

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HUMAN SERVICES COMMITTEE

Wednesday, August 19, 2015
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative Kathy Hogan, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives Kathy Hogan, Bert Anderson, Gail Mooney, Naomi Muscha, Kylie Oversen, Jay Seibel, Peter F. Silbernagel; Senators Tyler Axness, Dick Dever, Oley Larsen, Judy Lee, Tim Mathern

Members absent: Representatives Dick Anderson, Chuck Damschen, Alan Fehr, Curt Hofstad, Dwight Kiefert

Others present: See [Appendix A](#)

The Legislative Council staff reviewed the [Supplementary Rules of Operation and Procedure of the North Dakota Legislative Management](#).

STUDY OF BEHAVIORAL HEALTH NEEDS

At the request of Chairman Hogan, the Legislative Council staff presented a memorandum entitled [Study of Behavioral Health Needs - Background Memorandum](#). The Legislative Council staff said the Human Services Committee has been assigned the responsibility of studying behavioral health needs. The study must include:

- Consideration of behavioral health needs of youth and adults and access, availability, and delivery of services.
- A review of services related to autism spectrum disorder.
- Input from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions.
- Monitoring and reviewing of strategies to improve behavioral health services implemented pursuant to legislation enacted by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.

The Legislative Council staff said, during the 2013-14 interim, the Human Services Committee contracted with Ms. Renee Schulte, Schulte Consulting, LLC, for a study of behavioral health needs of youth and adults. The final report identified six primary opportunities to better address behavioral health needs of youth and adults in North Dakota, which include service shortages, expand workforce, change insurance coverage, change the structure and responsibilities of the Department of Human Services (DHS), improve communication, and expand data collection and research. In addition, the report recommended North Dakota further investigate and review transportation, judicial matters, definitions of services, tribal partnerships, and advocate training.

The Legislative Council staff said, during the 2013-14 interim, the Behavioral Health Stakeholders Group also presented a report to the Human Services Committee that identify recommendations to improve behavioral health services in the state.

The Legislative Council staff said the 64th Legislative Assembly approved the following bills related to behavioral health services:

- House Bill No. 1048, which requires behavioral health licensure boards to develop a plan, in collaboration with the other boards, for the administration and implementation of licensing and reciprocity standards for licensees.
- House Bill No. 1049, which adds a new section to North Dakota Century Code Chapter 43-45 relating to loans for certain behavioral health professions, amends Section 43-45-04 relating to duties of the Board of Addiction Counseling Examiners, provides legislative intent relating to internship sites for addiction counselors, and provides an appropriation of \$200,000 from the student loan trust fund to the Bank of North Dakota for the addiction counselor internship loan program revolving fund.

- Senate Bill No. 2012:
 - Adds \$388,492 from the general fund for extended services for individuals with serious mental illness to add 35 additional slots.
 - Increases funding of \$302,109 from the general fund for traumatic brain injury prevocational skills training to increase from two to four hours the amount of time allocated each month for each of the 50 slots.
 - Increases funding of \$180,783 from the general fund for extended services for individuals with traumatic brain injury to add 35 additional slots.
 - Increases funding by \$237,500 from the general fund to provide total funding of \$2,303,920 for controlled substance treatment services.
 - Adds \$146,459 from the general fund to provide a statewide telemedicine residency program.
 - Adds \$130,000 from the general fund for the ND Cares Task Force which provides support for service members, veterans, families, and survivors.
 - Adds \$903,983 of which \$685,895 is from the general fund for a 10-bed crisis residential and transitional living unit in the north central region.
 - Adds \$283,500 from the general fund for a four-bed unit alternative care services for the west central region.
 - Adds \$250,000 from the general fund to provide Mobile-on-Call crisis services in the west central region.
 - Adds 11 full-time equivalent (FTE) positions and funding of \$1,520,369 from other funds to increase the Tompkins program from a 90- to a 105-bed unit.
- Senate Bill No. 2046, which adds a new section to Chapter 50-24.1 to require DHS to allow marriage and family therapists to enroll and be eligible for payment for behavioral health services provided to recipients of medical assistance.
- Senate Bill No. 2048, which adds a new section to Chapter 15.1-13 relating to teacher licensure requirements and a new section to Chapter 15.1-07 relating to mental health training provided by school districts. This bill also provides an appropriation of \$150,000 from the general fund to DHS to facilitate behavioral health services authorized by the Legislative Assembly, and \$750,000 from the general fund to DHS to establish and administer a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs.

The Legislative Council proposed the following study plan:

1. Receive information from DHS regarding a behavioral health system of care, including consideration of behavioral health needs of youth and adults and access, availability, and delivery of services, in addition, receive information on public involvement with mental health and substance abuse treatment, and mental health and substance abuse services for children and adults.
2. Receive information from the Department of Corrections and Rehabilitation regarding a behavioral health system of care, including consideration of behavioral health needs of youth and adults and access, availability, and delivery of services, in addition, receive information on public involvement with mental health and substance abuse treatment, and mental health and substance abuse services for children and adults.
3. Receive testimony from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions.
4. Receive information from a national expert regarding a review of the state's legal obligations as they relate to behavioral health-related services provided by the state.
5. Receive information from DHS regarding the review of strategies to improve behavioral health services implemented pursuant to legislation enacted by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.
6. Receive information from the Department of Corrections and Rehabilitation regarding the review of strategies to improve behavioral health services implemented pursuant to legislation enacted by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.

7. Receive comments by interested persons regarding the study of behavioral health needs.
8. Develop recommendations and any bill drafts necessary to implement the recommendations.
9. Prepare a final report for submission to the Legislative Management.

In addition to the behavioral health needs study responsibilities assigned to the Human Services Committee for the 2015-16 interim, the Legislative Council staff said the committee has also been assigned to:

- Receive a report from the Board of Addiction Counseling Examiners, Board of Counselor Examiners, North Dakota Board of Social Work Examiners, State Board of Psychologist Examiners, North Dakota Board of Medicine, and Marriage and Family Therapy Licensure Board regarding plans and any legislative changes necessary to implement those plans for administration and implementation of licensing and reciprocity standards for licensees (Section 1 of 2015 House Bill No. 1048).
- Receive a report from the Board of Addiction Counseling Examiners regarding the status of the periodic evaluation of the initial licensure coursework requirements and clinical training requirements (Section 4 of 2015 House Bill No. 1049).
- Receive a report from DHS regarding its quarterly behavioral health services reports (Section 26 of 2015 Senate Bill No. 2012).
- Receive a report from DHS regarding the rules adopted to establish and administer the voucher system to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs (Section 4 of 2015 Senate Bill No. 2048).
- Receive a report from the Department of Public Instruction regarding mental health training provided by school districts (Section 5 of 2015 Senate Bill No. 2048).
- Receive a report from DHS regarding the outcomes of the study of statutory references to mental health professionals to determine whether changes in the law may help to more fully utilize these professionals within their scope of practice, as it relates to the responsibilities of DHS to provide services or license facilities together with any recommendations (Section 1 of 2015 Senate Bill No. 2049).

Autism Spectrum Disorder Services - Background Memorandum

The Legislative Council staff said the behavioral health services study is to include a review of autism spectrum disorder services. The Legislative Council staff presented a memorandum entitled [Autism Spectrum Disorder Services - Background Memorandum](#).

Autism Spectrum Disorder Task Force

The Legislative Council staff said 2009 Senate Bill No. 2174, codified as Section 50-06-32, established an Autism Spectrum Disorder Task Force. The task force examines early intervention services, family support services that would enable an individual with autism spectrum disorder to remain in the least restrictive home-based or community setting, programs transitioning an individual with autism spectrum disorder from a school-based setting to adult day programs and workforce development programs, the cost of providing services, and the nature and extent of federal resources that can be directed to the provision of services for individuals with autism spectrum disorder.

Autism Spectrum Disorder Program Pilot Project

The Legislative Council staff said 2013 House Bill No. 1038, codified as Section 50-06-32.1, requires DHS to establish a voucher program pilot project beginning July 1, 2014, to assist in funding equipment and general educational needs related to autism spectrum disorder for individuals below 200 percent of the federal poverty level from age 3 to under age 18 who have been diagnosed with autism spectrum disorder. In addition, DHS is required to adopt rules addressing management of the voucher program pilot project and to establish eligibility requirements and exclusions for the voucher program pilot project. The department is required to provide a report to the Legislative Management regarding the autism spectrum disorder program pilot project.

The Legislative Council staff said Section 13 of 2015 Senate Bill No. 2012 provides for the continuation of Section 50-06-32.1, to require DHS to continue the autism spectrum disorder voucher program pilot project and to report to the Legislative Management regarding the autism spectrum disorder program pilot project.

Other Autism Spectrum Disorder Reports

The Legislative Council staff said the Human Services Committee has also been assigned to:

- Receive annual reports from the Autism Spectrum Disorder Task Force (Section 50-06-32).

- Receive a report from DHS regarding the autism spectrum disorder program pilot project (Section 50-06-32.1).

Definition of Behavioral Health

Chairman Hogan called on Dr. Elizabeth Faust, Senior Director for Behavioral Health, Health Network Innovation, Blue Cross Blue Shield of North Dakota, to present information ([Appendix B](#)) regarding the definition of "behavioral health." Dr. Faust said mental illness and substance abuse disorders are considered interrelated brain-based diseases that are included under the same umbrella of behavioral health conditions.

Dr. Faust said mental health and substance abuse disorders are diseases that affect 20 percent of Americans. She said mental health and substance abuse disorders often occur together and increase morbidity and mortality. She said there is no standard system currently in place to ensure people with mental health and substance abuse disorders receive effective medical and psychosocial interventions. She said substance abuse disorder treatment systems and mental health treatment systems were originally organized and funded separately at the federal, state, and local levels.

Substance Abuse Disorder Treatment

Dr. Faust said Alcoholics Anonymous began in 1935 and defined alcoholism as a disease. She said, at that time, addiction was not considered a disease by the medical community and hospitalization was not available for alcohol-related withdrawals or complications. She said the American Medical Association officially recognized alcoholism as a disease in 1956. She said hospitals and treatment programs began to develop specific techniques for addictions. She said the techniques have eventually evolved into the treatment programs and services currently being provided.

Mental Health Treatment

Dr. Faust said in the 1930s, mentally ill patients were being cared for in state hospitals under the control of psychiatrists. She said, during this time, no psychiatric medications were available. She said during the 1940s and 1950s, the dominant theoretical model was psychoanalysis. In addition, she said only environmental and developmental factors were considered to cause mental illness. During the 1960s, she said, psychiatry was beginning to expand its scope to include both social and biological mental illness treatments. She said the scope was beginning to expand beyond just containment of mentally ill individuals. Development of antidepressants and lithium began during this time period. In the 1970s, she said, advancement in brain research and increased use of effective medications for mental illness began. During this time, thousands of patients were being deinstitutionalized, but with minimal community supports. In addition, she said there were funding reductions for mental health services. She said a rise in homelessness began because many patients did not have community survival skills. During the 1980s, community health centers began receiving deinstitutionalized patients and young chronically-ill adults. She said use of both alcohol and drugs began to increase which increased "dual diagnosis" treatments. She said individuals genetically susceptible to mental illness are at high risk of being susceptible to substance abuse disorders; and individuals genetically susceptible to substance abuse disorders are at higher risk of being susceptible to mental illness.

Origination of Behavioral Health

Dr. Faust said deinstitutionalization, availability of drugs and alcohol, and the lessening of traditional family, community, and social supports have increased behavioral health issues. In addition, she said mental health and substance abuse treatment systems may have competing philosophies relating to the use of medicines, role of self-help supports, and role of various health professionals. She said each system identifies the disease it treats as primary and any symptoms from the other disease as secondary. She said, as a result, each system focuses only on one disease. She said dually diagnosed patients respond poorly to treatments because conditions from the other system may not be recognized or managed appropriately.

The 21st Century

Dr. Faust said the federal Mental Health Parity and Addiction Equity Act of 2008 and the federal Patient Protection and Affordable Care Act of 2010 anticipate improving delivery and access to treatments for mental health and substance abuse disorders. She said federal, state, and local systems are changing treatment of behavioral health conditions from integrated funding streams, research, and administration of treatment into blended systems which consider relationships and overlap between conditions and its impact on other medical conditions. She said evidence-based medication treatment and psychosocial interventions exist but are not available for routine clinical care of mental health and substance abuse disorders. She said gaps between what is known and what is commonly practiced includes access, training, insurance coverage, quality measurement, and fragmentation of care.

Dr. Faust said only 30 to 55 percent of patients with multiple physical and mental disorders receive recommended care. She said the use of medications, psychosocial interventions including therapy and community supports, the level and duration of services, and the setting of service delivery needs should be specific for each individual's needs.

Behavioral Health Recommendations Provided in Schulte Consulting, LLC Report and Behavioral Stakeholders Group

Chairman Hogan called on Ms. Nancy McKenzie, representative of the Behavioral Health Stakeholders Group, who presented information ([Appendix C](#)) regarding the study report prepared by Schulte Consulting, LLC for the Legislative Management's 2013-14 Human Services Committee and the recommendations of the Behavioral Health Stakeholders Group. She said the Legislative Management contracted with Schulte Consulting, LLC to study the behavioral health delivery system in North Dakota. She said, because of the limited funds available and the short amount of time to complete the study, a group of concerned individuals formed the Behavioral Health Steering Committee to supplement the work of the consultant.

Ms. McKenzie said the report prepared by Schulte Consulting, LLC provides a broad overview of the current behavioral health and substance abuse delivery system in North Dakota. She said the report prepared by the Behavioral Health Stakeholders Group provides more detail relating to the behavioral health and substance abuse delivery system in North Dakota. She said key differences between the report prepared by Schulte Consulting, LLC and the report prepared by the Behavioral Health Stakeholders Group include the following:

- The report prepared by Schulte Consulting, LLC:
 - Covers a "snapshot" in time;
 - Provides a framework for system changes; and
 - Was limited in scope and depth due to the short time frame and limited funds to complete the study.
- The report prepared by the Behavioral Health Stakeholders Group provides greater details through the development of specific goals and objectives in the four key areas, which include substance abuse, adult mental health, children mental health, and workforce issues.

Ms. McKenzie said the work of the steering committee and stakeholders group is ongoing and the group continues to work on implementing changes that are evidence-based and measurable. She said the stakeholders continue to strive for positive changes to the behavioral health delivery system while implementing new programs and services that they have initiated or as a result of legislative action. She said the stakeholders group believes collaboration, consistent evaluation, and review will assist with providing a viable and sustainable continuum of care for behavioral health and substance abuse services which can serve as a model for other states.

Definition of a Current Behavioral Health System of Care

Chairman Hogan called on Dr. Nancy Vogeltanz-Holm, Professor and Director, Center for Health Promotion and Prevention Research, Department of Psychiatry and Behavioral Science, University of North Dakota School of Medicine and Health Sciences, to present information ([Appendix D](#)) regarding the definition of a current behavioral health system of care. She said behavioral health disorders are common, treatable, and often not accessible because of:

- Stigma, culture, and ubiquitousness;
- Shortages of providers and maldistribution;
- Reduced reimbursement; and
- Lack of integration across care system.

National Behavioral Health System of Care and Services

Dr. Vogeltanz-Holm said, behavioral health service settings include specialty behavioral health clinics and hospitals, outpatient independent providers, health clinics, hospitals, long-term care centers, mutual support groups and peer-run organizations, schools and educational settings, jails and prisons, other community settings, and home-based services. She said treatment services include assessment and diagnosis, counseling and psychotherapy, medications, and supportive services, including care management and coordination. She said behavioral health service providers include:

- **Specialty behavioral health providers** - Psychiatrists, psychologists, specialty nurses and social workers, addiction counselors, and other master-level licensed behavioral health therapists services.

- **Primary care physicians** - Family medicine, pediatrics, internal medicine, obstetrics and gynecology, emergency services, and others.
- **Social and human services** - School counselors, criminal justice professionals, aging and disability services, and other service providers.
- **Informal volunteers** - Support groups, peer counselors, and others.

Dr. Vogeltanz-Holm cited the following items as indicators of the need for behavioral health services in the United States:

- Nearly one-third of adult individuals have a diagnosable behavioral health disorder;
- Depression is the leading cause of disabilities worldwide;
- Individuals with behavioral health disorders have higher morbidity and mortality rates;
- One in five individuals aged 13 to 18 will have a serious mental illness;
- Suicide is the third leading cause of death for individuals aged 10 to 24;
- Seventy-five percent of behavioral health disorders over an individual's lifetime emerge by age 24 and 50 percent emerge by age 14;
- Higher rates of behavioral health disorders for incarcerated and homeless individuals;
- Medicaid-eligible individuals are twice as likely to have behavioral health disorders; and
- Fifty to sixty percent of individuals with behavioral health disorders do not receive treatment.

Action Steps

Dr. Vogeltanz-Holm said transforming the behavioral health care system will require "disruptive" innovation. She said a 2009 report by the Congressional Research Service include the following actions needed for improving behavioral health services:

- Routine and systematic use of evidence-based practice;
- Resolving the workforce shortage issues;
- Ensuring access to care by removing financial barriers;
- Coordinating mental health care with general health care and social services; and
- Developing a way to systematically measure and improve the quality of care delivered.

Dr. Vogeltanz-Holm said measuring the quality of mental health care requires collection of data for many measures over a sustained period of time. She said the measures need to reflect patterns, which include the process of obtaining care and the outcome of the care received.

Dr. Vogeltanz-Holm said although North Dakota has high workforce shortages, it also has a lower overall need because of higher levels of education and access to insurance. She said reforming workforce eligibility and reimbursement policies would improve workforce shortages. She said the state provides more of its behavioral health services in human service centers compared to the United States. She said the state should better integrate public and private services. She said the state should develop consumer-centered resources for accessing behavioral health services in both public and private settings.

In response to a question from Senator Mathern, Dr. Vogeltanz-Holm said identifying behavioral health issues in children is more common once a child begins attending school. She said behavioral health issues are more difficult to detect in children because a parent may be more reluctant to accept that a child may have a behavioral health issue.

In response to a question from Representative Seibel, Dr. Vogeltanz-Holm said including better systems of telepsychiatry and better reimbursement incentives provide immediate solutions to workforce shortages in the state. In addition, she suggested having a psychiatry residency program in the state.

In response to a question from Representative Silbernagel, Dr. Vogeltanz-Holm said development of a centralized database of services should include input from care providers.

Senator Lee suggested the Legislative Council staff provide information regarding voluntary and involuntary treatment laws in other states to the committee.

Services Provided by the Department of Human Services

Chairman Hogan called on Ms. Pamela Sagness, Director, Behavioral Health Services Division, Department of Human Services, who presented information ([Appendix E](#)) regarding services and current structure of DHS's Behavioral Health Services Division. She said DHS's behavioral health system includes a policy division which is called the Behavioral Health Services Division and a services division. She said the goal of DHS's behavioral health system is to provide quality, efficient, and effective human services to improve the lives of people.

Behavioral Health System Values

Ms. Sagness said DHS's behavioral health system is based on the following values:

- **Recovery-oriented systems** - Which includes systems of health and human services that affirm hope for recovery, exemplify a strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging individuals with mental health and substance abuse conditions into care and promoting their resilience and long-term recovery from which they and their families may choose.
- **Person-centered care** - Which is based on the individual's self-identified hopes, aspirations, and goals, builds on the individual's own assets, interests, and strengths, and is carried out collaboratively with a broadly defined recovery management team which includes formal care providers and others who support the individual's own recovery efforts and process, such as employers, landlords, teachers, and neighbors.
- **Integrated care** - Which is the collaboration between behavioral health and primary care providers to ensure the most effective and informative care for the consumer. Integrated care focuses on consumers and family members as partners in the health care process.
- **Trauma-informed** - Which is an approach to the delivery of behavioral health services including an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.

Behavioral Health Services Division

Ms. Sagness said the Behavioral Health Services Division provides leadership for the planning, development, and oversight of the state's behavioral health system by improving access to services, addressing behavioral health workforce needs, developing policy, and ensuring quality services are available for those with behavioral health needs. She said the policy role of DHS's Behavioral Health Services Division includes the following:

- **Health and safety** - Licensing, certification, administrative rule updates, contracts, law and policy changes, training and technical assistance, data-driven planning, partners, and compliance requirements.
- **Access to services** - Priority status, partnerships, grant funding and request for proposals (RFP), policy and law changes, payments and partnership with payers including Medicaid, and training and technical assistance.
- **Quality** - Outcome-based contracts, best practice requirements, training and technical assistance, evaluation and data collection, process and outcome measures, prevention resource and media center, analysis of system changes, and fidelity.

Ms. Sagness said the core functions of the DHS's Behavioral Health Services Division include:

- **Regulation** - Substance abuse licensing, opioid treatment program licensing, human service center licensing, psychiatric residential treatment facility licensing, Driving Under the Influence seminar program licensing, and administrative rules.
- **Administration** - Mental health block grants, substance abuse block grants, community and tribal prevention, problem gambling, brain injury, First Link 2-1-1, and the Robinson Recovery Center.
- **Workforce development** - Training and technical assistance, behavioral health conferences, mental health first aid, and partnerships with institutions and consortiums.
- **Prevention and promotion** - Parents Listen, Educate, Ask Discuss (LEAD) program, prevention resource and media center, Speaks Volumes program, tribal prevention programs, community prevention programs, and prescription drug take back.
- **Partnership** - Mental Health and Substance Abuse Planning Council, Governor's Prevention Advisory Council, State Epidemiological Outcomes Workgroup, Brain Injury Advisory Committee, Problems Gambling Advisory Council, and ND Cares.

Behavioral Health Service Delivery System

Dr. Rosalie Etherington, Superintendent/Administrator, State Hospital, said DHS's services division system includes eight regional human service centers across the state and the State Hospital. She said the division provides, directly or through contracts, a full continuum of integrated behavioral health services. The services provided include:

- **Extended care services** - Integrated and full continuum of medically necessary treatment and rehabilitative services for individuals with severe and persistent mental illness to enhance opportunity for:
 - Productive community living* - 24-hour emergency care and access to hospitalization, assertive community treatment, and intensive case management;
 - Active chronic disease management* - Medication management and therapy services including addiction therapy; and
 - Other services* - Psychosocial rehabilitation and day treatment, peer and family support services, supported employment, supported housing, and various levels of residential environments.
- **Specialized children's services** - An integrated and full continuum of treatment and support services for severely emotionally disturbed children including mental health, substance abuse, social, educational and juvenile services.
- **substance abuse disorder services** - An integrated and full continuum of psychotherapeutic and rehabilitation services with priority given to Schedule IV drug users, pregnant females, and uninsured individuals.

Dr. Etherington provided more specific information on certain services including:

- **24-hour emergency services** - In-person and telephonic crisis assessment, crisis residential services, and mobile crisis management.
- **Specialized assessment and engagement services** - Open-access assessment, court-ordered substance abuse evaluation, and disaster assessment.
- **Comprehensive and intensive case management services** - Chronic disease management.
- **Psychotherapy services** - Individual and group addiction counseling, psychotherapy of severely traumatized children and adults, integrated dual disorders treatment, and low-risk sex offender treatment including the residential treatment of sexually dangerous individuals.
- **Medication services** - Daily delivery and monitoring of medication adherence, and adherence counseling.
- **Residential and supported housing.**
- **Supported employment.**
- **Psychological testing and assessment services** - Parental capacity and sex offender risk assessment.
- **Peer support services** - Recovery center environments, peer-managed support groups, and recovery management education.

Dr. Etherington said electronic health records would improve client safety and services, increase provider efficiency and satisfaction, and meet accreditation and payers requirements of The Joint Commission, Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, Medicaid, and commercial payers.

In response to a question from Senator Mathern, Dr. Etherington said because of the different levels of service provided by DHS, waiting times vary. She said the waiting time is generally longer for a service that is more specialized.

In response to a question from Senator Mathern, Dr. Etherington said DHS is developing an Open Access Assessment tool to help human service centers reduce wait times. She said an abbreviated version of the tool may be implemented soon, which could assess an individual more rapidly and begin services immediately. She said the assessment is not yet systemwide.

Committee Discussion of Behavioral Health Needs Study

Chairman Hogan said the committee did receive approval from the Chairman of the Legislative Management to pay the costs of a national expert to provide the committee with a review of legal obligations related to behavioral

health services. She said the expert is from the Bazelon Center for Mental Health Law and the plan is to have the presentation at the next Human Services Committee meeting, which is tentatively scheduled for Tuesday, November 3, 2015.

Senator Lee suggested the committee consider hiring a consultant to assist the committee with providing information relating to consumer-centered resources for accessing behavioral health services for both a public and private setting, which was recommended by Dr. Vogeltanz-Holm.

Ms. Sagness said a study being conducted by DHS may provide information relating to consumer-centered resources for accessing behavioral health services for both a public and private setting.

Chairman Hogan directed DHS, when available, to provide the committee with information from its study relating to the consumer-centered resources for accessing behavioral health services for both a public and private setting.

Senator Mathern expressed concern regarding behavioral health advocacy efforts in the state, specifically relating to consumer leadership development. He said that it is very important for the state to have strong advocacy efforts. He suggested, as part of the behavioral health study plan, that the committee receive information from behavioral health advocacy groups.

Chairman Hogan said that a new coalition called the Mental Health Advocacy Network of North Dakota has been formed. She said the committee should consider adding the coalition to the list of organizations the committee receives information from.

It was moved by Representative Silbernagel, seconded by Senator Mathern, and carried on a voice vote that the committee proceed with the study of behavioral health needs as follows:

- 1. Receive information from DHS regarding a behavioral health system of care, including consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. In addition, receive information on public involvement with mental health and substance abuse treatment, and mental health and substance abuse services for children and adults.**
- 2. Receive information from the Department of Corrections and Rehabilitation regarding a behavioral health system of care, including consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. In addition, receive information on public involvement with mental health and substance abuse treatment, and mental health and substance abuse services for children and adults.**
- 3. Receive testimony from stakeholders, including representatives of law enforcement, social and clinical service providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions.**
- 4. Receive information from a national expert regarding a review of the state's legal obligations as they relate to behavioral health-related services provided by the state.**
- 5. Receive information from DHS regarding the review of strategies to improve behavioral health services implemented pursuant to legislation enacted by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.**
- 6. Receive information from the Department of Corrections and Rehabilitation regarding the review of strategies to improve behavioral health services implemented pursuant to legislation enacted by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.**
- 7. Receive information from behavioral health advocacy groups, including the Mental Health Advocacy Network of North Dakota.**
- 8. Receive comments by interested persons regarding the study of behavioral health needs.**
- 9. Develop recommendations and any bill drafts necessary to implement the recommendations.**
- 10. Prepare a final report for submission to the Legislative Management.**

STUDY OF FAMILY CAREGIVER SUPPORTS AND SERVICES

Background Memorandum

The Legislative Council staff presented a memorandum entitled [Study of Family Caregiver Supports and Services](#). The Legislative Council staff said the Human Services Committee has been assigned the responsibility to study family caregiver supports and services to identify policies, resources, and programs available for family caregivers and encourage additional innovative and creative means to support family caregivers so they are able to continue to provide in-home support for older adults. The study must include:

- Providing an inventory of the resources available to family caregivers;
- Consideration of recommendations for administrative actions to support family caregivers; and
- Input from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal governments, state and local agencies and institutions, and caregivers in the state.

Section 1 of 2015 House Bill No. 1279 allows the Legislative Council to contract for consulting and coordination of study services to assist the Legislative Management in conducting the family caregiver supports and services study.

The Legislative Council said a related study was conducted during the 2007-08 interim by the Long-Term Care Committee, which studied dementia-related services. The Long-Term Care Committee recommended a bill to direct DHS to contract for a dementia care services program in each area of the state serviced by a regional human service center and to provide personalized care consultation services, training, and education relating to dementia. In addition, it recommended a \$1.2 million general fund appropriation for the program and required DHS to provide a report to the Legislative Management regarding the outcomes of the program.

The Legislative Council staff said DHS's Division of Aging Services - Dementia Care Services Program is a state-funded program that provides care consultation and training to caregivers to address the unique and individual needs that arise throughout the various stages of dementia. The Department of Human Services Division of Aging Services North Dakota Family Caregiver Support Program receives federal funding under the federal Older Americans Act to provide support and services to caregivers in the state. The North Dakota Family Caregiver Support Program is designed to provide training, supportive services, and respite care to caregivers who provide unpaid care on a 24-hour basis to enable older adults to remain in their homes.

The Legislative Council staff said the 2015 Legislative Assembly provided \$1.2 million from the general fund to DHS for the Dementia Care Services Program for the 2015-17 biennium.

The Legislative Council staff said the 2015 Legislative Assembly provided funding for family caregiver supports and services as follows:

	General Fund	Other Funds	Total
Department of Human Services			
Division of Aging Services	\$0	\$1,048,424	\$1,048,424
Human Service Centers	274,072	513,505	787,577
Total Department of Human Services	\$274,072	\$1,561,929	\$1,836,001

The Legislative Council staff proposed the following study plan:

1. Receive information from DHS regarding family caregiver support and services policies, resources, and programs available for family caregivers.
2. Receive testimony from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal government, state and local agencies and institutions, and caregivers in this state.
3. Consider hiring a consultant to assist with the study.
4. Receive comments by interested persons regarding the study of family caregiver supports and services.
5. Develop recommendations and any bill drafts necessary to implement the recommendations.
6. Prepare a final report for submission to the Legislative Management.

Private Family Caregiver Supports and Services

Ms. Jane Strommen, North Dakota Partners in Nursing Gerontology Consortium, North Dakota State University Extension Service, presented information ([Appendix F](#)) regarding private family caregiver support systems.

Ms. Strommen said, in 2013 an estimated 62,100 family caregivers provided 58 million hours of unpaid care in the state. She said the value of these services was estimated to be \$860 million. She said caregivers include spouses, partners, adult children, other family members, neighbors, and friends. She said caregivers provide transportation, personal care, and assistance with managing finances and grocery shopping. She said each caregiver situation is unique. She said privately funded support and services for family caregivers in North Dakota include:

- **HEART Program** of Enderlin, North Dakota - Provides free and confidential volunteer services to people age 65 and older that live in the Enderlin or Sheldon area.
- **Faith in Action Health Coalition** of Cavalier, North Dakota - Provides trained volunteers that offer holistic health care services for people of all ages that live in rural and underserved areas of Pembina County.
- **Volunteer Caregivers for the Elderly** of Bismarck, North Dakota - Provides nonmedical services and supports to help the elderly stay safely in their homes. The program includes 90 volunteers and partners with the University of Mary to provide 14 nursing students to serve a seven-week rotation each summer.
- **Faith in Action Health Coalition** of Harvey, North Dakota - Includes an interfaith network of volunteers providing transportation, companionship, and assistance with household tasks to rural residents.
- **Community of Care** - Provides a one-stop service center, a volunteer program, a faith community nurse program, and health and education. The program began in 2003 as a pilot project for the Evangelical Lutheran Good Samaritan Society.
- **HeartSprings Community Healing Center** of Fargo, North Dakota - Provides health, hope, and healing for people dealing with issues, including stress and chronic disease, cancer, mental health, and posttraumatic stress disorder.
- **Faith community nurses** - The Faith Community Nursing and Health Ministry Division of Sanford Health in Fargo has a directory of churches and agencies in the Fargo region that have at least one faith community nurse. The faith community nurses provide services to older adults and their family members.
- **Adult day care and respite services** - The First Lutheran Church in Fargo offers a program called The Gathering, which is designed to support, educate, and equip caregivers with skills and tools to care for their loved ones. Respite care is provided onsite to care recipients while the program is being delivered for family caregivers.
- **AARP North Dakota** - Provides statewide educational workshops on topics for older adults and family members. In addition, AARP has a comprehensive *Caregiving Resource Center* on its website.
- **North Dakota State University Extension Service** - Provides a national evidence-based program called the *Powerful Tools for Caregivers Program*. The program includes information on reducing stress, improving self-confidence, communicating feelings, balancing lives, increasing the ability to make tough decisions, and information regarding how to locate helpful resources.
- **Alzheimer's Association of Minnesota-North Dakota Chapter** - Provides a dementia care program and offers a series of community educational workshops on dementia.
- **Aging life care management** - A service provided by Lutheran Social Services of North Dakota that provides long-term care planning, support, and solutions to improve quality of life for the aging adult and reduce the responsibilities of primary caregivers.
- **Dignity care** - A service offered in the Fargo area that empowers individuals affected by dementia through quality of life assessments and highly personalized caregiving strategies.
- **Northland Care Coordination for Seniors** - A Medicaid-approved health management program that provides services at no charge to individuals age 55 and enrolled in Medicare.
- **Mom's Meals NourishCare** - Provides nutritious home-delivered meals that are delivered by FedEx.
- **Easter Seals Goodwill of North Dakota, Inc.** - Provides a variety of services on behalf of elderly individuals and people with disabilities. Services include an equipment loan program, respite care, advocacy, supportive home care, family support services, individualized supportive living arrangements, and services for the elderly.
- **Personal care services** - Includes private agencies and qualified service providers that offer bathing, dressing, housekeeping, cooking, and companionship services.

- **Home health agencies, hospice, long-term care facilities, and hospitals** - Includes health care providers, including nursing homes, that have expanded services to offer a broader continuum of care in the community.

Ms. Strommen said where an individual lives affects their access to resources. She said more resources are available to family caregivers in metro areas. She said it is more difficult for individuals in rural areas to access resources including transportation, health care, and housing. She said future decisions relating to family caregiving should include accessibility of resources in rural areas.

Status Report of Family Caregiver Supports and Services

Mr. Josh Askvig, AARP North Dakota, and Ms. Elaine Ryan, Vice President, AARP State Advocacy and Strategic Integration, presented information ([Appendix G](#)) regarding a status report of family caregiver supports and services in the United States and in North Dakota.

Caregiving Research Study

Ms. Ryan presented information regarding a study conducted by the National Alliance for Caregiving and AARP in June 2015, which focused on caregivers who support a loved one for at least 21 hours each week, medical and nursing tasks, caregivers in the workplace, and caregivers age 75-plus. She said the study determined the following:

- A typical caregiver is a 49 year old female caring for a 69 year old relative with a long-term physical condition.
- Thirty-two percent of caregivers are higher-hour caregivers. Of this group, the average caregiver provides 62 hours per week caring for a loved one.
- Caregivers age 75-plus are typically caring for a close relative and are the sole provider. Of this group, the average caregiver provides 34 hours per week and provides caregiving services for an average of 5.5 years.
- Sixty percent of caregivers were employed during the past year.
- Seventy percent of caregivers who perform medical and nursing tasks determined that caregiving affects their jobs.
- Thirty-nine percent of caregivers who left their job did so to spend more time to provide caregiving. Thirty-four percent of caregivers who left their job did so because of a lack of flexible work hours.
- Eighty percent of higher-hour caregivers are performing medical and nursing tasks. Of this group, 60 percent have no prior medical or nursing experience.
- Sixty-eight percent of caregivers have no paid help.

Ms. Ryan said the study surveyed 1,677 family caregivers and determined the following:

- Family caregivers perform complicated medical and nursing tasks, and medication management.
- Training is limited.
- Most care recipients do not receive home visits by health professionals.
- Performing medical and nursing tasks may prevent nursing home placement.
- The quality of a caregivers life is affected.

Profile of a North Dakota Caregiver

Ms. Ryan said tasks performed by caregivers in the state include the following:

- Fifty-six percent perform nursing and medical tasks.
- Sixty-six percent perform complex care, including managing medications.
- Seventy-four percent perform meal preparation.
- Eighty-two percent perform household chores.
- Eighty-four percent provide transportation.
- Ninety percent perform shopping activities.

Policy Solutions

Ms. Ryan said policy solutions should include:

- Support during hospital transitions;
- Removing barriers to practice and care;
- Respite care;
- Workplace flexibility;
- Uniform guardianship and power of attorney laws; and
- Access to direct workers.

Services Provided by Department of Human Services

Ms. Sheryl Pfliger, Interim Director, Aging Services Division, Department of Human Services, presented information ([Appendix H](#)) regarding family caregiver supports and services provided by DHS. She said the department provides a family caregiver support program, dementia care services program, family home care, and family personal care.

Family Caregiver Support Program

Ms. Pfliger said the family caregiver support program is designed to provide training, supportive services, and respite care to caregivers who provide unpaid care on a 24-hour basis to enable individuals age 60 and older to remain in their own homes. She said participation in the program is allowed for caregivers caring for individuals of any age with dementia. She said the program also assists grandparents or relative caregivers who are caring for a child age 18 or younger or for an adult child with a disability. She said if an individual is being paid privately or receives respite services from another publicly funded program, the individual is not eligible to receive support through the program.

Ms. Pfliger said family caregiver services include:

- Information to caregivers about available services;
- Assistance in gaining access to the services, counseling, support groups, and training;
- Respite care; and
- Supplemental services to assist with the cost of devices and supplies to ease caregiving tasks.

Ms. Pfliger said during federal fiscal year 2014, a total of 298 unduplicated caregivers were served. She said the primary funding source for the program is federal Title III-E funding from the 1965 Older Americans Act.

Dementia Care Services Program

Ms. Pfliger said the dementia care services program provides care consultation and training to caregivers to address the unique and individual needs that arise throughout the various stages of dementia. She said people with dementia and their caregivers receive one-on-one assistance that enables them to better manage care and make more informed decisions regarding services and treatments. She said the program also provides education on dementia to medical professionals, law enforcement, caregivers, and the general public regarding the symptoms of dementia, the benefits of early detection, and treatment. She said, for the purposes of this program, dementia means a condition of an individual involving loss of memory, and impairment of cognitive functions severe enough to interfere with the individual's daily life. She said anyone who has a need is eligible to receive services. She said eligibility is not based on diagnosis, age, or income level.

Ms. Pfliger said the program is a state-funded program which was established by the 2009 Legislative Assembly. She said the department, through a competitive bid, contracts with the Alzheimer's Association Minnesota-North Dakota Chapter to provide services. She said during the 2013-15 biennium, the program served a total of 889 individuals with dementia and 1,893 caregivers and family members.

Family Home Care

Ms. Pfliger said the purpose of family home care is to assist individuals to remain with their family members and in their own communities. She said the program provides an option for individuals experiencing functional impairments that contribute to the individuals inability to accomplish activities of daily living.

Ms. Pfliger said in order to receive family home care services, the individual must be eligible for the service payments for the elderly and disabled (SPED) or expanded service payments for the elderly and disabled

(Ex-SPED) program and the services must be provided by a qualified family member as defined in of Section 50-24.7-01(7). She said the client and the qualified family member must reside in the same residence and both must agree to the arrangement. She said the provider does not need to be present in the home on a 24-hour basis if the client can be left alone for routine temporary periods of time without adverse impact to the client's welfare and safety. She said the client must agree to be left alone. She said if clients cannot be safely left alone, respite care must be authorized so the provider can take necessary breaks from caregiving responsibilities. She said as of August 2015, 221 individuals in SPED and 30 individuals in Ex-SPED are receiving family home care.

Family Personal Care

Ms. Pfliger said the purpose of family personal care is to assist individuals to remain with their family members and in their own communities. She said the program provides for the provision of extraordinary care payments to the legal spouse of a recipient for the provision of personal care or similar services. She said the individual receiving family personal care must be eligible for the home and community-based services Medicaid waiver. She said the client and the qualified provider must reside in the same residence and both must agree to the arrangement. She said the provider does not need to be present in the home on a 24-hour basis if the client can be left alone for routine temporary periods of time without adverse impact to the client's welfare and safety. She said the client must agree to be left alone. She said if clients cannot be safely left alone or supervision is an authorized task, respite care must be authorized so the spouse can take necessary breaks from caregiving responsibilities. She said as of August 2015, 67 individuals in the Medicaid waiver are receiving family personal care services.

Committee Discussion of Family Caregiver Supports and Services

Chairman Hogan presented information ([Appendix I](#)) regarding a proposed family caregiver supports and services RFP. She said Section 1 of 2015 House Bill No. 1279 allows the Legislative Council to contract for consulting and coordination of study services to assist the Legislative Management in conducting the family caregiver supports and services study.

Chairman Hogan said if the committee chooses to proceed with hiring a consultant, the timeline could be as follows:

1. Release a RFP and receive proposals in September and October 2015;
2. Review proposals and hire a consultant in November 2015;
3. Receive updates on consultant study activities in March 2016;
4. Receive the consultant's final report in May 2016;
5. Develop committee recommendations July through September 2016; and
6. Present final report to the Legislative Management in November 2016.

Chairman Hogan said potential items to be included in a RFP for a consultant to assist with the family caregiver study include:

1. Identify current public and private resources, services, and supports for family caregivers, both public and private, and by region and/or county.
2. Identify barriers and challenges family caregivers experience, which includes the need for training, respite care services, medical leave policies, and delegation of tasks to family members and nonmedical aides.
3. Identify best practice models for family caregiver support programs from other states.
4. Identify emerging practices and technology that can enhance caregiver and patient home supports.
5. Provide recommendations to the interim committee.

Senator Mathern suggested that the executive branch be kept informed during the process of the study and that input from the executive branch is considered.

Representative Silbernagel suggested language be included in a RFP to identify specific dates for materials to be presented to the committee.

Senator Axness suggested including, as part of the study, family caregiver supports and services for veterans.

Representative Oversen suggested the study plan include studying supports and services provided to family caregivers in other states.

Chairman Hogan directed the Legislative Council staff to amend the RFP for the family caregiver supports and services study to add language to strengthen specific dates for material to be delivered to the committee, and to include veterans as part of the study. In addition, Chairman Hogan authorized the Legislative Council staff to add an item, as part of the study plan, to study supports and services provided to family caregivers in other states.

It was moved by Senator Lee, seconded by Senator Mathern, and carried on a roll call vote that the Legislative Council staff distribute a RFP for consulting and coordination of study services to assist in conducting the family caregiver supports and services study. Representatives Hogan, B. Anderson, Mooney, Muscha, Oversen, Seibel, and Silbernagel, and Senators Axness, Dever, Lee, and Mathern voted "aye." No negative votes were cast.

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

1. **Receive information from DHS regarding family caregiver support and services policies, resources, and programs available for family caregivers.**
2. **Receive testimony from stakeholders, including representatives of hospitals, social and clinical providers, advocacy organizations, tribal government, state and local agencies and institutions, and caregivers in this state.**
3. **Consider hiring a consultant to assist with the study.**
4. **Identify best practice models for family caregiver support programs from other states.**
5. **Receive comments by interested persons regarding the study of family caregiver supports and services.**
6. **Develop recommendations and any bill drafts necessary to implement the recommendations.**
7. **Prepare a final report for submission to the Legislative Management.**

OTHER COMMITTEE RESPONSIBILITIES

Background Memorandum

The Legislative Council staff presented a memorandum entitled [*Other Duties of the Human Services Committee - Background Memorandum*](#). The Legislative Council staff said, in addition to the study responsibilities assigned to the Human Services Committee for the 2015-16 interim, the committee has also been assigned to:

- Receive annual reports from DHS describing enrollment statistics and costs associated with the children's health insurance program (CHIP) state plan (Section 50-29-02).
- Receive a report from DHS regarding the outcomes of the Medicaid and Medicaid Expansion cost-sharing provisions study and the associated legislative recommendations and related draft legislation (Section 1 of 2015 House Bill No. 1037).
- Receive a report from DHS relating to life skill services, including evidence-based return-to-work model provided for individuals with a traumatic brain injury (Section 1 of 2015 House Bill No. 1046).
- Receive a report from DHS regarding development activities of the developmental disabilities system reimbursement project (Section 14 of 2015 Senate Bill No. 2012).
- Receive a report from DHS regarding eligibility for developmental disability waivers (Section 1 of 2015 Senate Bill No. 2234).
- Receive a report from a statewide family-controlled parent-to-parent support organization receiving a grant under Section 19 of 2015 Senate Bill No. 2012, regarding the use of grant funds (Section 19 of 2015 Senate Bill No. 2012).
- Receive a report from a statewide family-to-family health information and education organization receiving a grant under Section 20 of 2015 Senate Bill No. 2012, regarding the use of grant funds (Section 20 of 2015 Senate Bill No. 2012).
- Receive a report from DHS regarding the adult protective services program, including the effectiveness of the program, information on services and outcomes, and funding by human service region and in total (Section 23 of 2015 Senate Bill No. 2012).

Children's Health Insurance Program

The Legislative Council staff said Section 50-29-02 provides DHS is to prepare, submit, and implement a CHIP state plan and report annually to the Legislative Management and describe enrollment statistics and costs associated with the plan. The Legislative Assembly appropriated funding of \$20.5 million, of which \$2.8 million is from the general fund, for the 2015-17 biennium. The federal medical assistance percentage will be increasing from 65 to 88 percent beginning September 30, 2015. There were 3,879 children enrolled in the program as of June 30, 2014, and is anticipated to decline during the 2015-17 biennium.

Medicaid Expansion

The Legislative Council staff said Section 1 of 2015 House Bill No. 1037 provides DHS to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs and to provide a report to the Legislative Management regarding the outcome of the study and the associated legislative recommendations and related draft legislation.

Brain Injury Life Skill Services

The Legislative Council staff said Section 1 of 2015 House Bill No. 1046 requires DHS to provide a report to the Legislative Management on the use funds appropriated to the department for the purpose of providing life skill services.

Developmental Disabilities

The Legislative Council staff said Section 14 of 2015 Senate Bill No. 2012 requires DHS to provide a report to the Legislative Management regarding the development activities of the developmental disabilities system reimbursement project.

Developmental Disability Waiver Eligibility

The Legislative Council staff said Section 1 of 2015 Senate Bill No. 2234 requires DHS to study eligibility for developmental disability waivers and to provide a report to the Legislative Management regarding the eligibility for developmental disability waivers.

House Bill No. 1556 (2009) provided for DHS to contract with an independent contractor to study the methodology and calculation for a rate setting structure used by the department to reimburse all developmental disabilities service providers. The independent contractor recommended changing to a prospective reimbursement process using an independent rate setting and resource allocation model for the entire developmental disabilities client base. The 2011 Legislative Assembly directed DHS to develop a developmental disability payment system with an independent rate model utilizing the support intensity scale. During the 2013-15 biennium, it was determined, the steering committee should address the following items prior to implementation of a new system:

- Reviewing concerns with ratesetting;
- Identifying audit requirements and cost-related reporting;
- Finalizing North Dakota Administrative Code, service descriptions, and related policies and procedures;
- Submitting waiver and Medicaid state plan changes to the Centers for Medicare and Medicaid Services; and
- Implementing the billing module within the case management system to accommodate making payments under the new payment system.

Family-Controlled Parent-to-Parent Support

The Legislative Council staff said Section 19 of 2015 Senate Bill No. 2012 requires grant recipients of a family-controlled parent-to-parent support grant to provide a report to the Legislative Management regarding the use of grant funds.

Family-to-Family Health Information and Education

The Legislative Council staff said Section 20 of 2015 Senate Bill No. 2012 requires grant recipients of a family-to-family health information and education grant to provide a report to the Legislative Management regarding the use of grant funds.

Adult Protective Services Program

The Legislative Council staff said Section 23 of 2015 Senate Bill No. 2012 requires DHS to provide a report to the Legislative Management regarding the adult protective services program, including the effectiveness of the program, information on services and outcomes, and funding by human service region and in total.

At the request of Chairman Hogan, Ms. Maggie D. Anderson, Executive Director, Department of Human Services, said enrollment for CHIP has been decreasing as a result of changing the modified adjustable gross income threshold as a result of the federal Affordable Care Act. She said eligibility for the program has changed from adjusted net income not exceeding 160 percent of the federal poverty level to modified adjusted gross income not exceeding 175 percent of the federal poverty level. She said the declining enrollment began in January 2014 when the department began applying the new modified adjustable gross income changes. She said a number of children who previously were enrolled in the CHIP may now be eligible for Medicaid under Medicaid Expansion.

Committee Discussion of Other Committee Responsibilities

Chairman Hogan presented information ([Appendix J](#)) regarding a proposed tentative schedule for the 2015-16 interim Human Services Committee. She said the next meeting is tentatively scheduled for November 3, 2015.

No further business appearing, Chairman Hogan adjourned the meeting at 3:30 p.m.

Michael C. Johnson
Fiscal Analyst

ATTACH:10