor activity of the facility and residents through front office security camera system and interaction with residents, document and report to co-worker and supervisor.*
2. Participate in meetings and in-service training.
3. Provide supportive listening for residents.
4. Provide a safe environment for residents.
5. Complete designated chores
6. Obtain required training.
7. Monitor security of the front entrance, monitor and document entry and exit of residents and guests
8. Search belongings of residents and guests upon entrance
9. Monitor/log alcohol entering the building

*Staff spend a large portion of their time checking on residents and taking appropriate action when there are medical or safety concerns; providing intervention in situations that could easily escalate to violence (which in turn would result in mandatory eviction); providing emotional support to those that are struggling with issues such as deaths, friend and family alienation etc. that are common among this population; assisting residents with basic skills such as how to turn on and use their appliances, how to prepare the food they receive from food assistance, how to wash laundry, etc. as most either do not have these skills or haven't utilized them recently and need some education; assisting residents to cope with mental health issues as they go through periods of increase in symptoms; providing structured social activities to promote a more sober lifestyle; and a general walking through the facility on a regular basis to be observant for potential issues within apartments.

C. MINIMUM TRAINING AND EXPERIENCE:

1. Requires equivalent of high school graduation.
2. Must hold valid driver's license.
3. Experience and/or training with persons who have mental illness and/or chemical dependency.

North Dakota Department of Human Services
Changes in DD Grants from 2009-2011 Appropriation to 2011-2013 Executive Budget

Description	2009-2011 Appropriation	Funding Shift *	Cost Changes	Caseload/ Utilization Changes	FMAP	3/3 Inflation	Total Changes	2011-2013 Executive Budget
Family Subsidy	1,746,336		4,404,912	(5,289,240)		39,192	(845,136)	901,200
Intermediate Care Fac. for Mentally Retarded	113,446,346		6,146,123	4,556,953		5,342,697	16,045,773	129,492,119
ICF/MR Adult	55,183,151		1,924,354	5,232,362		2,630,911	9,787,627	64,970,778
ICF/MR Physically Handicap	30,722,072		2,233,687	(1,036,850)		1,395,616	2,592,453	33,314,525
ICF/MR Children	27,541,122		1,988,082	361,441		1,316,171	3,665,694	31,206,816
DD Home & Community Based Services	217,483,407		10,529,469	17,174,815	(17,392)	11,149,463	38,836,355	256,319,762
Day Supports	51,867,987		3,333,587	4,160,856		2,668,824	10,163,267	62,031,254
Family Support Services - In Home Support (FSS)	12,755,898		895,111	2,192,775		726,667	3,814,553	16,570,451
Infant Development	13,630,303		(1,644,132)	(348,403)		534,344	(1,458,191)	12,172,112
Individualized Supported Living Arrangement (ISLA)	77,425,367		3,554,850	(403,848)		3,676,743	6,827,745	84,253,112
Minimally Supervised Living Arrangement (MSLA)	21,216,554		3,842,656	3,486,303		1,275,583	8,604,542	29,821,096
Transitional Community Living - Training (TCLF)	17,418,837		2,891,366	(216,403)		920,722	3,595,685	21,014,522
Remaining Services	23,168,461		(2,343,969)	8,303,535	(17,392)	1,346,580	7,288,754	30,457,215
Autism Waiver **	1,038,000		(148,272)	889,728		80,868	822,324	1,860,324
DD Funding Buckets ^	7,828,457		227,996	0		366,175	594,171	8,422,628
Total DD Grants	341,542,546	0	21,160,228	17,332,256	(17,392)	16,978,395	55,453,487	396,996,033
General Funds	110,730,341	1,190,654	10,652,533	2,363,437	41,819,324	7,475,018	63,500,966	174,231,307

* BND Loan Funds of $1,190,654 were replaced with general funds

** The 09-11 budget for the Autism Waiver was for 12 months, therefore the caseload increase reflected above is to fund the waiver for 24 months in the 11-13 biennium.

^ Enhanced funding for various critical needs provided to children and adults with disabilities.

- Tina Bay
- Attachment Eight
- SB 2012
- March 21, 2011

North Dakota Department of Human Services
2011-2013 Biennium
DD Hourly Wage Comparisons

DD Standard Hourly Wage Allowances	Effective 7/1/2010	3% Inflation Effective 7/1/2011	3% Inflation Effective 7/1/2012
	Wage Allowance	**Wage Allowance**	**Wage Allowance**
Group Homes			
1st Approved FTE (residential manager)	**$17.24**	**$17.76**	**$18.29**
2nd Approved FTE	**$15.73**	**$16.20**	**$16.69**
Remaining Approved FTE	**$13.72**	**$14.13**	**$14.56**
Standby	**$11.81**	**$12.16**	**$12.53**
Day Services			
Day Supports Approved FTE	**$14.38**	**$14.81**	**$15.26**

History of Fringe Benefit Percentages:

July 1, 1988 thru June 30, 1999 - **25%** of salaries

July 1, 1999 thru June 30, 2003 - **30%** of salaries

July 1, 2003 to current - **33%** of salaries

- Tina Bay
- SB 2012
- March 21, 2011
- Attachment NINE

North Dakota Department of Human Services
Developmental Disability Grants
Selected Services Report
2009/2011 DD Funding Bucket Allotment Information

09/11 DD Funding Bucket Allotments	Total Funds Available	Bucket 1	Bucket 2	Bucket 3	Bucket 4	Bucket 5	Bucket 6
		Children's ICF/MR Intense Medical Need	Children's ICF/MR Behaviorally Challenging	Anne Carlsen Center Severely Medically Fragile	Intense Medical Need - Family Homes	Intense Medical Need - Adult Residential	Critical Need - Medically Fragile & Behavioral Challenging
09/11 Total	$7,828,457	$663,167	$606,219	$909,329	$644,330	$805,412	$4,200,000
Age limit		<21	<21	<21	All Ages	≥21	All Ages
Assessment Used		Oregon	Oregon	Oregon	Oregon	Oregon	Oregon
Qualifing assessment score		≥ 16	≥ 50	≥ 40	≥ 16	≥ 16	Medical ≥ 13 Behavioral ≥ 50
Number of eligible scores		44	94	15	35	102	1151

- Tina Bay
- Attachment TEN
- SB 2012
- March 21, 2011

-Tina Bay
-SB 2012
-March 21, 2011
-Attachment ELEVEN

North Dakota Department of Human Services
Developmental Disability Grants
Selected Services Report
Reconciliation of 09-11 Day Support Rates to 11-13 Executive Budget Rates

Day Supports

07-09 Avg (Aug 07- April 08)	11.67
5% Inflation (7/1/2008)	0.59
$1 Salary Increase (7/1/2009)	1.00
6% on $1 salary increase	0.06
Fringe Benefits ($1.06 X 33%)	0.35
Subtotal	13.67
6% Inflation 7/1/2009	0.82
Historical Cost Rate Adjustments From Cost Reports, Based on Administrative Code	0.26
09-11 Avg (Aug 09 - April 10)	14.75
6% Inflation 7/1/2010	0.88
3/3% Inflation 11-13	0.71
2011-2013 Executive Budget	16.34

Family Support Services - In Home Support - The SFY 2011 hourly rate for all providers is $14.38. However the number of hours of support provided to each client varies based upon the needed services. The current average number of hours per month, per client is 49.4.

North Dakota Department of Human Services
Developmental Disability Grants
Infant Development - Fee for Service Effective 7/1/2010

Fee for Service Calculation for State Fiscal Year 2011

SFY 2011 Projected Costs
(Projected Expenditures for SFY 2010 + 6% Inflation) $ 6,069,823

	Estimated Hours for each Service	# of Services Per Year per Client	Total Hours	% of Total Hours	Allocation of Projected Costs (Based upon % of Time	# of Clients	Total Yearly Service Units	Estimated Fee for Service
	A	*B*	*C*	*D*	*E*	*F*	*G*	*H*
			A X B = C	*C / 194.3 (Total Hours)*	*D X Projected Costs*		*F X B = G*	*E / G = H*
Evaluation	22.5	1	22.5	0.11	667,681	1,625	1,625	$411
Individual Family Service Plan	18	2	36	0.19	1,153,266	1,448	2,896	$398
Home Visits	3.5	34	119	0.61	3,702,592	909	30,906	$120
Consultation	7	2.4	16.8	0.09	546,284	909	2,182	$250
Total			194.3	1.00	6,069,823		37,609	

2011-2013 Executive Budget

	Total Units of Service for 2011-2013 Biennium	Monthly Average Cost Per Unit	2011-2013 Executive Budget *
Evaluation	2,340	$405.79	949,549
Individual Family Service Plan	3,960	$393.27	1,557,349
Home Visits	69,372	$118.19	8,198,984
Consultation	5,940	$246.84	1,466,230
Total	81,612		12,172,112

149.15 Monthly Average Cost Per Unit

	Total Units of Service for 2011-2013 Biennium	Adjusted Monthly Average Cost Per Unit	2011-2013 Executive Budget with Adjusted Rates
Evaluation	2,340	$429.85	1,005,849
Individual Family Service Plan	3,960	$416.28	1,648,469
Home Visits	69,372	$125.51	8,707,057
Consultation	5,940	$261.48	1,553,191
Total	81,612		12,914,566

158.24 Monthly Average Cost Per Unit

(742,454) Total Budget Shortfall
(302,933) General Fund Sortfall

* The unit rates used in the preparation of the 11-13 Executive Budget did not include the 6% inflationary increase effective 7/1/2010.

- Brenda Weiss - March 21, 2011 - Attachment TWELVE - SB 2012

North Dakota Department of Human Services
Developmental Disability Grants
Infant Development - Fee for Service Effective 7/1/2010

Fee for Service Calculation for State Fiscal Year 2011

SFY 2011 Projected Costs
(Projected Expenditures for SFY 2010 + 6% Inflation) $ 6,069,823

	Estimated Hours for each Service	# of Services Per Year per Client	Total Hours	% of Total Hours	Allocation of Projected Costs (Based upon % of Time	# of Clients	Total Yearly Service Units	Estimated Fee for Service
	A	B	C	D	E	F	G	H
			A X B = C	C / 194.3 (Total Hours)	D X Projected Costs		F X B = G	E / G = H
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3/21/2011

North Dakota Department of Human Services
Medical Services Division

Adult Family Foster Care Information

March 2011

Adult Family Foster Home

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- For clients receiving Adult Family foster Care in the HCBS waiver, the monthly cap is $2,172 per month or $70.07 per day.
- Respite care is also available with a cap of $873 per month. This allows the AFFC caregiver to take time away from the job up to 8 hours per day and the provider can still bill for that day.

North Dakota Department of Human Services
Medical Services Division

Comparison of Medicaid Eligibles

North Dakota

	Number Eligible
July 2008	51,061
January 2011	63,924
Total Difference	**12,863**
Difference - Children	**9,629**

75% of growth has been children

South Dakota

	Number Eligible
FY 2009	104,520
FFY 2012 (budget)	119,452
Total Difference	**14,932**
Difference - Children	**10,810**

72% of growth has been children

Montana

	Number Eligible
November 2009	88,420
December 2010	102,913
Total Difference	**14,493**
Difference - Children	**13,214**

91% of growth has been children

3/18/2011

INCOME LEVELS EFFECTIVE * JANUARY 1, 2011

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/09)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 750	$674	$ 903	$1,083	$1,201	$1,219	$1,444	$1,670	$1,805	$2,031
2	417	1008	1011	1,215	1,457	1,615	1,640	1,943	2,247	2,429	2,732
3	523	1267		1,526	1,831	2,030	2,060	2,442	2,823	3,052	3,434
4	629	1526		1,838	2,205	2,444	2,481	2,940	3,400	3,675	4,135
5	735	1784		2,150	2,579	2,859	2,902	3,439	3,976	4,299	4,836
6	841	2,043		2,461	2,953	3,273	3,323	3,938	4,553	4,922	5,537
7	947	2,302		2,773	3,327	3,688	3,743	4,436	5,130	5,545	6,239
8	1,053	2,560		3,085	3,701	4,102	4,164	4,935	5,706	6,169	6,940
9	1,159	2,819		3,396	4,075	4,517	4,585	5,435	6,283	6,792	7,641
10	1,265	3,078		3,708	4,449	4,931	5,006	5,935	6,859	7,415	8,342
+1*	107	259		312	374	415	421	500	577	624	702

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/09)	Community Spouse Maximum Asset Allowance (Effective 01/01/09)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/09)
$21,912	$109,560	$2,267	$607

Average Cost of Nursing Care

Average Monthly Cost of Care (Effective 01/01/11)	Average Daily Cost of Care (Effective 01/01/11)
$6,238	$205.07

Note: LTC income level increased from $40 to $50 effective with the benefit month of 01/01/02
*Caring for Children eligibility guidelines changed from 141-170% FPL to 151-200% FPL as of 11/01/08
(Due to Healthy Steps eligibility guidelines change to 160% as of 07/01/09) There has been no change in income levels since 07-01-09.

Rev 01/2011

P:\Medical Service\Mcs\...\Information for County Use\...\...\Income Level Chart - Effective ...

North Dakota Department of Human Services

Medicaid and CHIP Income Disregards and Deductions

(As of January 2011)

Disregarded Income - ***disregards are not considered an income source***

The following types of income are disregarded in determining eligibility for Medicaid/CHIP:

1. State or tribal money payments for foster care, subsidized guardianship, the subsidized adoption program, or the State LTC Subsidy Program ;
2. Temporary Assistance for Needy Families (TANF) benefit and support services payments;
3. Benefits received through the Low Income Home Energy Assistance Program;
4. Refugee cash assistance payments;
5. County general assistance payments;
6. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;
7. Family subsidy program payments;
8. Housing assistance payments;
9. Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property. This includes distributions of per capita judgment funds;
10. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;
11. Income earned by a child who is a full-time student, or a part-time student who is not employed one hundred hours or more per month;
12. Supplemental Security Income (SSI) - *CHIP disregards all SSI. Medicaid disregards lump sum SSI payments. Medicaid counts SSI if the client chooses to be eligible under the children and family category. If they choose to be eligible under the aged and disabled category, they get an income level equal to the level that established SSI eligibility.*
13. Compensation received by volunteers participating in certain federal volunteer programs;

14. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
15. All income, allowances, and bonuses received as a result of participation in the Job Corps Program;
16. Occasional small gifts;
17. In-kind income except in-kind income received in lieu of wages;
18. Income tax refunds and earned income credits;
19. Homestead tax credits;
20. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, and work-study received by a student.
21. Any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution;
22. Training funds received from Vocational Rehabilitation;
23. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;
24. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Investment Act (WIA), and through the Job Opportunities and Basic Skills program;
25. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs;
26. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act;
27. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act;
28. Agent Orange payments;
29. Crime Victims Reparation payments;
30. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
31. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a presidentially declared major disaster (but not disaster assistance unemployment compensation);

32. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects;
33. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286;
34. Radiation Exposure Compensation, Public Law 101-426;
35. Interest or dividend income earned on liquid assets;
36. Additional pay received by military personnel as a result of deployment to a combat zone;
37. Fifty dollars per month of current child support, received on behalf of children in the SCHIP unit;
38. All wages paid by the Census Bureau for temporary employment related to census activities;
39. Reimbursements from an employer, training agency or other organization for past or future training, or volunteer related expenses

Income Deductions - ***deductions are subtracted after the income is calculated***

The following income deductions are allowed in determining Medicaid/CHIP eligibility:

1. Mandatory payroll deductions and union dues withheld, or ninety dollars, whichever is greater;
2. Mandatory retirement plan deductions;
3. Expenses of a blind person reasonably attributed to earning income;
4. Reasonable child care expenses, not otherwise reimbursed, that the Medicaid/CHIP Unit is responsible to pay, if necessary to engage in employment or training;
5. Non-voluntary child and spousal support payments if actually paid;
6. For individuals who are employed or in training, thirty dollars may be deducted as a work or training allowance (does not apply to children in school);
7. The cost of premiums for health insurance for members of the unit who are not eligible for Medicaid/CHIP; and
8. Medical expenses for necessary medical or remedial care for members of the unit who are not eligible for Medicaid/CHIP.

Additional Income Deductions allowed for Medicaid

The following additional income deductions are allowed in determining Medicaid eligibility

1. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.
2. Premiums for long term care insurance.
3. Transportation expenses necessary to secure medical care.
4. Reasonable adult dependent care expenses.
5. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available.
6. A disregard of $20 per month for aged, blind and disabled applicants or recipients.
7. Guardian or conservator fees, up to a maximum of five percent of countable gross monthly income.
8. For all aged, blind, or disabled applicants or recipients, sixty-five dollars plus one-half of the remaining monthly gross earned income.

North Dakota Department of Human Services
Medical Services Division
Children's Health Insurance Program (CHIP)
Surrounding State Comparison Information
January 2011

South Dakota

Information provided by Larry Iverson, South Dakota Department of Social Services.

South Dakota looks at gross income, but has the following allowable deductions:

1. Less than 140% - there is a 20% earning disregard or $90, whichever is higher.
2. Childcare expenses
3. First $50 in child support payment received
4. Child support payments made

SD has two CHIP programs. One is the Medicaid "look-alike" that goes to 140% FPL. The other is an expansion from 141% to 200%. All CHIP kids receive all of the services the Medicaid kids do, including dental and vision services.

Minnesota

Information provided by Patricia Callaghan, Minnesota Department of Human Services.

Minnesota CHIP covers the noncitizen pregnant women (through the unborn child group) up to 275% FPL. Effective July 1, 2010, Minnesota adopted Medicaid coverage for noncitizen pregnant women and children lawfully residing in the U.S. This meant that coverage for some lawfully residing pregnant women shifted from the CHIP unborn group into Medicaid pregnant woman coverage (e.g. pregnant women within the 5-year bar period).

Effective January 31, 2009, Minnesota terminated (as required by CMS) its CHIP section 1115 waiver for parents with income between 100 and 200% FPL. The coverage for this population has been switched to the MinnesotaCare program.

Minnesota CHIP continues to cover a Medicaid expansion group of infants under age 2 with income between 275 and 280% FPL.

Minnesota's regular Medicaid program (State Plan) covers children between ages 2 and 19 with net income up to 150% FPL. Under a Medicaid section 1115 waiver program known as MinnesotaCare, the state covers families and children under age 21 up to 275% FPL based on family gross income and household size.

Note: Parents and children whose income levels overlap with MinnesotaCare are permitted to choose between the two programs, in other words they may choose to pay a premium under the MinnesotaCare program.

~ OVER ~

Montana

Information provided by Katherine Buckley-Patton from the Montana Health Kids Program

July 2007 MT CHIP eligibility level went to 175%. (Was previously 150%)
Effective October 1, 2009, the income eligibility level was raised to 250% FPL
Effective Oct 1, 2009, Montana CHIP became part of the Healthy Montana Kids (HMK) Program, the result of a ballot initiative passed in November 2008. The HMK Program combines under one 'umbrella' the Healthy Montana Kids *Plus* coverage group (formerly children's Medicaid) and the Healthy Montana Kids coverage group (formerly CHIP).

Montana allows these deductions in the HMK coverage group:

1. $1,440 per year for each family member with earned income.
2. $2,400 per year for dependent care expenses for each individual who has dependent care expenses. (Parents have to be working or going to school.)

Montana CHIP covers dental and vision. Dental services are limited to $350 per child per year. Effective 10/1/2010 (and in compliance with CHIPRA) MT's "Basic Dental Benefit" available to all enrolled members is $1200 in reimbursable services with a benefit year (Oct 1-Sept 30). MT's basic dental is now benchmarked on the state employee benefit plan. The Extended Dental Plan is in addition to the Basic Dental Plan and dentists can apply for additional funding (up to $1000 per child) for children with extensive needs.

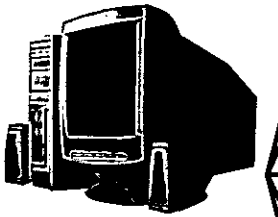
As requested during the Hearings on Senate Bill 2264 and House Bill 1377

~ OVER ~

Seeking Services with "No Wrong Door"



Phone-in



LINK Portal



Face-to-Face

Customer Concerns:

- Driving
- Meal Preparation
- Difficulty with Medications
- Forgetfulness
- Vision Impairment
- Hard of Hearing
- Incontinence
- Mental Health Concerns
- Other…

Options Counseling

Agency Screening

- OAA Aging Services
- Hospitals, Nursing Homes
- Community Services
- Transportation Providers
- Senior Centers
- State County Social Services
- Home Health
- Centers for Independent Living

DHS Shared Client Database and Resource LINK Service Provider Database

Referral

Service Providers

Care/Service Options:

- Transportation
- Home Delivered Meals
- In-Home Assistance
- Home Health
- Vision /Hearing Assist
- Personal Care
- Mental Health Services
- Other…

Outcomes of Dementia Care Services Program (provided by the UND Center for Rural Health - independent evaluator)

Outcomes of the Dementia Care Services Program

Contacts with Caregivers	*N = 907 Contacts in North Dakota*
Type of Contact	**Care Consultations in Person**
Care Consultations: 360	In Person: 206
Information Helpline: 342	By Phone: 154
Follow-Up Care Consultation: 150	
Follow-Up Information Helpline: 55	
Total Care Consultations: 510	

Caregiver Demographics *N = 471 caregivers in North Dakota*

Age (Avg = 62.54)	**Gender**	**Rurality of Residence**	**Relationship to PWD**
<50 yrs: 45	Female: 362	Isolated Rural: 112	Spouse: 113
50-64 yrs: 70	Male: 104	Small Rural: 28	Wife: 74
65-74 yrs: 39		Large Rural: 84	Family: 239
75-84 yrs: 44		Urban: 233	Child: 182
85+ yrs: 17			Female Child: 146
			Self: 28
			Professional: 69
			Other: 22

Persons with Dementia (PWD) Demographics *N = 320 PWDs in North Dakota*

Age (Avg = 78.45)	**Gender**	**Veteran**	**Living Arrangement**
<50 yrs: 4	Female: 168	Yes: 49	Home Alone: 107
50-64 yrs: 17	Male: 139	No: 254	Home with Spouse: 71
65-74 yrs: 39			Home with Other: 30
75-84 yrs: 105			Assisted Living: 33
85+ yrs: 65			Long Term Care Facility: 40
			Other: 39

Estimated Long-Term Care Costs Avoided

based on 32 caregivers with two or more reports that showed a decrease of either estimated time to placement or estimated liklihood to place in LTC

	Cost Avoided
Median	**$1,664,071**
Low	$1,248,498
High	$3,353,935

Estimated Health Care Costs Avoided

based on comparison of incidence reports of 200 caregivers after 1-3 months to 55 after 4 or more months

Hospital	$31,955	*(three month savings)*
Emergency Room	None	
Ambulance	Urb $1,048; Rur $626	**Total 3 Month Savings**
911 Calls	$213	**$33,842**

alzheimer's association

Minnesota-North Dakota Chapter
4550 W 77th Street, Ste 200
Minneapolis, MN 55435

Eastern North Dakota Office
4357 13th Avenue SW, Ste 203
Fargo, ND 58103
701-277-9757 p
701-277-9785 f

Western North Dakota Office
1110 College Drive, Ste 216
Bismarck, ND 58501
701-258-4933 p
701-258-4914 f

ALZHEIMER'S ASSOCIATION NORTH DAKOTA

Dickinson Staff Office
235 Sims Street, Ste 26B
Dickinson, ND 58601
701-225-7988 p
701-225-9172 f

Jamestown Staff Office
114 1st Ave S. Ste 160
Jamestown, ND 58401
701-952-0800 p
701-322-4939 f

Grand Forks Staff Office
311 S 4th Street, Ste 202
Grand Forks, ND 58201
701-775-8544 p
701-775-8612 f

Minot Staff Office
P.O. Box 2234
Minot, ND 58702
701-837-0062 p
701-837-0811 f

North Dakota Dementia Care Services Program

www.alz.org/mnnd 1.800.272.3900 alzheimer's association

No matter where you are, the Alzheimer's Association is here for you.

We offer trained care consultants in every county across North Dakota.

Care Consultation

Individualized assistance, problem solving and identification of resources are available to individuals with memory loss and care partners through care consultation. Individuals with dementia and their care partners will receive valuable one-on-one assistance that will enable them to better manage care and make more informed decisions regarding services and treatments, including clinical trials. Care consultation can be provided in the location most convenient for the people accessing it.

Education

We offer workshops on disease-related topics, such as understanding memory loss, partnering with your doctor and understanding communication. Classes available for the general public, professional and family care partners, medical professionals and law enforcement.



24/7 Information Helpline

Our 24/7 Information Helpline is available to provide information, support, printed materials and referrals to area resources. This service is available for anyone with Alzheimer's or related disorders and their family and professional care partners. Interpreters are available in more than 60 languages.

MedicAlert® + Alzheimer's Association Safe Return®

We offer a 24-hour nationwide emergency response service for individuals with Alzheimer's or a related dementia who wander or have a medical emergency. We provide 24-hour, nationwide assistance, no matter when or where the person is reported missing.



"Our care consultant helped us understand how the mind of a person with Alzheimer's thinks, what is difficult for them to understand, the impact on the caregiver and what to expect in the future."

Support Groups

We have many affiliated support groups led by trained facilitators for individuals and their care partners affected by Alzheimer's disease and related disorders. These groups provide support, assistance and encouragement to help manage and cope with the disease.

In-Person: These groups provide a way for care partners of people with dementia to interact, learn and gain valuable support from others. There are various locations throughout the state.

Telephone Support Groups: Care partners of people with dementia can call in from any location by telephone. Calls are toll-free and participants may remain anonymous. Pre-registration is required.

The Alzheimer's Association would like to acknowledge AARP for their financial support in producing and distributing this brochure.

ore information about any of these services, please call the Alz r's Association Information Helpline at 1.800.272.3900 or visit v lz.org/mnnd.

Prepared by the North Dakota Legislative Council staff for House Appropriations
March 2, 2011

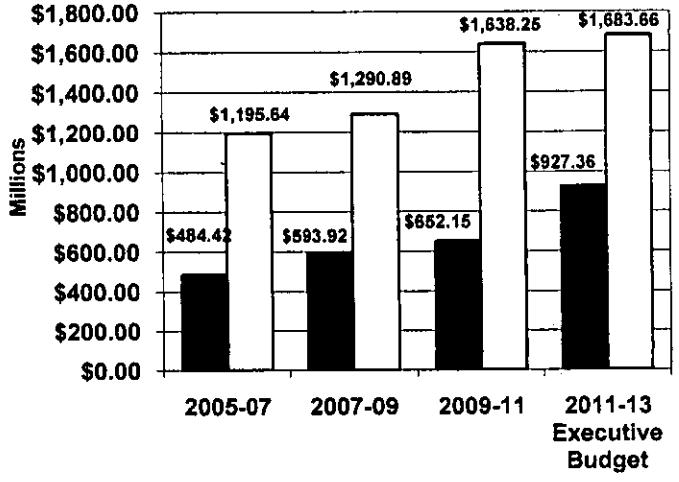
- Attachment TWO
- March 28, 2011

Department 325 - Department of Human Services
Senate Bill No. 2012

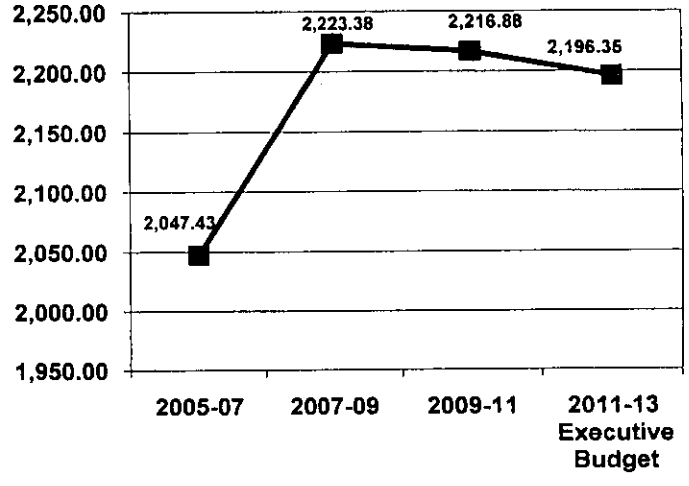
	FTE Positions	General Fund	Other Funds	Total
2011-13 Executive Budget	2,196.35	$927,363,658	$1,683,661,250	$2,611,024,908
2009-11 Legislative Appropriations	2,216.88	652,145,814	1,638,250,137	2,290,395,951[1]
Increase (Decrease)	(20.53)	$275,217,844	$45,411,113	$320,628,957

[1]The 2009-11 appropriation amounts include $2.65 million, $1.5 million of which is from the general fund, for the agency's share of the $16 million funding pool appropriated to the Office of Management and Budget for special market equity adjustments for executive branch employees. The 2009-11 appropriation amounts do not include $31,704,000, of which $2,465,760 is from the general fund, for carryover from the 2007-09 biennium and $11,264,771 of additional special funds authority resulting from Emergency Commission action during the 2009-11 biennium.

Agency Funding



FTE Positions



Ongoing and One-Time General Fund Appropriations

	Ongoing General Fund Appropriation	One-Time General Fund Appropriation	Total General Fund Appropriation
2011-13 Executive Budget	$925,563,658	$1,800,000	$927,363,658
2009-11 Legislative Appropriations	647,849,516	4,296,298	652,145,814
Increase (Decrease)	$277,714,142	($2,496,298)	$275,217,844

First House Action

Attached is a summary of first house changes.

Executive Budget Highlights (With First House Changes in Bold)

	General Fund	Other Funds	Total
Departmentwide			
1. Reflects the additional state matching funds required due to changes in the state's federal medical assistance percentage (FMAP). The FMAP determines the federal and state share of Medicaid, foster care, and other program expenditures. North Dakota's FMAP is decreasing from 60.35 percent in federal fiscal year 2011 to 55.40 percent in federal fiscal year 2012. The department anticipates North Dakota's FMAP to remain at 55.40 percent for federal fiscal year 2013. These changes are also reflected in selected program amounts below.	$104,887,387	($104,904,779)	($17,392)
2. Replaces federal fiscal stimulus funding relating to FMAP and child support enforcement appropriated for the 2009-11 biennium with funding from the general fund and removes other	$69,307,001	($99,095,205)	($29,788,204)

federal fiscal stimulus funding provided in the 2009-11 biennium. These changes are also reflected in selected program amounts below.			
3. Provides a 3 percent per year inflationary increase for human service providers. The 2009 Legislative Assembly approved a 6 percent inflationary increase for the second year of the 2009-11 biennium for rebased services (hospitals, physicians, chiropractors, and ambulances) and dentists and a 6 percent per year inflationary increase for providers of other services.	$25,516,808	$28,757,382	$54,274,190
4. Changes the funding source for medical services and long-term care services from the Bank of North Dakota loan proceeds in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$8,500,000	($8,500,000)	$0
5. Changes the funding source for breast and cervical cancer assistance from the community health trust fund in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$790,015	($790,015)	$0
6. Changes the funding source for nursing facility payments from the health care trust fund in the 2009-11 biennium to the general fund. These changes are also reflected in selected program amounts below.	$4,124,506	($4,124,506)	$0
7. Removes funding from the general fund for medical services and long-term care program expenditures and allows the department to continue general fund appropriations for the 2009-11 biennium and utilize unexpended funds in the 2011-13 biennium. These changes are also reflected in selected program amounts below.	($12,800,000)		($12,800,000)
8. Reduces funding for salaries and wages by $2,935,680 from the general fund in anticipation of savings resulting from employee turnover and position vacancies.	($2,935,680)	$0	($29,35,680)
9. Includes funding for paying accrued annual leave and sick leave of employees anticipated to retire during the 2011-13 biennium.	$186,370	$305,094	$491,464
Management			
1. Adds 4 FTE positions in information technology services as requested by the department in its hold-even budget request	$171,236	$283,803	$455,039
2. Removes federal fiscal stimulus funding provided in the 2009-11 biennium		($307,000)	($307,000)
3. Adjusts funding for program and cost changes (detailed changes not identified)	$3,811,984	$11,591,551	$15,403,535
4. Adds funding for telepharmacy equipment over $5,000		$138,400	$138,400
Program and Policy			
1. Provides $4,990,361, of which $3,025,754 is from the general fund and $1,964,607 is from retained funds, for **Indian county payments**.	$1,066,213	($99)	$1,066,114
2. Reduces funding for temporary assistance for needy families (TANF) costs to $16,739,250, of which $5,531,958 is from the general fund and $5,785,053 is from retained funds. The funding level is anticipated to provide services for an average monthly caseload of 2,253 and to provide an average payment of $309.57 per case.		($7,668,672)	($7,668,672)
3. Provides $20,554,852, of which $252,686 is from the general fund, $6,894,858 is from retained funds, and the remainder from federal funds, for **child care grants**. The change reflects a decrease of $97,511 from the general fund, an increase of $631,497 in retained funds, and a decrease of $2,338,968 in federal funds.	($97,511)	($1,707,471)	($1,804,982)
4. Increases federal funding for supplemental nutrition assistance program (SNAP) or **food stamp** benefits to provide a total of $241,942,496.		$30,506,121	$30,506,121
5. Decreases funding for the low-income home energy assistance program (LIHEAP) to provide a total of $39,436,277.		($13,126,445)	($13,126,445)

6. Provides $632,712,356, of which $200,203,906 is from the general fund, for **medical assistance grants** in the medical services program compared to $491,365,038 provided for the 2009-11 biennium, of which $119,205,576 was from the general fund. Major components of the additional funding are listed below:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$15,043,064	$116,988,725	$132,031,789
Adds additional general fund support as a result of FMAP changes	$35,291,452	($35,291,452)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$21,302,590	($21,302,590)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$3,954,780	$5,360,749	$9,315,529
7. Increases funding for **Healthy Steps** (children's health insurance program) to provide a total of $27,990,521, of which $8,661,586 is from the general fund, to provide health insurance coverage for an average of 4,256 children at a monthly premium of $274.03. The executive budget recommends maintaining eligibility requirements for the program at 160 percent of the federal poverty level based on net income. **The Senate added funding of $1,834,357, of which $567,367 is from the general fund, for increasing the eligibility for Healthy Steps from 160 percent to 175 percent of the federal poverty level. A section was added to the bill to provide for the related statutory change.**	$3,062,787	$3,295,198	$6,357,985
8. Includes $26,307,479, of which $25,152,575 is from the general fund and $1,154,904 is from estate collections, for making Medicare Part D prescription drug **"clawback" payments** to the federal government for the estimated prescription drug costs paid by Medicare for individuals eligible for both Medicare and Medicaid. The amount provided is an increase of $6,891,217 from the 2009-11 biennium appropriation of $19,416,262, of which $18,624,262 was from the general fund.	$6,528,313	$362,904	$6,891,217
9. Provides $459,123,033, of which $196,559,601 is from the general fund, for **nursing facility care** under the long-term care program compared to $425,713,210, of which $132,267,271 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are listed below:			
Changes the funding source from Bank of North Dakota loan proceeds in the 2009-11 biennium to the general fund	$2,692,917	($2,692,917)	$0
Changes the funding source from the health care trust fund in the 2009-11 biennium to the general fund	$4,124,506	($4,124,506)	$0
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$11,920,336	$23,364,899	$35,285,235
Adds general fund support as a result of FMAP changes	$32,078,542	($32,078,542)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$20,409,761	($20,409,761)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers and a portion of a $12.8 million general fund reduction relating to authorizing 2009-11 carryover funding in the 2011-13 biennium	($7,933,732)	$6,058,320	($1,875,412)
10. Provides $25,972,395, of which $14,812,502 is from the general fund, for **basic care services** compared to $18,113,925, of which $8,219,552 was from the general fund, for the 2009-11 biennium. Major components of the additional funding are listed below:			

Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$4,146,608	$2,575,848	$6,722,456
Adds general fund support as a result of FMAP changes	$1,169,030	($1,169,030)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$524,151	($524,151)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$753,161	$382,853	$1,136,014
11. Decreases funding for service payments for elderly and disabled (SPED) and expanded SPED to $14,759,712, of which $14,070,562 is from the general fund, compared to the 2009-11 biennium appropriation of $18,221,905, of which $17,347,138 was from the general fund. Major changes include:			
Reduces funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	($3,890,633)	($215,669)	($4,106,302)
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$614,057	$30,052	$644,109
12. Increases funding for the **home and community based care waiver** to $10,268,386, of which $4,538,744 is from the general fund, compared to the 2009-11 biennium appropriation of $8,707,606, of which $2,831,505 was from the general fund. Major changes include:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$352,436	$757,866	$1,110,302
Adds general fund support as a result of FMAP changes	$690,477	($690,477)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$464,566	($464,566)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$199,760	$250,718	$450,478
13. Decreases funding for **targeted case management** to $1,564,749, of which $690,422 is from the general fund, compared to the 2009-11 biennium appropriation of $1,957,896, of which $641,694 was from the general fund. Major changes include:			
Reduces funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	($152,133)	($309,333)	($461,466)
Adds general fund support as a result of FMAP changes	$74,544	($74,544)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$96,026	($96,026)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$30,291	$38,028	$68,319
14. Increases funding for the **personal care option** to $29,149,905, of which $12,886,305 is from the general fund, compared to the 2009-11 biennium appropriation of $25,044,599, of which $8,214,016 was from the general fund. Major changes include:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$893,104	$1,937,517	$2,830,621
Adds general fund support as a result of FMAP changes	$2,057,413	($2,057,413)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$1,156,599	($1,156,599)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$565,173	$709,512	$1,274,685

15. Provides $396,996,033, of which $174,231,307 is from the general fund, for **developmental disabilities services** under the long-term care program compared to $341,542,546, of which $110,730,341 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$13,015,970	$25,476,514	$38,492,484
Adds general fund support as a result of FMAP changes	$36,993,542	($36,993,542)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$23,091,088	($23,091,088)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$7,475,018	$9,503,377	$16,978,395
The Senate added funding of $11,364,049, of which $5,021,489 is from the general fund, for a supplemental payment to developmental disabilities providers to allow for a 50-cent per hour salary and benefit increase for employees beginning July 1, 2011.			
16. Provides $66,850,710, of which $12,122,010 is from the general fund, for **foster care services** compared to $58,089,459, of which $6,961,934 was from the general fund, provided for the 2009-11 biennium. Major components of the additional funding are:			
Adds funding for cost and caseload/utilization changes, including the cost to continue inflationary increases provided in the 2009-11 biennium	$1,703,728	$4,119,388	$5,823,116
Adds general fund support as a result of FMAP changes	$455,959	($455,959)	$0
Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$1,683,112	($1,683,112)	$0
Executive budget changes, including 3 percent per year inflationary adjustments for human services providers	$1,666,421	$1,271,714	$2,938,135
17. Provides $20,208,724, of which $9,159,965 is from the general fund, for **subsidized adoption** compared to the 2009-11 biennium appropriation of $17,847,086, of which $7,003,216 was from the general fund	$2,156,749	$204,889	$2,361,638
18. Provides funding and 7 FTE positions to perform functions necessary to comply with the provisions of federal health care reform	$225,507	$305,588	$531,095
19. Adds funding for a grant to the Silver Haired Legislative Assembly. **The Senate removed this funding.**	$10,000		$10,000
20. Increases funding for senior service providers to assist with the costs of providing meals to the elderly	$300,000		$300,000
21. Provides one-time federal funding for completion of vocational rehabilitation training and information technology contracts funded with federal fiscal stimulus funds in the 2011-13 biennium		$519,175	$519,715
22. Adds 1 FTE position in medical services as requested by the department in its hold-even budget request	$19,668	$61,236	$80,904
23. Adds 6 FTE positions in mental health and substance abuse as requested by the department in its hold-even budget request	$23,730	$861,666	$885,396
State Hospital			
1. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$337,029	($337,029)	$0
2. Reflects the additional state matching funds required due to changes in the state's FMAP	$97,624	($97,624)	$0
3. Adds 1 FTE pharmacist position	$190,305	$45,105	$235,410

4. Adjusts funding for program, cost, and caseload/utilization changes	$3,341,627	($2,696,650)	$644,977
5. Provides ongoing funding for extraordinary repairs	$733,650		$733,650
6. Provides one-time funding for capital projects. **The Senate increased funding for capital projects by $161,840, from $1,800,000 to $1,961,840.**	$1,800,000		$1,800,000
7. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($246,220)		($246,220)
8. Removes funding provided in the 2009-11 biennium for bond payments (The bonds were paid in full in the 2009-11 biennium.)	($437,729)		($437,729)
9. Removes one-time funding provided in the 2009-11 biennium for extraordinary repairs (The amount shown does not reflect extraordinary repair carryover funding from the 2007-09 biennium.)	($2,731,017)		($2,731,017)
Developmental Center			
1. Deletes 40.53 FTE positions not requested by the department for the Developmental Center	($1,448,609)		($1,448,609)
2. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$2,531,825	($2,531,825)	$0
3. Reflects the additional state matching funds required due to changes in the state's FMAP	$1,899,418	($1,899,418)	$0
4. Adjusts funding for program, cost, and caseload/utilization changes	($1,836,244)	$1,856,344	$20,100
5. Provides ongoing funding for extraordinary repairs	$579,469		$579,469
6. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($75,000)		($75,000)
7. Removes funding provided in the 2009-11 biennium for bond payments (The bonds were paid in full in the 2009-11 biennium.)	($501,657)		($501,657)
8. Removes one-time funding provided in the 2009-11 biennium for extraordinary repairs (The amount shown does not reflect extraordinary repair carryover funding from the 2007-09 biennium.)	($712,675)		($712,675)
Human Service Centers			
1. Adds 1 FTE position at the North Central Human Service Center as requested by the department in its hold-even budget request	$284,474	$148,977	$433,451
2. Removes funding provided in the 2009-11 biennium for equipment over $5,000	($26,966)	($28,534)	($55,500)
3. Replaces federal fiscal stimulus funding relating to FMAP appropriated for the 2009-11 biennium with funding from the general fund	$2,513,432	($2,513,432)	$0
4. Reflects the additional state matching funds required due to changes in the state's FMAP	$1,372,441	($1,372,441)	$0
5. Adjusts funding for program, cost, and caseload/utilization changes	$2,131,783	($1,675,992)	$455,791
6. Provides ongoing funding for extraordinary repairs	$35,671		$35,671
7. Provides funding for equipment over $5,000	$34,372	$4,628	$39,000
8. Provides for inflationary increases of 3 percent for each year of the 2011-13 biennium	$1,093,928	$147,348	$1,241,276
9. Provides funding for contracting for beds in a crisis stabilization unit for the seriously mental ill (North Central Human Service Center)	$1,444,661		$1,444,661
10. Provides funding for increasing psychiatric inpatient hospitalization contract rates at the human service centers	$3,431,017		$3,431,017
11. Provides funding for contracting for chemical dependency residential services (Southeast Human Service Center)	$939,159		$939,159

12. Provides funding for expanding residential adult crisis bed capacity from 10 beds to 14 beds (West Central Human Service Center)	$309,128		$309,128
13. Provides funding for leasing a new office facility for nonvocational rehabilitation operations (Badlands Human Service Center)	$174,110	$16,105	$190,215

Other Sections in Bill

Transfers - Section 3 provides that the Department of Human Services may transfer appropriation authority between line items within each subdivision and between subdivisions for the 2011-13 biennium. The department is to report to the Budget Section after June 30, 2012, on any transfers made in excess of $50,000 and to the Appropriations Committees of the 63rd Legislative Assembly any transfers made.

Medicaid management information system replacement project - Section 4 provides for the continuation of the 2007-09 legislative appropriation for the Medicaid management information system replacement project in the 2011-13 biennium.

Continuation of appropriation authority - Section 5 provides for the continuation of the department's unexpended 2009-11 general fund appropriation authority to the 2011-13 biennium. The continued funding is to be used for medical assistance grants during the 2011-13 biennium. The department estimates $12.8 million of funding from the general fund will be unexpended on June 30, 2011.

Office space lease limitation - Section 6 provides that the department may not expend more than $12.50 per square foot per year for leasing office space in the Prairie Hills Plaza in Bismarck in the 2011-13 biennium.

FTE positions - Section 8 provides legislative intent that the department only fill the 7 new FTE positions relating to implementing federal health care reform after receiving applicable rules from the federal Department of Health and Human Services.

Continuing Appropriations

Child support collection and disbursement - North Dakota Century Code Section 14-09-25 - Allows the department to receive child support payments and provide the funds to the custodial parent or appropriate governmental entity for those custodial parents receiving governmental assistance.

Child support improvement account - Section 50-09-15.1 - Allows the department to receive federal child support incentive funds and spend the funds in accordance with its business plan to improve the child support collection process.

Child support cooperative agreements - Section 50-09-33 - Allows the department to accept federal funds and other income generated by the department under a cooperative agreement with an Indian tribe for child support enforcement services for hiring staff and payment of other expenses as necessary for carrying out the department's duties under the agreement.

Significant Audit Findings

There were no significant audit findings for the department.

Major Related Legislation

House Bill No. 1040 extends the moratorium on the state's licensed basic care bed capacity and the state's nursing facility bed capacity from July 31, 2011, to July 31, 2013.

House Bill No. 1152 appropriates $3,454,061, of which $1,527,802 is from the general fund, for supplemental payments to critical access hospitals.

House Bill No. 1169 increases the allowable annual education expenditures used in nursing home rates.

House Bill No. 1199 provides that the Legislative Management is to contract with a consultant to study guardianship services for vulnerable adults in the state.

House Bill No. 1320 allows a deduction from income claimed for medical assistance eligibility for real estate taxes paid on rental property for individuals screened as requiring nursing home care.

House Bill No. 1325 extends the moratorium on the state's licensed basic care bed capacity and the state's nursing facility bed capacity from July 31, 2011, to July 31, 2013, and creates a 24-month bed layaway program for up to 25 percent of a nursing facility's bed.

House Bill No. 1373 provides a $1 million general fund appropriation to the department for grants to federally designated Head Start programs.

House Bill No. 1395 requires the department to establish a substance abuse services pilot voucher payment program.

Senate Bill No. 2043 provides that the Department of Human Services is to implement a prospective or related payment system rate model for developmental disabilities service providers.

Senate Bill No. 2075 relates to excess assets in pre-need funeral service contracts.

Senate Bill No. 2121 repeals Chapter 6-09.6 relating to the developmentally disabled facility loan program and transfers the remaining loans in the program to the Bank of North Dakota.

Senate Bill No. 2163 appropriates $110,000 from the general fund to the department for traumatic brain injury services.

Senate Bill No. 2192 relates to foster care services.

Senate Bill No. 2242 increases funding in the senior citizen services and programs fund.

Senate Bill No. 2298 relates to the establishment of early childhood services inclusion support services and a grant program for licensed early childhood services providers who care for children with special needs.

ATTACH:1

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Funding Summary

	Executive Budget	Senate Changes	Senate Version
DHS - Management			
Salaries and wages	$16,513,336		$16,513,336
Operating expenses	62,408,138		62,408,138
Capital assets	138,400		138,400
Total all funds	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	0	47,538,412
General fund	$31,521,462	$0	$31,521,462
FTE	116.10	0.00	116.10
DHS - Program/Policy			
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50
DHS - State Hospital			
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51
DHS - Developmental Center			
Developmental Center	$51,809,247		$51,809,247
Total all funds	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	0	31,391,817
General fund	$20,417,430	$0	$20,417,430
FTE	400.76	0.00	400.76
DHS - Northwest HSC			
Northwest Human Service Center	$8,749,068		$8,749,068
Total all funds	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	0	3,790,236
General fund	$4,958,832	$0	$4,958,832
FTE	45.75	0.00	45.75
DHS - North Central HSC			
North Central Human Service Center	$22,433,884		$22,433,884
Total all funds	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	0	9,023,857
General fund	$13,410,027	$0	$13,410,027
FTE	117.78	0.00	117.78
DHS - Lake Region HSC			
Lake Region Human Service Center	$11,418,231		$11,418,231

Total all funds	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	0	4,536,041
General fund	$6,882,190	$0	$6,882,190
FTE	60.00	0.00	60.00
DHS - Northeast HSC			
Northeast Human Service Center	$28,182,609		$28,182,609
Total all funds	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	0	14,972,886
General fund	$13,209,723	$0	$13,209,723
FTE	138.30	0.00	138.30
DHS - Southeast HSC			
Southeast Human Service Center	$38,464,720		$38,464,720
Total all funds	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	0	16,278,987
General fund	$22,185,733	$0	$22,185,733
FTE	182.15	0.00	182.15
DHS - South Central HSC			
South Central Human Service Center	$16,953,699		$16,953,699
Total all funds	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	0	7,610,152
General fund	$9,343,547	$0	$9,343,547
FTE	85.50	0.00	85.50
DHS - West Central HSC			
West Central Human Service Center	$26,740,493		$26,740,493
Total all funds	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	0	12,630,961
General fund	$14,109,532	$0	$14,109,532
FTE	135.30	0.00	135.30
DHS - Badlands HSC			
Badlands Human Service Center	$11,789,654		$11,789,654
Total all funds	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	0	5,260,362
General fund	$6,529,292	$0	$6,529,292
FTE	72.70	0.00	72.70
Bill Total			
Total all funds	$2,611,024,908	$13,350,246	$2,624,375,154
Less estimated income	1,683,661,250	7,609,550	1,691,270,800
General fund	$927,363,658	$5,740,696	$933,104,354
FTE	2196.35	0.00	2196.35

Senate Bill No. 2012 - DHS - Management - Senate Action

Other changes affecting Management programs or multiple programs of the department:

A section of legislative intent is added regarding office space leases.

Senate Bill No. 2012 - DHS - Program/Policy - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
Salaries and wages	$50,346,211		$50,346,211
Operating expenses	90,850,363		90,850,363
Grants	487,016,037	(10,000)	487,006,037
Grants - Medical assistance	1,613,737,618	13,198,406	1,626,936,024
Total all funds	$2,241,950,229	$13,188,406	$2,255,138,635
Less estimated income	1,510,481,136	7,609,550	1,518,090,686
General fund	$731,469,093	$5,578,856	$737,047,949
FTE	374.50	0.00	374.50

[1]

PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	374.50	$731,469,093	$1,510,481,136	$2,241,950,229
Program and Policy - Senate changes:				
Economic Assistance Policy Program				
No changes		$0	$0	$0
Child Support Program				
No changes		0	0	0
Medical Services Program				
Add funding relating to increase in eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		567,367	1,266,990	1,834,357
Long-Term Care Program				
Add funding for a supplemental payment to developmental disabilities providers to allow for a 50-cent salary and benefit increase for employees beginning July 1, 2011		5,021,489	6,342,560	11,364,049
Aging Services Program				
Remove funding added in the executive budget for a grant to the Silver Haired Legislative Assembly		(10,000)	0	(10,000)
Children and Family Services Program				
No changes		0	0	0
Mental Health and Substance Abuse Program				
No changes		0	0	0
Developmental Disabilities Council				
No changes		0	0	0
Developmental Disabilities Division				
No changes		0	0	0
Vocational Rehabilitation				

No changes		0	0	0
Total Senate changes - Program and Policy	0.00	$5,578,856	$7,609,550	$13,188,406
Senate version - Program and policy subdivision	374.50	$737,047,949	$1,518,090,686	$2,255,138,635

Other changes affecting Program and Policy programs:

Adds a section of legislative intent that the 7 new FTE positions included in the executive budget relating to health care reform may not be filled by the department until the department receives applicable rules relating to federal health care reform implementation.

Senate Bill No. 2012 - DHS - State Hospital - Senate Action

	Executive Budget	Senate Changes[1]	Senate Version
State Hospital	$73,473,200	$161,840	$73,635,040
Total all funds	$73,473,200	$161,840	$73,635,040
Less estimated income	20,146,403	0	20,146,403
General fund	$53,326,797	$161,840	$53,488,637
FTE	467.51	0.00	467.51

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Executive budget recommendation	467.51	$53,326,797	$20,146,403	$73,473,200
State Hospital - Senate changes:				
Add funding for extraordinary repairs to provide a total of $1,961,840 from the general fund		$161,840	$0	$161,840
Total Senate changes - State Hospital	0.00	$161,840	$0	$161,840
Senate version - State Hospital	467.51	$53,488,637	$20,146,403	$73,635,040

Senate Bill No. 2012 - DHS - Developmental Center - Senate Action

The Senate did not change the executive recommendation for the Developmental Center.

Senate Bill No. 2012 - DHS - Human Service Centers - Senate Action

The Senate did not change the executive recommendation for the human service centers.

- Attachment ONE
- March 28, 2011
- Rep. Wieland
- SB 2012

~~2. Each county shall reimburse the department of human services the amount required to be appropriated under subsection 3 of section 50-03-08.~~

SECTION 6. REPEAL. Section 50-09-21.1 of the North Dakota Century Code is repealed.

SECTION 7. STUDY - ADMINISTRATION AND FUNDING OF STATE AND COUNTY SOCIAL SERVICES PROGRAMS. During the 2011-12 interim, the department of human services shall study and develop a plan for restructuring the administration and funding of all state and county social services programs. The plan must provide for the unification of all state and county social services programs into state administered and funded social services programs. Before June 1, 2012, the department shall present its findings, the proposed plan, and any legislative changes necessary to implement that plan to the legislative management.

SECTION 8. EXPIRATION DATE. Section 1 of this Act is effective through December 31, 2011, and after that date is ineffective.

- Attachment THREE

11.8152.02009
Title.
Fiscal No. 3

Prepared by the Legislative Council staff for
Representative Kreidt
March 25, 2011 - March 28, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace lines 7 through 9 with:

"Grants - Medical assistance	1,300,642,323	326,493,701	1,627,136,024
Total all funds	$1,870,492,778	$384,845,857	$2,255,338,635
Less estimated income	1,381,801,240	136,489,446	1,518,290,686"

Page 3, replace lines 4 and 5 with:

"Grand total special funds	1,549,066,932	142,403,868	1,691,470,800
Grand total all funds	$2,195,416,448	$429,158,706	$2,624,575,154"

Page 3, after line 15, insert:

"Government nursing facility payment	0	200,000"

Page 3, replace lines 18 and 19 with:

"Total all funds	$92,329,503	$2,681,015
Less estimated income	88,033,205	719,175"

Page 4, after line 28, insert:

"SECTION 9. GOVERNMENT NURSING FACILITY PAYMENT - HEALTH CARE TRUST FUND. The grants - medical assistance line item in subdivision 2 of section 1 of this Act includes $200,000 from the health care trust fund which the department shall provide as a one-time grant to a government nursing facility that participated in the intergovernmental transfer payment program and is located in a city with a population of less than five hundred according to the 2000 census."

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	47,538,412	0	47,538,412
General fund	$31,521,462	$31,521,462	$0	$31,521,462
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	$200,000	$2,255,338,635
Less estimated income	1,510,481,136	1,518,090,686	200,000	1,518,290,686
General fund	$731,469,093	$737,047,949	$0	$737,047,949
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	$0	$53,488,637

DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	$0	$4,958,832
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC				
Total all funds	$11,418,231	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	4,536,041	0	4,536,041
General fund	$6,882,190	$6,882,190	$0	$6,882,190
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	$0	$13,209,723
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	$0	$22,185,733
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	$0	$9,343,547
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	$0	$14,109,532
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	$0	$6,529,292
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	$200,000	$2,624,575,154
Less estimated income	1,683,661,250	1,691,270,800	200,000	1,691,470,800
General fund	$927,363,658	$933,104,354	$0	$933,104,354

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes	House Version
Salaries and wages	$50,346,211	$50,346,211		$50,346,211
Operating expenses	90,850,363	90,850,363		90,850,363
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024	200,000	1,627,136,024
Total all funds	$2,241,950,229	$2,255,138,635	$200,000	$2,255,338,635
Less estimated income	1,510,481,136	1,518,090,686	200,000	1,518,290,686
General fund	$731,469,093	$737,047,949	$0	$737,047,949
FTE	374.50	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of House Changes

	Adds Funding for a One-Time Grant[1]	Total House Changes
Salaries and wages		
Operating expenses		
Grants		
Grants - Medical assistance	200,000	200,000
Total all funds	$200,000	$200,000
Less estimated income	200,000	200,000
General fund	$0	$0
FTE	0.00	0.00

[1] This amendment adds $200,000 from the health care trust fund for a one-time grant to a government nursing facility which participated in the intergovernmental transfer payment program and is located in a city with a population of less than 500 in the 2000 census.

- March 28, 2011
- SB 2012

- Attachment Four
- Chairman Pellett (Rep.)

DHS can qualify for 90/10 funding from CMS to conduct an initial analysis of how Medicaid and CHIP will interact with the Health Benefit Exchange.

We are proposing that approximately $250,000 ($25,000 General Fund) be considered for these activities that would take place between the end of legislative session and the special session in November 2011.

This would allow us to make progress during this timeframe in order to provide increased coordination with the Insurance Commissioner and the Information Technology Department (ITD) regarding the base architecture of the exchange.

The funding would support staff from ITD in the areas of business analysis and systems architecture as well as allow DHS staff to explore (along with the Insurance Commissioner) successful models in other states. If funding is made available for this purpose, DHS would also contract with a Subject Matter Expert (Don Mueller) to assist us in this analysis of successful models. Don is from North Dakota, has worked for both ITD and DHS is the past on our current eligibility systems. Since he left DHS in the mid-1990's he has been working with Utah's Department of Human Services as a consultant.

Amendment for County Eligibility Computer System

#28 Amendment

ITD Recommendation
Allocation of Eligibility System and Staff

	OAR Total	42,617,925			
		Allocation	General	Federal/Other	Total
Medicaid 90-10	60.00%	25,570,754	2,557,075	23,013,679	25,570,754
TANF	20.00%	8,523,585	8,523,585		8,523,585
SNAP	15.00%	6,392,689	3,196,345	3,196,344	6,392,689
Child Care	3.00%	1,278,538	1,278,538		1,278,538
LIHEAP	2.00%	852,359		852,359	852,359
	100.00%	42,617,925	15,555,543	27,062,382	42,617,925

Current OAR as Submitted	18,370,221	24,247,704	42,617,925
Difference	**(2,814,678)**	**2,814,678**	-

Health Reform in 2014. The computer system is suppose to be ready.. Eligibility has to be ready.
Really?

- Attachment FIVE
- Rep. Bellew
- March 28, 2011
- SB 2012

	Total	General	Federal
Hospital Rebasing **	20,189,649	8,921,806	11,267,843
Physician Rebasing **	36,456,076	16,109,940	20,346,136
Dental Rebasing **	2,245,329	992,211	1,253,118
Ambulance Rebasing **	1,842,634	814,260	1,028,374
Chiropractor Rebasing **	286,768	126,723	160,045
	61,020,456	26,964,940	34,055,516

Physicians:	annual	biennial
Reduction - Physician to **100%** of Medicare (currently at 142% of medicare)	19,743,069	39,486,139

Each 1% reduction is equal to: 940,146

Reduction proposed 36,456,076

Percentage of the reduction 39

Physicians would be at approximately **103%** of the Medicare (42% - 39%)

-Attachment 5/X
-Rep. Kaldor
-SB 2012
-March 28, 2011

ND RHC MEDICAID PAYMENT RATES

SUMMARY FOR LEGISLATIVE CONTACT

As the North Dakota Medical Services Department did not include the rebasing of the RHC Medicaid payment rates in their 2011 – 2013 budget, the industry will have to take action and contact local representatives to encourage them to consider this in the Medical Services appropriations. Tim Blasl, Vice President of the North Dakota Hospital Association has indicated this is an item on their platter as well and they are trying to get funding for the rebasing. Additional personal contacts or a few letters from local clinic administrators may also be helpful. There is no bill to reference but Tim felt a letter to the Senate Appropriations Committee would be our next best option along with direct contacts to local representatives.

It was suggested that the letters be personal and not a blanket form letter. Also, personal contact with the local representatives is recommended and possibly selected members of the Senate Appropriations Committee that you may know. The following are some key points to include in your letter or use as you visit with your representatives.

- The state adopted a prospective payment reimbursement system for the ND Rural Health Clinics effective July 1, 2001. The rates established at that time were to be based on the actual costs of services in 1999 and 2000 and then inflated for each year going forward. The rates established at that time were not reflective of the true costs. In fact for many clinics the rate established was an "alternate payment amount" and this default rate was the Medicare payment limit as of July 1, 2001 which did not consider the true costs of services. Therefore, the beginning rates were significantly understated and do not reimburse the clinics for the cost of service as was intended by the conversion to the fully inclusive prospective rate.

- In 2010, the North Dakota Medical Services Department contracted with Myers & Stauffer, CPA's to conduct an analysis, calculation and report outlining the estimated cost of rebasing current payment rates for the Rural Health Clinics to rates utilizing the actual cost of providing these services. The result of the analysis was provided to the clinics via a telephone conference call on October 20, 2010.

- The overall impact for the entire state for the biennium was estimated to be approximately $1,688,000 and the state's share of about $722,000. This truly indicates that the clinics have been significantly under reimbursed over the past ten years. For our local clinic or clinics, this comes to about $xxxxxx for the two years which is substantial and would assist our operating margin for upgrading services and facilities (optional sentence).

- The Medical Services staff indicated this would be included in their budget for the 2011-2013 biennium, however, this was not included in the Medical Services Department budget. I'm

disappointed that the Medical Services Department led us to believe this would be included and then at the last minute decided to not include it.

- As rural health clinic administrators, we believe the rebasing is necessary to bring the Medicaid payment rates in line with the cost of services. We feel we provide necessary services to the patients in our communities and surrounding areas but we cannot continue to be reimbursed less than cost and provide the quality of services we are so proud of in our communities. The increased Medicaid reimbursement is necessary to continue our mission.

- We are asking your support in providing funding for this very important rebasing of the Rural Health Clinic Medicaid payment rates as identified in the Medical Services report from Myers Stauffer. Thank you for your consideration and please feel free to contact me if you have any questions regarding this important topic.

MANAGEMENT SUBDIVISION	FTE	General Fund	Estimated Income	Total
Senate version	116.10	$31,521,462	$47,538,412	$79,059,874
Management - House changes:				
Departmentwide				
1) Reduce funding for salaries and wages for anticipated savings from vacant positions and employee turnover		($750,000)	$0	($750,000)
2) Reduce funding for operating expenses by $100,000 from the general fund for the human service centers and $375,000 from the general fund for all other divisions		(475,000)	0	(475,000)
Administration - Support				
3) Remove attorney position and related funding included in the department's base budget	(1.00)	(102,300)	(82,157)	(184,457)
Information Technology Services				
4) Remove provider outreach and information system training position and relating funding included in the department's base budget	(1.00)	(120,473)	(64,586)	(185,059)
5) Add funding for activities relating to the eligibility system replacement project		25,000	225,000	250,000
Total House changes - Management	(2.00)	($1,447,773)	($146,743)	($1,594,516)
House version - Management Subdivision	114.10	$30,073,689	$47,391,669	$77,465,358

Other changes affecting Management programs or multiple programs of the department:

6) Remove Section 6 of the engrossed bill relating to office space lease limitation. This section was added by the Senate.

7) Add a section relating to a study of the human services delivery system or a study of administration and funding of state and county social services programs.

8) Add a section relating to a Legislative Management study of patient-centered medical homes.

9) Add a section providing for a report to Legislative Management on the dementia care services program.

	PROGRAM AND POLICY SUBDIVISION	FTE	General Fund	Estimated Income	Total
	Senate version	374.50	$737,047,949	$1,518,090,686	$2,255,138,635
	Program and Policy - House changes:				
	Economic Assistance Policy Program				
1)	Remove position and funding added in the executive budget relating to health care reform	(1.00)	($17,805)	$0	($17,805)
	Child Support Program				
2)	Remove position and funding added in the executive budget relating to health care reform	(1.00)	(62,714)	(121,742)	(184,456)
	Medical Services Program				
3)	Option A - Remove funding added by the Senate to increase eligibility for the state children's health insurance program from 160 percent of the federal poverty level to 175 percent of the federal poverty level		(5,021,489)	(6,342,560)	(11,364,049)
4)	Option B - Provide funding to increase eligibility for the state children's health insurance program from 175 percent of the federal poverty level as provided for by the Senate to 200 percent of the federal poverty level	1.00	4,832,046	15,648,196	20,480,242
5)	Reduce funding for the state children's health insurance program to reflect a revised premium amount		(42,989)	(95,928)	(138,917)
6)	Remove positions and funding added in the executive budget relating to health care reform	(5.00)	(144,988)	(183,846)	(328,834)
	Decrease funding for medical services to reduce projected caseload/utilization rates		(2,739,780)	(3,460,220)	(6,200,000)
8)	Option A - Reduce funding for Medicaid payments to physicians to 100 percent of the Medicare rate		(22,037,214)	(17,448,925)	(39,486,139)
9)	Option B - Remove funding included in the executive budget for 3 percent per year inflationary adjustments for physicians		(2,065,704)	(2,634,500)	(4,700,204)
10)	Provide funding for rebasing rural health clinics to cost		722,000	966,000	1,688,000
	Long Term Care Program				
11)	Remove funding added by the Senate to provide for a supplemental payment to allow for a 50-cent salary and benefit increase for developmental disabilities providers employees beginning July 1, 2011		(5,021,489)	(6,342,560)	(11,364,049)
12)	Add funding for long-term care program expenditures. The executive budget allowed the department to continue unspent general fund appropriations for the 2009-11 biennium and utilize unexpended funding in the 2011-13 biennium. This amendment removes Section 5 of the engrossed bill relating to the carryover of general fund authority; requires the department to turnback any unexpended general fund authority from the 2009-11 biennium; and appropriates funds from the general fund for the 2011-13 biennium.		12,800,000	0	12,800,000
13)	Add funding for House Bill No. 1169 which relates to allowable education expenditures in nursing facility rates		56,423	70,085	126,508
	Add one-time funding from the health care trust fund for a grant to a hospital in a city that has a government nursing facility which participated in the intergovernmental transfer payment program		0	200,000	200,000
15)	Decrease funding for long-term care to reduce projected caseload/utilization rates		(6,716,880)	(8,483,120)	(15,200,000)
16)	Add funding for developmental disabilities grants to transition individuals from the		1,900,000	2,400,000	4,300,000

Development Center to the community

Aging Services Program				
No changes			0	
Children and Family Services Program				
Increase funding for special needs adoption contract services to allow for an increase of two additional staff for the program		314,453	0	314,453
Increase funding to provide a 3 percent per year inflationary adjustment for the special needs adoption contract		73,401	0	73,401
Mental Health and Substance Abuse Program				
No changes			0	
Developmental Disabilities Council				
No changes			0	
Developmental Disabilities Division				
Add funding for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043		887,500	887,500	1,775,000
Increase funding for corporate guardianship services to allow for the increase of one additional staff to lower caseloads		141,814	0	141,814
Increase funding for petitioning costs for indigent people with developmental disabilities		21,970	0	21,970
Increase funding to provide for 15 additional guardianship slots		67,342	0	67,342
Vocational Rehabilitation				
No changes			0	
Total House changes - Program and Policy	(6.00)	($22,054,103)	($24,941,620)	($46,995,723)
House version - Program and policy subdivision	368.50	$714,993,846	$1,493,149,066	$2,208,142,912

Other changes affecting Program and Policy programs:

Add a section to provide that the department utilize $250,000 of federal funds appropriated to the mental health and substance abuse division for grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts.

Add a section to provide legislative intent regarding developmental disabilities grants.

Add a section to provide for a Legislative Management study of the state's qualified service provider system or a section to provide that the department is to report to the Legislative Management and the 2013 Legislative Assembly on the status of the qualified service provider system

STATE HOSPITAL	FTE	General Fund	Estimated Income	Total
Senate version	467.51	$53,488,637	$20,146,403	$73,635,040
State Hospital - House changes:				
Remove funding added by the Senate for one-time capital projects. The Senate had added $161,840 from the general fund to provide a total of $1,961,840 from the general fund for one-time capital projects.		($161,840)	$0	($161,840)
Decrease funding relating to the reduction of 3 beds in the secured services unit		($519,000)	$0	($519,000)
Total House changes - State Hospital	0.00	($680,840)	$0	($680,840)
House version - State Hospital	467.51	$52,807,797	$20,146,403	$72,954,200

Other changes affecting the State Hospital:

None

DEVELOPMENTAL CENTER	FTE	General Fund	Estimated Income	Total
Senate version	400.76	$20,417,430	$31,391,817	$51,809,247
Developmental Center - House changes:				
No changes			$0	
			0	
			0	
Total House changes - Developmental Center	0.00	$0	$0	$0
House version - Developmental Center	400.76	$20,417,430	$31,391,817	$51,809,247

Other changes affecting the Developmental Center:
None

NORTHWEST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	45.75	$4,958,832	$3,790,236	$8,749,068
Northwest Human Service Center - House changes:				
No changes			$0	
			0	
			0	
Total House changes - Northwest Human Service Center	0.00	$0	$0	$0
House version - Northwest Human Service Center	45.75	$4,958,832	$3,790,236	$8,749,068

NORTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	117.78	$13,410,027	$9,023,857	$22,433,884
North Central Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for beds in a crisis stabilization unit for the seriously mental ill		($1,444,661)	$0	($1,444,661)
			0	
Total House changes - North Central Human Service Center	0.00	($1,444,661)	$0	($1,444,661)
House version - North Central Human Service Center	117.78	$11,965,366	$9,023,857	$20,989,223

LAKE REGION HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	60.00	$6,882,190	$4,536,041	$11,418,231
Lake Region Human Service Center - House changes:				
Reduce funding for temporary salaries		($37,930)	($52,047)	($89,977)
			0	
			0	
Total House changes - Lake Region Human Service Center	0.00	($37,930)	($52,047)	($89,977)
House version - Lake Region Human Service Center	60.00	$6,844,260	$4,483,994	$11,328,254

NORTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	138.30	$13,209,723	$14,972,886	$28,182,609
Northeast Human Service Center - House changes:				
No changes			$0	
			0	
Total House changes - Northeast Human Service Center	0.00	$0	$0	$0
House version - Northeast Human Service Center	138.30	$13,209,723	$14,972,886	$28,182,609

SOUTHEAST HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	182.15	$22,185,733	$16,278,987	$38,464,720
Southeast Human Service Center - House changes:				
Remove funding added in the executive budget for contracting for chemical dependency residential services		($939,159)	$0	($939,159)
Remove funding added in the department's base budget for additional staff at the Cooper House		(350,400)	0	(350,400)
			0	
Total House changes - Southeast Human Service Center	0.00	($1,289,559)	$0	($1,289,559)
House version - Southeast Human Service Center	182.15	$20,896,174	$16,278,987	$37,175,161

SOUTH CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	85.50	$9,343,547	$7,610,152	$16,953,699
South Central Human Service Center - House changes:				
No changes			$0	
			0	
Total House changes - South Central Human Service Center	0.00	$0	$0	$0
House version - South Central Human Service Center	85.50	$9,343,547	$7,610,152	$16,953,699

WEST CENTRAL HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	135.30	$14,109,532	$12,630,961	$26,740,493
West Central Human Service Center - House changes:				
Remove funding added in the executive budget for expanding residential adult crisis bed capacity from 10 beds to 14 beds		($309,128)	$0	($309,128)
			0	
Total House changes - West Central Human Service Center	0.00	($309,128)	$0	($309,128)
House version - West Central Human Service Center	135.30	$13,800,404	$12,630,961	$26,431,365

BADLANDS HUMAN SERVICE CENTER	FTE	General Fund	Estimated Income	Total
Senate version	72.70	$6,529,292	$5,260,362	$11,789,654
Badlands Human Service Center - House changes:				
No changes			$0	
			0	
Total House changes - Badlands Human Service Center	0.00	$0	$0	$0
House version - Badlands Human Service Center	72.70	$6,529,292	$5,260,362	$11,789,654

Other changes affecting the Human Service Centers:
None

Prepared by the North Dakota Legislative Council staff

March 2011

ENGROSSED SENATE BILL NO. 2012 - POTENTIAL LEGISLATIVE STUDY AND LEGISLATIVE INTENT LANGUAGE

GENERAL FUND TRANSFER TO BUDGET STABILIATION FUND

SECTION _. GENERAL FUND TRANSFER TO BUDGET STABILIZATION FUND - EXCEPTION - USE OF GENERAL FUND AMOUNTS. Notwithstanding section 54-27.2-02, the state treasurer and the office of management and budget may not include in the amount used to determine general fund transfers to the budget stabilization fund at the end of the 2009-11 biennium under chapter 54-27.2 any general fund amounts resulting from the increased federal share of medical assistance payments resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and H.R. 1586. The state treasurer and the office of management and budget shall separately account for these amounts resulting from federal medical assistance percentage changes under the federal American Recovery and Reinvestment Act of 2009 and H.R. 1586 and use these amounts to defray the expenses of continuing program costs of the department of human services from the general fund, for the biennium beginning July 1, 2011, and ending June 30, 2013, including $25,516,808 for inflationary increases for human service providers.

DEPARTMENT OF HUMAN SERVICES STUDY

Option A

SECTION _. DEPARTMENT OF HUMAN SERVICES STUDY - HUMAN SERVICES DELIVERY STYSTEM. During the 2011-12 interim, the department of human services shall review, study, and develop various plans for restructuring the human services delivery system in this state. The review and study must consider the requirements imposed on the department of human services by federal agencies under federal law, federal regulations, program state plans, and program waivers for the administration of and receipt of payment under federal programs. One of the plans for restructuring must provide for the creation of administrative units that are authorized to deliver all of the economic assistance and therapeutic social services programs and services that are currently being provided or authorized to be provided by counties and regional human service centers. The administrative units must have a direct relationship with the department of human services in administering federal programs in the state and must be locally administered. Before August 1, 2012, the department shall present its findings and plans to the legislative management.

Option B

SECTION _. STUDY - ADMINISTRATION AND FUNDING OF STATE AND COUNTY SOCIAL SERVICES PROGRAMS. During the 2011-12 interim, the department of human services shall study and develop a plan for restructuring the administration and funding of all state and county social services programs. The plan must provide for the unification of all state and county social services programs into state administered and funded social services programs. Before June 1, 2012, the

department shall present its findings, the proposed plan, and any legislative changes necessary to implement that plan to the legislative management.

PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MANAGEMENT STUDY

SECTION _. PATIENT-CENTERED MEDICAL HOMES - LEGISLATIVE MAANGEMENT STUDY. During the 2011-12 interim, the legislative management shall consider studying and evaluating the positive and negative impacts of implementation of patient-centered medical homes in the state, including consideration of whether implementation would result in North Dakotans experiencing health care savings and improved medical results as well as whether implementation would impact North Dakota's critical access hospitals. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

DEMENTIA CARE SERVICES PROGRAM

SECTION _. - REPORT ON THE DEMENTIA CARE SERVICES PROGRAM. During the 2011-12 interim, the department of human services must periodically report to Legislative Management regarding the status of the dementia care services program. The reports should include information as to budgeted and actual program expenditures, program services, and program outcomes.

RISK BEHAVIOR PREVENTION EFFORTS

SECTION _ - RISK BEHAVIOR PREVENTION GRANTS - MATCHING REQUIREMENT. The department of human services shall use $250,000 of federal funding appropriated in subdivision 2 of Section 1 of this Act for the mental health and substance abuse division for providing grants to support a statewide school and community-based youth network dedicated to implementing risk behavior prevention efforts for the biennium beginning July 1, 2011, and ending June 2013. The department shall require an entity receiving a grant under this section to provide one dollar of matching funds for each dollar of state funds provided.

DEVELOPMENTAL DISABILITIES GRANTS

SECTION _. - LEGISLATIVE INTENT - DEVELOPMENTAL DISABILITIES GRANTS. It is the intent of the legislative assembly that the department of human services use any anticipated unexpended appropriation authority relating to developmental disabilities grants resulting from caseload or cost changes during the 2011-13 biennium for costs associated with transitioning individuals from the developmental center to communities during the 2011-13 biennium.

QUALIFIED SERVICE PROVIDERS

Option A

SECTION _. - LEGISLATIVE MANAGEMENT STUDY - QUALIFIED SERVICE PROVIDER SYSTEM. During the 2011-12 interim, the legislative management shall consider studying and

evaluating the state's qualified service provider system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-third legislative assembly.

Option B

SECTION _. - QUALIFIED SERVICE PROVIDER SYSTEM - REPORTS. The department of human services shall report to the Legislative Management during the 2011-12 interim and to the sixty-third legislative assembly on the status of the qualified service provider system. The report must include information on appropriateness of payments to qualified service providers and the necessity of increasing the payment levels.

- Attachment TWO
- March 30, 2011

11.8152.02010
Title.
Fiscal No. 4

Prepared by the Legislative Council staff for
Representative Wieland
March 25, 2011

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2012

Page 2, replace line 4 with:

"Operating expenses	75,461,417	17,163,946	92,625,363"

Page 2, replace lines 8 through 10 with:

"Total all funds	$1,870,492,778	$386,420,857	$2,256,913,635
Less estimated income	1,381,801,240	137,176,946	1,518,978,186
Total general fund	$488,691,538	$249,243,911	$737,935,449"

Page 3, replace lines 3 through 5 with:

"Grand total general fund	$646,349,516	$287,642,338	$933,991,854
Grand total special funds	1,549,066,932	143,091,368	1,692,158,300
Grand total all funds	$2,195,416,448	$430,733,706	$2,626,150,154"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

Senate Bill No. 2012 - Summary of House Action

	Executive Budget	Senate Version	House Changes	House Version
DHS - Management				
Total all funds	$79,059,874	$79,059,874	$0	$79,059,874
Less estimated income	47,538,412	47,538,412	0	47,538,412
General fund	$31,521,462	$31,521,462	$0	$31,521,462
DHS - Program/Policy				
Total all funds	$2,241,950,229	$2,255,138,635	$1,775,000	$2,256,913,635
Less estimated income	1,510,481,136	1,518,090,686	887,500	1,518,978,186
General fund	$731,469,093	$737,047,949	$887,500	$737,935,449
DHS - State Hospital				
Total all funds	$73,473,200	$73,635,040	$0	$73,635,040
Less estimated income	20,146,403	20,146,403	0	20,146,403
General fund	$53,326,797	$53,488,637	$0	$53,488,637
DHS - Developmental Center				
Total all funds	$51,809,247	$51,809,247	$0	$51,809,247
Less estimated income	31,391,817	31,391,817	0	31,391,817
General fund	$20,417,430	$20,417,430	$0	$20,417,430
DHS - Northwest HSC				
Total all funds	$8,749,068	$8,749,068	$0	$8,749,068
Less estimated income	3,790,236	3,790,236	0	3,790,236
General fund	$4,958,832	$4,958,832	$0	$4,958,832
DHS - North Central HSC				
Total all funds	$22,433,884	$22,433,884	$0	$22,433,884
Less estimated income	9,023,857	9,023,857	0	9,023,857
General fund	$13,410,027	$13,410,027	$0	$13,410,027
DHS - Lake Region HSC				

Total all funds	$11,418,231	$11,418,231	$0	$11,418,231
Less estimated income	4,536,041	4,536,041	0	4,536,041
General fund	$6,882,190	$6,882,190	$0	$6,882,190
DHS - Northeast HSC				
Total all funds	$28,182,609	$28,182,609	$0	$28,182,609
Less estimated income	14,972,886	14,972,886	0	14,972,886
General fund	$13,209,723	$13,209,723	$0	$13,209,723
DHS - Southeast HSC				
Total all funds	$38,464,720	$38,464,720	$0	$38,464,720
Less estimated income	16,278,987	16,278,987	0	16,278,987
General fund	$22,185,733	$22,185,733	$0	$22,185,733
DHS - South Central HSC				
Total all funds	$16,953,699	$16,953,699	$0	$16,953,699
Less estimated income	7,610,152	7,610,152	0	7,610,152
General fund	$9,343,547	$9,343,547	$0	$9,343,547
DHS - West Central HSC				
Total all funds	$26,740,493	$26,740,493	$0	$26,740,493
Less estimated income	12,630,961	12,630,961	0	12,630,961
General fund	$14,109,532	$14,109,532	$0	$14,109,532
DHS - Badlands HSC				
Total all funds	$11,789,654	$11,789,654	$0	$11,789,654
Less estimated income	5,260,362	5,260,362	0	5,260,362
General fund	$6,529,292	$6,529,292	$0	$6,529,292
Bill total				
Total all funds	$2,611,024,908	$2,624,375,154	$1,775,000	$2,626,150,154
Less estimated income	1,683,661,250	1,691,270,800	887,500	1,692,158,300
General fund	$927,363,658	$933,104,354	$887,500	$933,991,854

Senate Bill No. 2012 - DHS - Program/Policy - House Action

	Executive Budget	Senate Version	House Changes	House Version
Salaries and wages	$50,346,211	$50,346,211		$50,346,211
Operating expenses	90,850,363	90,850,363	1,775,000	92,625,363
Grants	487,016,037	487,006,037		487,006,037
Grants - Medical assistance	1,613,737,618	1,626,936,024		1,626,936,024
Total all funds	$2,241,950,229	$2,255,138,635	$1,775,000	$2,256,913,635
Less estimated income	1,510,481,136	1,518,090,686	887,500	1,518,978,186
General fund	$731,469,093	$737,047,949	$887,500	$737,935,449
FTE	374.50	374.50	0.00	374.50

Department No. 328 - DHS - Program/Policy - Detail of House Changes

	Provides Funding for Reimbursement Project[1]	Total House Changes
Salaries and wages		
Operating expenses	1,775,000	1,775,000
Grants		
Grants - Medical assistance		
Total all funds	$1,775,000	$1,775,000
Less estimated income	887,500	887,500
General fund	$887,500	$887,500
FTE	0.00	0.00

[1] This amendment adds funding of $1,775,000, of which $887,500 is from the general fund and $887,500 from federal funds, for expenses associated with implementing the developmental disabilities system reimbursement project provided for in Senate Bill No. 2043.

- March 30, 2011
- Attachment THREE
- Rep. Wieland
- SB 2012

11.0243.03000

Sixty-second
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT with House Amendments
ENGROSSED SENATE BILL NO. 2043

Introduced by

Legislative Management

(Long-Term Care Committee)

A BILL for an Act to provide for a developmental disabilities system reimbursement project; and to provide an appropriation.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. DEVELOPMENTAL DISABILITIES SYSTEM REIMBURSEMENT PROJECT. The department of human services, in conjunction with developmental disabilities service providers, shall develop a prospective or related payment with an independent rate model utilizing the support intensity scale.

1. The department shall establish a steering committee consisting of representatives from all interested providers and department representatives. The steering committee shall guide the development of the new payment system including assisting a consultant to conceptualize, develop, design, implement, and evaluate a new payment system.
2. The department shall contract with a consultant by September 1, 2011, to develop, in collaboration with the steering committee, the payment system and the resource allocation model tying funding to support intensity scale assessed needs of clients.
3. After the prospective or related payment system rates are developed, the new rates must be tested on a sampling of clients and providers, the sample to be determined by the steering committee, allowing sufficient time to capture provider cost, client realized need, and service provision data. The consultant shall provide the appropriate sampling number to sufficiently test the rates, types of services, and needs of clients with the intent to include as many providers as fiscally feasible.
4. The department shall contract with a team of support intensity scale assessors by September 1, 2011. The team shall begin assessing immediately the identified client pilot group identified by the consultant contracted in subsection 2.

5. Once testing is complete, the data must be analyzed by the consultant and the consultant shall make any needed rate adjustments, resource allocation modifications, or process assumptions.
6. Beginning in June 2012, the department and the steering committee shall report development activities and status information to an interim legislative committee.
7. Implementation of any system developed under this Act may not occur before the implementation of the department's new medicaid management information system.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $887,500, or so much of the sum as may be necessary, and from special funds derived from federal funds and other income, the sum of $887,500, to the department of human services for the purpose of the developmental disabilities system reimbursement project, for the biennium beginning July 1, 2011, and ending June 30, 2013.

Comparison of Payment Methodology of Selected Services

Amounts Below are Expressed in Millions

	2009-2011 Appropriation	2011-2013 Executive Budget (includes 3/3)	100% Rebasing Report	75% Rebasing Report	68% Rebasing Report	The Amount Medicare Would Pay
Hospitals - **(PPS only)**	180.6	206.6	22.0	16.5	15.0	Medicaid is prohibited from paying hospitals more than what Medicare would pay for similar services. The Upper Payment Limit remaining for PPS Hospitals for 2010 is $3.4 million. Therefore, Medicaid is paying less than Medicare by $3.4 million.
LTC - Nursing Homes *(Not part of Legislative Rebasing)*	425.7	471.9 *	Based upon NDCC - rates are rebased every year based upon allowable costs and limits are rebased every 4 years. Cost of rebasing the limits for 6 months of CY 2013 is $1.4 million. (includes inflation of 3/3)	Cost of rebasing the limits for 6 months of CY 2013 is $0.7 million	Cost of rebasing the limits for 6 months of CY 2013 is $0.3 million	Medicaid is prohibited from paying nursing homes more than the upper payment limit. ND Medicaid nursing home rates for 2011 are $8.2 million below the upper payment limit; however, there is no available comparison to Medicare.
Physicians	99.6	109.4	53.0	39.8	36.0	Medicare would pay 42% less based upon the July 2010 Medcaid fee schedule.
Chiropractor	0.9	1.3	0.4	0.3	0.3	Medicare would pay 41% less based upon the July 2010 Medcaid fee schedule.
Ambulance **	5.6	5.5	2.3	1.7	1.6	Medicare would pay 0.18% more based upon the July 2010 Medcaid fee schedule.
Dentists ***	17.0	24.0	3.3	2.4	2.2	Medicare does not cover routine dental services

This Section is Not Presented in Millions

	2009-2011 Estimated Cost Per Pregnancy (Based upon February 2011 reimbursement rates)	2011-2013 Estimated Cost Per Pregnancy	100% Rebasing Report	75% Rebasing Report	68% Rebasing Report	The Amount Medicare Would Pay
Uncomplicated Childbirth Prenatal & Delivery	5,286	5,526	N/A	N/A	N/A	Medicare does not pay for prenatal or delivery costs

Notes

* The 2011-2013 Nursing Home amount reflected above includes the $12.8 million general fund turnback.

** Ambulances were not rebased as a percentage of the report, but insead were rebased to the Medicare fee schedule.

*** The Dentists were rebased at 75% of billed charges due to their limited participation in the cost survey and thus no cost rebasing report was able to be presented. Therefore the rebasing amounts reflected above are calculated based upon billed charges.

Senate Warner

NDLTCA data from page 5, Nursing Facilities Nursing Salaries – CNA
NDACP data from 10-10 Wage Survey

	DD	LTC
Entry	$10.97	$11.22
Average	$12.41	$12.79

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