

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH SERVICES COMMITTEE

Tuesday, August 18, 2015
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Judy Lee, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Judy Lee, Howard C. Anderson, Jr., Tyler Axness, Joan Heckaman, Dave Oehlke, Representatives Rich S. Becker, Gail Mooney, Gary Paur, Todd Porter, Karen M. Rohr, Jay Seibel

Members absent: Senator John M. Warner; Representatives Alan Fehr, Dwight Kiefert, Marie Strinden

Others present: See [Appendix A](#)

Mr. Allen H. Knudson, Legislative Budget Analyst and Auditor, reviewed the [Supplementary Rules of Operation and Procedure of the North Dakota Legislative Management](#) for the 2015-16 interim.

COMMENTS BY COMMITTEE CHAIRMAN

Chairman Lee welcomed the committee. She said the dental services and death investigation studies are a continuation of the committee's work from last interim. She said the committee looks forward to gathering more information regarding these and the other studies and duties of the committee and to formulating recommendations for the Legislative Management.

DENTAL SERVICES STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled [Dental Services Study - Background Memorandum](#) relating to the committee's study of dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state. The Legislative Council staff said the study is a continuation of the 2013-14 Health Services Committee study regarding how to improve access to dental services and ways to address dental service provider shortages, including the feasibility of utilizing mid-level providers, whether the use of incentives for dental service providers to locate in underserved areas in the state may improve access, and whether the state's medical assistance reimbursement rates impact access to dental services. The Legislative Council staff said the committee received information regarding state dental care programs, dental service provider programs, the North Dakota State College of Science dental program, the dental health workforce, and access to dental services. The committee reviewed proposals to increase access to dental services, including a proposed case management program in communities with the most need and creating mid-level providers and expanded function dental assistants and dental hygienists. The 2013-14 Health Services Committee determined additional information was necessary and recommended 2015 Senate Concurrent Resolution No. 4004 directing the Legislative Management to continue to study dental services in the state.

The Legislative Council staff said during the 2011-13 biennium, Medicaid dental services totaled \$27 million and 2013-15 biennium Medicaid dental services were estimated to total \$28.7 million. The 2015 Legislative Assembly appropriated \$29.5 million to the Department of Human Services for Medicaid dental services during the 2015-17 biennium. Programs available in the state to provide free or low-cost dental care include Medicaid, Healthy Steps, Caring for Children, Health Tracks, mobile dental services, donated dental services, and the Smiles for Life fluoride varnish program.

The Legislative Council staff said programs to increase the number of dental service providers in the state include the dentists' loan repayment program, federal/state loan repayment program, and National Health Service Corps loan repayment program. In 2015 Senate Bill No. 2205, the Legislative Assembly repealed North Dakota Century Code Section 43-28.1-01.1 and included dentists willing to serve in public health and nonprofit dental clinics in the same loan repayment program as dentists serving small communities. The dentists are eligible to receive funds, not to exceed a total of \$100,000 per applicant, for the repayment of their educational loans. The funds are payable over a five-year period (\$20,000 per year). Total funding available for the combined dental loan

repayment program based on defined need during the 2015-17 biennium is \$720,000, of which \$360,000 is from the general fund and \$360,000 is from the student loan trust fund.

The Legislative Council staff said the University of North Dakota School of Medicine and Health Sciences conducted research on the health care workforce in the state, including dental providers, and published a report entitled *2010 Snapshot of North Dakota's Health Care Workforce*. There were 392 dentists in the state in 2010, and in April 2014 there were 435 dentists, an increase of 10.9 percent from 2010. There were also 653 dental assistants and 747 dental hygienists in the state in April 2014. In 2014, 34 percent of the counties in the state were either fully or partially designated as dental health professional shortage areas, down from 36 percent in 2010.

The Legislative Council staff said nationally, the recommended ratio is one dentist per 1,612 residents and in North Dakota the ratio of dentists to population is approximately one dentist per 1,750 residents. This ratio compares favorably with South Dakota (1:1,890) and Iowa (1:1,825), but not with Minnesota (1:1,630). North Dakota's growing economy has brought more dentists to the state to practice and the number of licenses issued by the State Board of Dental Examiners has been steadily increasing. The favorable ratio of dentists to population indicates the state does not have a shortage of dentists but rather a misdistribution of dentists around the state.

The Legislative Council staff said the University of North Dakota School of Medicine and Health Sciences Center for Rural Health published a report titled *North Dakota Oral Health Report: Needs and Proposed Models, 2014*. The report was the result of a Center for Rural Health assessment of the oral health needs in the state. Based on data, input member responses, and stakeholder meetings, three primary oral health needs were identified, including prevention programs, dental insurance revision and/or care access, and greater workforce and improved access to care. The report indicated the greatest need for oral health literacy and prevention was among special populations--children, aging, Medicaid patients, low-income, homeless, new Americans, American Indians, rural, and those with physical/mental disabilities. The stakeholder and input groups developed and discussed 24 possible oral health models and the stakeholder working group identified the following top five stakeholder priority models:

1. Increase funding and reach of safety net clinics to include services provided in western North Dakota, using models, ideas, and support from nonprofit oral health programs similar to Apple Tree Dental and Children's Dental to promote hub-and-spoke models of care.
2. Increase funding and reach of the Seal! ND Dental Sealant Program to include using dental hygienists to provide care and incorporating case management and identification of a dental home as proposed under the North Dakota Dental Association's case management model, including Medicaid reimbursement for services rendered.
3. Expand scope of dental hygienists and utilize dental hygienists at the top of their current scope of work to provide community-based preventive and restorative services and education among populations of high need.
4. Create a system to promote dentistry professions among state residents and encourage practice in North Dakota through a consolidated loan repayment program and partnership/student spots at schools of dentistry.
5. Increase Medicaid reimbursement.

The Legislative Council staff said a shortage of dentists willing to accept Medicaid patients has resulted in a small number of dentists in the state treating the majority of children on Medicaid and limiting the availability of oral health services even in areas of the state where there is an adequate supply of dental professionals. Barriers to accessing oral health care exist in the state and include poverty, geography, workforce, an insufficient number of providers that accept Medicaid patients, lack of oral health education, language, cultural barriers, fear, and age, especially those in nursing homes. Additional barriers, particularly in reservation communities, include insufficient federal funding and administrative challenges in clinics. A complex and lengthy federal credentialing process makes it difficult to recruit dentists within the Indian Health Service system, and access to dentists and dental services on the reservations has been limited for decades. The state has four safety net dental clinics, three of which are federally qualified health centers (FQHCs), however safety net clinics have few places to refer patients needing more complex procedures, and patients often go without necessary care. A 2008 survey reported less than one-fourth of North Dakota dentists accept all Medicaid patients, one-third of dentists limit the number of new Medicaid patients, and rural dentists are more likely to accept all Medicaid patients than urban dentists. Medicaid payments for dental services are approximately 61.6 percent of billed charges in North Dakota.

The Legislative Council staff said the 2013-14 Health Services Committee reviewed proposals to increase access, including case management, the expanded function dental auxiliary, and mid-level providers such as dental therapists. The State Board of Dental Examiners approved amendments to North Dakota Administrative Code Title 20, which became effective April 1, 2015, to reorganize rules related to dental auxiliaries and expand their

functions. The 2013-14 Health Services Committee also reviewed recommendations advanced by the North Dakota Oral Health Coalition, which are similar to the models identified by the University of North Dakota School of Medicine and Health Sciences Center for Rural Health assessment, and include:

- Expand the Seal! ND Dental Sealant Program through the State Department of Health oral health programs to target low-income children at public schools;
- Expand funding for dental safety net clinics to include mobile, nonprofit, and FQHCs;
- Expand, simplify, and consolidate the North Dakota dental loan repayment programs;
- Provide funding for the case management outreach model supported through the State Department of Health and the North Dakota Dental Association;
- Facilitate the expansion of duties for dental assistants and hygienists through innovative, nontraditional, outreach education programs to minimize geographic and employment barriers for the current workforce.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding the effectiveness of case management services, including program and administrative costs, anticipated resources, and information regarding a pilot project for the reimbursement of outreach services. Organizations to request information from include the North Dakota Dental Association, the Department of Human Services, and the State Department of Health.
2. Gather and review information regarding the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.
3. Gather and review information regarding expanded function dental assistant and dental hygienist language approved by the State Board of Dental Examiners, including information regarding how the changes will improve access to dental services for underserved populations and in rural areas of the state. Organizations to request information from include the State Board of Dental Examiners, the North Dakota Dental Association, the North Dakota Dental Hygienists' Association, and the North Dakota Dental Assistants' Association.
4. Gather and review information regarding the impact of dental therapists in Minnesota.
5. Receive information from the Department of Human Services regarding billing and reimbursement for services provided by dental therapists and expanded function dental assistants and dental hygienists.
6. Receive updates from the Department of Human Services and the State Department of Health regarding changes to programs and services available to provide dental services in rural areas of the state.
7. Receive updates from the State Department of Health regarding changes to the dental loan repayment programs in the state, dentists participating in the loan programs, and the adequacy of the programs.
8. Receive information from the North Dakota University System regarding how University System programs will prepare students for the expanded functions of dental assistants and dental hygienists.
9. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
10. Prepare a final report for submission to the Legislative Management.

Ms. Kim Mertz, Family Health Division Director, State Department of Health, provided information ([Appendix B](#)) regarding programs and services available to provide dental services in rural areas of the state and to underserved populations. She said dental programs available through the department include:

- Donated dental services - Supported by the general fund (\$50,000 per biennium), the donated dental services program provides dental care through a network of 135 North Dakota volunteer dentists and 12 dental laboratories to the disabled, elderly, or medically-compromised individuals who cannot afford treatment.
- Smiles for Life fluoride varnish program - Funded by a DentaQuest Foundation grant, the program provides outreach and training in the application of fluoride varnish to health care providers.
- School-based fluoride varnish and Seal! ND Dental Sealant Program - Funded through a federal Centers for Disease Control and Prevention oral disease prevention program grant and a federal Health Resources and Services Administration's (HRSA) oral health workforce grant, the Seal! ND Dental Sealant Program is a school-based fluoride varnish and sealant program. Services include an initial screening, sealant

placement, and fluoride varnish application. Schools with 45 percent or greater of their students in the free or reduced school lunch program are given priority for the program.

- Ronald McDonald Care Mobile - The mobile dental clinic provides services to rural and underserved populations in the western half of the state. The mobile clinic's priorities include schools with 40 percent or greater of their student population in the free or reduced school lunch program, Head Start and Early Head Start, American Indian Reservation areas, and community health centers without dental services.
- Safety net clinics - Funded by a HRSA oral health workforce grant, the department partners with Bridging the Dental Gap to provide services to older adults living in long-term care facilities in Bismarck and Mandan. A DentaQuest Foundation grant funds older adult programs at Northland Community Health Center that serve Garrison and Turtle Lake.

Representative Porter suggested the committee receive information regarding Ronald McDonald Care Mobile missed appointments. Chairman Lee suggested the committee receive information from a representative of the Ronald McDonald Care Mobile at a future meeting.

Chairman Lee suggested the study plan include information from the State Department of Health regarding areas of increased need, including information regarding the funding necessary to meet those needs and ways to mitigate the loss of federal funds.

Ms. Maggie D. Anderson, Executive Director, Department of Human Services, provided information ([Appendix C](#)) regarding programs and services available to provide dental services in rural areas of the state and to underserved populations. She said dental-related programs administered by the Department of Human Services include Medicaid and the Children's Health Insurance Program (CHIP), also known as Healthy Steps. She said the Medicaid program provides health care coverage for qualifying families and children, pregnant women, the elderly, disabled, and adults under age 65 with incomes up to 138 percent of the federal poverty level. She said CHIP provides health care coverage for children up to age 19 with incomes up to 175 percent of the federal poverty level. She said both children's Medicaid and CHIP provide coverage for diagnostic, preventative, and restorative dental services, including orthodontia. She said the traditional Medicaid program provides dental coverage for qualified adults, including diagnostic, preventative, and restorative dental services, including dentures every five years. She said because dental services were not part of the benchmark coverage selected for Medicaid expansion, dental services are not covered for individuals qualifying for benefits under Medicaid expansion, unless the individual is 19 or 20 years of age. She said Health Tracks rules require dental coverage up to age 21. She said to increase dental provider access, the department developed the nonprofit clinic dental access project. She said the program supports the recruitment of additional dentists willing to serve Medicaid and CHIP patients by assisting dentists with school loan repayment. She said a part-time dentist may receive up to \$10,000 per year for three years, or a maximum of \$30,000, and the maximum for a full-time dentist is \$60,000. She said the department maintains information on a federal website listing dental providers who accept new Medicaid and CHIP recipients. She said North Dakota Health Tracks is a free, preventative health program for Medicaid eligible children 0 through 21 years of age that emphasizes preventative and primary care. She said North Dakota Health Tracks assists with referrals and scheduling appointments for services, including dental services.

In response to a question from Representative Paur, Ms. Anderson said approximately 66,000 individuals are enrolled in traditional Medicaid and approximately one-half of those are children. She said approximately 18,500 individuals are enrolled in expanded Medicaid. She said the department is in the process of enrolling dentists in more detail in the Medicaid management information system (MMIS) and will be able to generate a more detailed list of dentists serving Medicaid patients when the system is launched in October.

Chairman Lee suggested the committee receive information from the Department of Human Services regarding dentists accepting Medicaid and CHIP patients when the MMIS system report is available.

In response to a question from Representative Porter, Ms. Anderson said the nonprofit clinic dental access project grant program could be expanded to provide loan repayment grants to dentists in for profit clinics. She said the program was developed to encourage more providers to accept Medicaid patients and there is no regulation that prohibits "for profit" clinics, willing to accept Medicaid and CHIP patients, from receiving grants.

Senator Anderson suggested the committee receive information regarding the number of Medicaid clients served by dentists benefiting from the dental loan repayment program.

Chairman Lee said the Legislative Assembly will review essential benefits during the 2017 legislative session. She suggested the committee consider whether it would be appropriate to add adult dental services to expanded Medicaid.

In response to a question from Senator Heckaman, Ms. Anderson said incarcerated individuals are not eligible for Medicaid. However, she said, if an inmate is otherwise eligible for Medicaid, the cost of inpatient services will be covered when the MMIS is launched this fall. She said, except for the cost of inpatient services, the medical expenses of an inmate are the responsibility of the Department of Corrections and Rehabilitation. She said inmates leaving the Department of Corrections and Rehabilitation may be eligible for Medicaid after release.

In response to a request from Chairman Lee, Ms. Anderson provided a listing ([Appendix D](#)) of Medicaid dental rates effective July 1, 2014.

Mr. Patrick Gulbranson, Chief Executive Officer, Family HealthCare, Fargo, provided information ([Appendix E](#)) regarding dental services provided at Family HealthCare. He said Family HealthCare is a FQHC where uninsured and underinsured patients living at or below 200 percent of the federal poverty level can access medical and dental services through a sliding fee scale. He said Family HealthCare is one of four safety net dental clinics in the state. He said Family HealthCare partners with Lutheran Social Services of North Dakota to provide a medical home for refugees and serves over 400 refugee patients each year. He said prior to Medicaid Expansion, qualified refugees could access traditional Medicaid, or they could receive federal Refugee Medical Assistance which includes adult dental and vision coverage for up to eight months after they arrive in the United States. He said currently a refugee who does not qualify for Medicaid is evaluated for Medicaid Expansion next, and then Refugee Medical Assistance as a last resort. He said Medicaid Expansion does not include dental coverage for adults (ages 21-65), so as a result those that do not qualify for traditional Medicaid will most likely be without dental and vision coverage, because they typically qualify for Medicaid Expansion. He said although two parent households are now able to access coverage available through Medicaid Expansion, they are eligible for dental or vision coverage only if they are 19 or 20 years old. He said those that do not qualify for Medicaid or Medicaid Expansion are referred to the HealthCare.gov website to purchase a plan and to determine if they are eligible for tax credits.

In response to question from Representative Becker, Mr. Gulbranson said the clinic has been able to serve the number of refugees settling in the area to date.

In response to a question from Chairman Lee, Mr. Gulbranson said the clinic's experience with appointment "no shows" is approximately 20 percent. He said the clinic has created walk in slots and double books appointments to compensate for "no shows."

Dr. Brent Holman, Executive Director, North Dakota Dental Association, provided information ([Appendix F](#)) regarding ways to reduce barriers to dental care. He said pediatric dentists receive numerous referrals from safety net clinics like Family HealthCare, many of which are refugee children with complex dental needs. He said the North Dakota Dental Association has identified the following 10 solutions to barriers in dental care:

- Expand and support the state Seal! ND Dental Sealant Program;
- Expand and support the nonprofit dental safety net clinics;
- Support the North Dakota Dental Foundation;
- Improve dental Medicaid and maintain an adequate network of dentists;
- Utilized dental hygienists and dental assistants to their maximum level of education;
- Develop a volunteer or contracted network of credentialed dental professionals to serve in Indian Health Services and nonprofit clinics;
- Engage with tribal communities;
- Establish outreach programs in long-term care facilities;
- Support and strengthen the North Dakota Oral Health Coalition;
- Coordinate and facilitate the development of dental assisting training programs in the western part of the state.

In response to a question from Representative Mooney, Dr. Holman said sealants, and especially school-based sealants, are an evidence-based preventative measure.

In response to a question from Senator Anderson, Dr. Holman said the association, with the support of a grant, is working on a project to improve the Indian Health Service credentialing process.

Chairman Lee suggested the committee receive information from the Indian Affairs Commission regarding dental needs on the reservation and a credentialing project for health care professions providing services on the reservation.

Ms. Cheryl Underhill, Executive Director, North Dakota Oral Health Coalition, said a work group has been formed to facilitate stakeholder discussion regarding collaborative practice.

Mr. Rod St. Aubyn, North Dakota Dental Hygienists' Association, suggested the committee consider receiving information from the North Dakota Hospital Association regarding emergency room visits related to dental services. Representative Rohr suggested the data include information regarding whether or not the visits were truly emergent, whether the visit could have been avoided with timely dental care, and the financial impact of these visits. Chairman Lee suggested the North Dakota Hospital Association conduct a survey of its membership and report to the committee. Mr. Jerry Jurena, President, North Dakota Hospital Association, said the association will conduct a survey and report to the committee.

Senator Anderson said other health care loan repayment programs provide for a prorated benefit based on years of service, however the dental loan repayment program does not and includes a repayment penalty.

Chairman Lee said the Commission on Dental Accreditation, the accrediting body for all dental programs in the United States, voted to implement accreditation standards for mid-level dental providers.

It was moved by Senator Heckaman, seconded by Representative Seibel, and carried on a voice vote that the committee proceed with this study as follows:

- 1. Gather and review information regarding the effectiveness of case management services, including program and administrative costs, anticipated resources, and information regarding a pilot project for the reimbursement of outreach services. Organizations to request information from include the North Dakota Dental Association, the Department of Human Services, and the State Department of Health.**
- 2. Gather and review information regarding the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.**
- 3. Gather and review information regarding expanded function dental assistant and dental hygienist language approved by the State Board of Dental Examiners, including information regarding how the changes will improve access to dental services for underserved populations and in rural areas of the state. Organizations to request information from include the State Board of Dental Examiners, the North Dakota Dental Association, the North Dakota Dental Hygienists' Association, and the North Dakota Dental Assistants' Association.**
- 4. Gather and review information regarding the impact of dental therapists in Minnesota.**
- 5. Receive information from the Department of Human Services regarding billing and reimbursement for services provided by dental therapists and expanded function dental assistants and dental hygienists.**
- 6. Receive updates from the Department of Human Services and the State Department of Health regarding changes to programs and services available to provide dental services in rural areas of the state.**
- 7. Receive updates from the State Department of Health regarding changes to the dental loan repayment programs in the state, dentists participating in the loan programs, and the adequacy of the programs.**
- 8. Receive information from the University System regarding how University System programs will prepare students for the expanded functions of dental assistants and dental hygienists.**
- 9. Receive information from the State Department of Health regarding areas of increased need, including information regarding the funding necessary to meet those needs and ways to mitigate the loss of federal funds.**
- 10. Gather and review information regarding whether it would be appropriate to add adult dental services to expanded Medicaid.**
- 11. Receive information from the Indian Affairs Commission regarding dental needs on the reservation and a credentialing project for health care professions providing services on the reservation.**

12. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
13. Prepare a final report for submission to the Legislative Management.

DEATH INVESTIGATION AND FORENSIC PATHOLOGY CENTER STUDY

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled [Death Investigation and Forensic Pathology Center Study - Background Memorandum](#) relating to the committee's study of medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state and the feasibility and desirability of the University of North Dakota acquiring the building that houses the University of North Dakota Forensic Pathology Center. The Legislative Council staff said in 2015 the Legislative Assembly approved House Concurrent Resolution No. 3004, which provides the Legislative Management continue to study medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state, and House Bill No. 1004, in which Section 7 provides that during the 2015-16 interim, the Legislative Management consider studying the feasibility and desirability of the University of North Dakota acquiring the building that houses the Forensic Pathology Center.

The Legislative Council staff said the 1995 Legislative Assembly created a new section to North Dakota Century Code Chapter 23-01 allowing the State Department of Health to perform autopsies and to employ a State Forensic Examiner to conduct investigations into cause of death. Chapter 11-19.1 requires, under most circumstances, each organized county to have a county coroner. The coroner, the coroner's medical deputy, the sheriff, or the state's attorney may direct an autopsy be performed.

The Legislative Council staff said the number of forensic autopsies performed in North Dakota has been steadily increasing. The number of autopsies performed by the State Forensic Examiner increased 64.8 percent--from 196 autopsies in 2004 to 323 autopsies in 2011. In addition, the number of consultations increased 48 percent--from 83 consultations in 2010 to 123 consultations in 2011. The number of forensic autopsies performed by the department exceeded the number of autopsies recommended by the National Association of Medical Examiners in 2011. Accreditation standards indicate one forensic examiner should perform 225 to 250 autopsies per year. During the 2011-13 biennium, 764 autopsies were performed by the State Department of Health. Actual expenditures for the 2011-13 biennium were \$1,395,243, and the cost per autopsy for the biennium was \$1,826. In 2013 to accommodate the increased caseload, the Legislative Assembly provided \$480,000 from the general fund to contract with the University of North Dakota School of Medicine and Health Sciences to conduct medical examiner services for counties in the eastern part of North Dakota. In addition, the Legislative Assembly provided \$1,360,585 to continue funding for existing forensic examiner staff (3 full-time equivalent (FTE) positions) for a total of \$1,840,585 from the general fund for autopsy services during the 2013-15 biennium. Three forensic pathologists at the School of Medicine and Health Sciences performed autopsies at a morgue facility in Grand Forks during the 2013-15 biennium. The contract provided the School of Medicine and Health Sciences serve 13 counties in eastern North Dakota starting September 1, 2013, through June 30, 2015. Beginning July 1, 2014, eight additional counties began receiving services through the School of Medicine and Health Sciences through June 30, 2015, for a total of 21 counties. The State Department of Health also contracts with the School of Medicine and Health Sciences to provide services, when necessary due to department workload or vacation, at a rate of \$2,000 per case. During the 2013-15 biennium, the State Forensic Examiner performed 552 autopsies, including 17 autopsies performed by the School of Medicine and Health Sciences under the contract that provides services while the State Forensic Examiner is away. Expenditures for the State Forensic Examiner are estimated to total \$1,432,081 during the 2013-15 biennium, not including expenditures for the School of Medicine and Health Sciences eastern counties contract, or approximately \$2,594 per case. The School of Medicine and Health Sciences began performing autopsies for counties in the eastern part of the state in September 2013 and performed 448 autopsies during the 2013-15 biennium at a contract cost of \$459,000, or \$1,025 per case. A combined total of 1,000 autopsies were done by the State Forensic Examiner and the School of Medicine and Health Sciences during the 2013-15 biennium. Counties requesting the most autopsies include Cass (174), Grand Forks (124), Burleigh (86), Williams (72), and Ward (63). Of the 53 counties in the state, 25 requested five or fewer autopsies.

The Legislative Council staff said in 2015, the Legislative Assembly provided, in House Bill No. 1004, \$480,000 from the general fund to the State Department of Health to contract with the School of Medicine and Health Sciences for autopsy services in the eastern part of the state and, in House Bill No. 1003, \$160,000 from the general fund to the University of North Dakota School of Medicine and Health Sciences for Department of Pathology services to provide a total of \$640,000 from the general fund, \$160,000 more than the 2013-15 biennium. The Legislative Assembly also provided \$44,000 of one-time funding from the general fund for digital x-ray equipment for the State Forensic Examiner. In addition, the Legislative Assembly provided \$1,502,924 to

continue funding for existing forensic examiner staff (3 FTE positions) for a total of \$2,026,924 from the general fund for autopsy services during the 2015-17 biennium. The department anticipates the School of Medicine and Health Sciences will continue to serve the same 21 counties during the 2015-17 biennium.

The Legislative Council staff said the University of North Dakota School of Medicine and Health Sciences provides autopsy services in the Forensic Pathology Center. In August 2009, the University of North Dakota entered into a lease agreement with Aurora Medical Park, LLC, Fargo, for a 7,167 square foot building located within the Aurora Medical Center in Grand Forks. The lease agreement, for 120 months, was contingent upon the approval of a change of scope request for a federal HRSA grant which would provide funding for a portion of the total cost of construction. Construction costs totaled \$1,944,000, of which \$998,645 was paid through the HRSA grant. The remaining cost of \$945,355 was the basis for the lease (\$94,535 per year or \$7,878 per month). Lease costs do not include property taxes or condo fees. Subsequent lease amending agreements changed the lease term to 300 months and transferred the landlord's interest to 52nd Avenue Investments, LLC. In addition to the cost of construction, HRSA funds totaling \$652,356 were used to purchase major equipment and local funds, available from the Forensic Pathology Center forensic services, totaling \$150,000, were used for furnishings, signage, and small office equipment. The Forensic Pathology Center, constructed in 2010, began accepting cases in 2011. Information provided by the School of Medicine and Health Sciences indicates, based on an insurance estimate, the current value of the building is \$1.5 million. The Legislative Council staff said actual expenditures for the Forensic Pathology Center during the 2013-15 biennium totaled \$1,105,138, including 4.85 FTE positions, of which \$459,432 was provided through the State Department of Health contract. The Forensic Pathology Center budget for the 2015-17 biennium includes funding for 4.40 FTE positions and totals \$1,836,370, of which \$160,000 is provided by the Legislative Assembly from the general fund directly to the School of Medicine and Health Sciences, and \$480,000 is provided through the State Department of Health contract for autopsy services.

The Legislative Council staff said the 2013-14 Health Services Committee, pursuant to Section 9 of Senate Bill No. 2004, studied funding provided by the state for autopsies and state and county responsibilities for the cost of autopsies, including the feasibility and desirability of counties sharing in the cost of autopsies performed by the State Department of Health and the School of Medicine and Health Sciences. The committee received information regarding the current system of death investigation, autopsy costs, medicolegal death investigation system funding models, and recommendations for improvements to the medicolegal death investigation system in the state. The committee recommended House Bill No. 1042 to provide appropriations to the State Department of Health for information technology costs related to the electronic review of death records (\$15,000) and for the reimbursement of travel costs related to county coroner training and the planning of future coroner services in the state (\$39,375). House Bill No. 1042 was not approved by the Legislative Assembly. The 2013-14 Health Services Committee determined additional information was necessary and also recommended House Concurrent Resolution No. 3004 to continue the study of medicolegal death investigation in the state.

The Legislative Council staff said coroners are appointed in North Dakota by each county commission and the State Forensic Examiner provides expert consultation. A coroner investigates deaths that are the result of criminal or violent means, such as homicide, suicide, and accident; deaths of individuals who die suddenly when in apparent good health; or deaths of a suspicious or unusual manner. A coroner works closely with law enforcement to determine if a crime may have been committed and provides a particular medical perspective on the investigation. Issues of public health and safety, such as unusual contagious infections or deaths from environmental hazards, may be raised by a coroner or medical examiner. Because not all counties have a trained death investigator, not all deaths that warrant review may be investigated. A 2014 survey of counties found the duties of county coroners are performed by medical doctors (23 counties), sheriffs (13 counties), funeral directors (11 counties), registered nurses (3 counties), the medical school (1 county), a 911 coordinator/emergency manager, and a police chief.

The Legislative Council staff said prior to the creation of the State Forensic Examiner's office in 1995, counties were responsible for death investigations. Increasing costs to counties and desire to remove the perceived disincentive to requesting necessary autopsies and to increase consistency and professionalism led to legislation to shift part of the cost of conducting autopsies to the state. County costs include the cost of local coroners and transportation of the bodies for autopsy. Counties spent \$622,399 of property tax revenue in calendar year 2013 for coroner and autopsy services and budgeted \$722,759 for calendar year 2014.

The Legislative Council staff said medicolegal death investigation systems may be funded by a per capita model or a fee-for-service model. The per capita model may be more appropriate for smaller counties because costs may influence autopsy decisions in the fee-for-service model. In addition, medicolegal death investigation and forensic pathology may be a pure state model, a pure county model, or a hybrid. North Dakota is currently a hybrid model. In a pure state model, the state is responsible for the entire system. This model is generally used in geographically small states. There is generally a single, centrally located office, and all personnel involved in death investigations are from the state office. In the pure county model, each county is responsible for its own system. This model is most effective in counties with a population in excess of one million people.

The Legislative Council staff said, at the request of the 2013-14 Health Services Committee, the State Forensic Examiner's office collaborated with counties and other stakeholders to develop recommendations for a system approach to death investigation, recommendations for the framework of a regional death investigation system, and for the establishment and implementation of statewide standards for death investigation. The stakeholder group identified eight recommendations for improvement to the medicolegal death investigation system in the state.

The Legislative Council staff said the 2013-14 Health Services Committee determined future study of the long range plan for medicolegal death investigation should continue to formulate recommendations for improvements to the state's medicolegal death investigation system. The committee determined further study was needed regarding:

- Facilities in Bismarck and Grand Forks;
- Education and training of investigators and first responders;
- Financing and cost-sharing;
- National accreditation plan;
- Training and distribution of qualified and certified medicolegal death investigators in all regions of the state; and
- Governance.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Receive an update from the State Department of Health regarding the implementation of prior recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation on autopsy services and cost.
2. Gather and review information regarding trends in the number of autopsies performed in the state and the regions in which autopsies are originating.
3. Gather and review information regarding the effects of the School of Medicine and Health Sciences contract on autopsy costs, gaps in autopsy services, autopsy services in the eastern part of the state, and autopsies performed by the State Forensic Examiner during the 2013-15 biennium.
4. Gather and review information regarding further recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation on autopsy services, cost, legislation, and funding required for implementation.
5. Gather and review information regarding the impact of stakeholder recommendations and other issues to be considered by the committee on counties, including the feasibility and desirability of counties sharing in the cost of autopsies.
6. Gather and review information regarding the acquisition of the Forensic Pathology Center by the University of North Dakota, including acquisition cost, possible funding sources, issues related to ownership, and ongoing operating costs related to acquisition.
7. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
8. Prepare a final report for submission to the Legislative Management.

Mr. Kirby Kruger, Medical Services Section Chief, State Department of Health, provided information ([Appendix G](#)) regarding an update on the implementation of prior recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation of prior recommendations on autopsy services and cost. He said recommendations made to the 2013-14 interim Health Services Committee by the stakeholder group have been addressed by the department as follows:

- Maintain a manageable workload at the State Forensic Examiner's office in Bismarck - The department will continue to contract with the University of North Dakota School of Medicine and Health Sciences for autopsies in the eastern part of the state during the 2015-17 biennium;
- Provide authority to the State Forensic Examiner to review nonnatural deaths and amend the cause and manner of death if necessary - The department reviewed Section 11-19.1-18 and determined the State

Forensic Examiner has the authority to assume jurisdiction over a body and to make changes to the cause and manner of death, if warranted;

- Develop a system to prompt health care providers to consult with the local coroner in all deaths that are not natural deaths - The Division of Vital Records, State Department of Health, is developing a change to the electronic death certificate system in which a window would appear on the screen if a health care provider selected a nonnatural cause of death. The screen would remind the provider to consult with the local coroner before certifying the death;
- Allow copies of toxicology reports generated by the State Crime Laboratory to be sent to the State Forensic Examiner - The State Crime Laboratory has updated their toxicology request forms to include an option for local officials to send a copy of the results to the State Forensic Examiner;
- Increase the number of people in the state trained in death scene investigation - Plans for training the vital records nosologist are ongoing as time permits, the University of North Dakota death investigation course is available online. The State Forensic Examiner offers training, however, additional funding for travel costs related to annual training for coroners, law enforcement, paramedics, and other first responders was not approved by the 2015 Legislative Assembly;
- Develop the capacity of the State Crime Laboratory to produce quantitative toxicology results - Although the State Crime Laboratory does not see quantitative toxicology as a priority currently, the laboratory will work toward offering quantified toxicological testing as staffing and other resources allow;
- Allow the State Forensic Examiner and University of North Dakota School of Medicine and Health Sciences Department of Pathology to review death records electronically and allow these entities to send the electronic record to other medical providers for further review or correction - The estimated cost for modifications to the Division of Vital Records, State Department of Health, software was between \$10,000 and \$20,000, however, this funding was not included in the department's 2015-17 biennium budget; and
- Develop a mass fatality response plan for the state - The Emergency Preparedness and Response Section of the State Department of Health is coordinating a review of current mass fatality plans. The department is taking the lead in the planning and coordination for a mass fatality exercise tentatively scheduled for Fall 2016.

In response to a question from Chairman Lee, Mr. Kruger said the stakeholder group has not met since last interim, but is available to meet as needed.

In response to a question from Representative Rohr, Dr. William Massello, State Forensic Examiner, said in the absence of a medical professional willing to serve as the county coroner, the duty falls to the sheriff or anyone willing to serve. He said coroner candidates must complete eight hours of training in death investigation offered by the State Forensic Examiner.

In response to a question from Representative Rohr, Dr. Massello said if the coroner determines an autopsy is necessary there is no cost to the family. He said transportation for autopsy is the responsibility of the county and the cost of the autopsy and all toxicology tests are the responsibility of the state, either at the Bismarck facility or the Forensic Pathology Center.

In response to a question from Chairman Lee, Mr. Kruger said currently when any of the forensic examiners want to review a case, they must request paper copies of the death records. He said electronic records would provide for a more efficient review.

Dr. Mary Ann Sens, Chair, Department of Pathology, University of North Dakota School of Medicine and Health Sciences, provided information ([Appendix H](#)) regarding an update on the implementation of prior recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation of prior recommendations on autopsy services and cost. Dr. Sens said the Forensic Pathology Center has applied for National Association of Medical Examiners accreditation and anticipates accreditation by the end of the year. She said the Forensic Pathology Center has added a fourth forensic pathologist to serve the educational mission of the School of Medicine and Health Sciences and to provide autopsy and forensic pathology services. She said the Forensic Pathology Center provides a free online course in death investigation and forensic pathology and seminars and presentations for law enforcement, first responders, and others involved in death investigation. She said items to be addressed when planning for the future of death investigation in the state include workforce, facility location, staffing and system issues, and accountability and improvement in the health, safety, and security of citizens. She said any one performing death investigation and certification should meet minimum standards and facilities should be accredited.

In response to a question from Chairman Lee, Dr. Sens said because the Forensic Pathology Center building was intended to be part of a larger medical complex that didn't materialize, the building has some limitations.

In response to a question from Representative Becker, Dr. Sens said a regional system of death investigation is more viable, offers consistency, and allows for coverages even during times when a county coroner is away.

In response to a question from Representative Paur, Dr. Sens said facility rent is a large part of the Forensic Pathology Center's budget. She said the initial lease was for 10 years, but has been extended to 25 years. She said the lease does not contain a buyout option.

In response to a question from Senator Anderson, Mr. Kruger said the bond payment related to the State Forensic Examiner facility in Bismarck is included in the State Department of Health budget.

In response to a question from Representative Mooney, Dr. Sens said the operations of the State Forensic Examiner in Bismarck are not entirely the same as the operations of the Forensic Pathology Center. She said education is part of the Forensic Pathology Center's mission and it includes not just forensic pathology, but other aspects of pathology. Mr. Kruger said the Bismarck facility's mission is to provide forensic pathology expertise to county coroners and local officials.

It was moved by Representative Becker, seconded by Representative Mooney, and carried on a voice vote that the committee proceed with this study as follows:

- 1. Receive an update from the State Department of Health regarding the implementation of prior recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation on autopsy services and cost.**
- 2. Gather and review information regarding trends in the number of autopsies performed in the state and the regions in which autopsies are originating.**
- 3. Gather and review information regarding the effects of the School of Medicine and Health Sciences contract on autopsy costs, gaps in autopsy services, autopsy services in the eastern part of the state, and autopsies performed by the State Forensic Examiner during the 2013-15 biennium.**
- 4. Gather and review information regarding further recommendations for a system approach to death investigation, the framework of a regional death investigation system, and statewide standards for death investigation, including the effect of implementation on autopsy services, cost, legislation, and funding required for implementation.**
- 5. Gather and review information regarding the impact of stakeholder recommendations and other issues to be considered by the committee on counties, including the feasibility and desirability of counties sharing in the cost of autopsies.**
- 6. Gather and review information regarding the acquisition of the Forensic Pathology Center by the University of North Dakota, including acquisition cost, possible funding sources, issues related to ownership, and ongoing operating costs related to acquisition.**
- 7. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
- 8. Prepare a final report for submission to the Legislative Management.**

In response to a question from Chairman Lee, Dr. Sens said qualitative analysis is a quicker test to determine if a drug, or more often if a class of drug, is present. She said quantitative analysis measures how much of the drug is present in the sample. She said the State Crime Laboratory is not accredited to do quantitative analysis.

Senator Anderson said quantitative analysis is expensive and there may not be enough samples in the state to provide adequate experience for accreditation. He said, unless tests sent out of state are delayed excessively, it is likely more cost-effective to continue sending samples out of state for quantitative analysis.

In response to a question from Chairman Lee, Dr. Sens said it is possible for a body to be cremated prior to the death certificate being signed. She said some states require authorization from a physician before cremation occurs.

STUDY OF EMPLOYMENT RESTRICTIONS IN PUBLIC ASSISTANCE PROGRAMS

At the request of Chairman Lee, the Legislative Council staff presented a memorandum entitled [Study of Employment Restrictions in Public Assistance Programs - Background Memorandum](#) relating to the committee's study of issues relating to employment restrictions in public assistance programs. The Legislative Council staff said provisions of the resolution indicate that because workforce shortage issues are a major challenge for business development in the state, the study should determine a means to allow employees to work additional hours without automatically losing public assistance benefits.

The Legislative Council staff said the 2007-08 interim Human Services Committee, pursuant to Section 3 of 2007 Senate Bill No. 2186, studied the temporary assistance for needy families (TANF) program administered by the Department of Human Services. The committee learned North Dakota's work participation rate in August 2007 was 50.64 percent. The committee learned the TANF program may be used to address areas of worker shortage in North Dakota. Successful welfare-to-work programs emphasize employment and provide a wide range of services that include a strong education and training component. The job opportunities and basic skills program is the employment and training component of the state's TANF program which helps TANF recipients become economically self-sufficient. Through the job opportunities and basic skills program, the Department of Human Services has the ability to match TANF clients with various career options. The committee received information regarding other states' TANF initiatives, but made no recommendations regarding the TANF program study.

The Legislative Council staff reviewed National Conference of State Legislatures (NCSL) research related to assistance programs. Assistance programs such as the supplemental nutrition assistance program (SNAP), TANF, child care assistance, and some tax credits do not necessarily restrict work, but when income increases beyond the eligibility threshold, participants are no longer eligible for assistance. In some cases, the additional income does not offset the loss of benefits. For example, if a TANF cash grant, lost due to increased hours or income, exceeds the additional earnings, the participant has a decrease in net pay and benefits for the month as a result of accepting additional work hours or a wage increase. This dropoff in benefits that occurs when a person exceeds the income threshold is often referred to as the "cliff effect." The National Conference of State Legislatures has conducted research on the "cliff effect" and outlined strategies states use to address this issue. The focus of the research was on the income eligibility thresholds for various programs, including phase outs, how to define or establish those thresholds based on cost of living and a state definition of "self-sufficiency," and tax credits and other work supports that bridge the gap. Some states have been examining this issue closely in their child care assistance programs and have established phase-out or tiered levels of eligibility to allow a person to gradually transition off assistance as their wages increase.

The Legislative Council staff said while there are some federal rules that determine who may qualify for TANF-funded cash assistance, states determine the financial eligibility criteria and cash assistance benefit amounts. Income thresholds that determine whether a family is eligible for cash assistance and the benefit amounts paid vary widely among states. The Legislative Council staff reviewed a July 2014 *Congressional Research Service* report on TANF. The report includes a July 2012 summary by state of maximum monthly earnings to be eligible for TANF cash assistance; maximum monthly earnings to retain eligibility for cash assistance after 1, 4, and 13 months on the job; maximum monthly cash assistance benefits; maximum combined TANF and SNAP benefits; and a history of maximum aid to families with dependent children/TANF cash assistance benefits.

The Legislative Council staff said unless determined to be exempt, individuals who receive a TANF cash grant are required to participate in the job opportunities and basic skills program. Exceptions to this requirement include, a caretaker or parent over age 65, a caretaker or parent of a child younger than 4 months of age, and teens who are enrolled in school full-time. Program participants are required to complete a minimum number of hours each week in one or more of the approved work activities, including job readiness, job search, paid employment, high school, general educational development (GED), education directly related to employment, job skills directly related to employment, on-the-job training, vocational training, unpaid work experience, community service, or child care for another participant involved in community service. Involvement in education and training is limited and must be approved by a job opportunities and basic skills program coordinator. Unless responsible for the care of a child who is younger than six years of age, participants must complete a minimum average of 30 hours per week in one or more approved work activities. If caring for a child under age six, an individual must complete a minimum average of 20 hours per week in an approved work activity. The job opportunities and basic skills program offers some supportive services to help participants become self-sufficient, including transportation, child care, job readiness, relocation, and tuition assistance; money for license, certification, and examination fees; tools for employment; and care of incapacitated household members. Some of these supportive services can be provided to former TANF participants for up to six months after their TANF case closes in order to help them succeed in the workforce. Individuals who fail or refuse to participate in the job opportunities and basic skills program without a good reason, can be sanctioned.

The Legislative Council staff provided information on the North Dakota labor force. The labor force comprises all individuals ages 16 and over who are either employed or unemployed and actively seeking employment. The data does not account for other factors such as those that are under employed, students, family caregivers, and the unemployed not seeking work. The labor force participation rate refers to the proportion of people included in the labor force as a proportion of the entire population ages 16 and over. The unemployment rate refers to the unemployed portion of the labor force as a percentage of the total labor force. In 2014 North Dakota ranked 1st in the nation for labor force participation with an adjusted rate of 72.8 percent. North Dakota has maintained a very low unemployment rate in recent years. Much like the state's labor force participation, North Dakota's unemployment rate, which has historically outperformed the national average, reached a high in 2009 of 4.1 percent and dropped to 2.8 percent in 2014, the lowest in the nation. According to an annual Job Service North Dakota publication, the top five industries by highest average employment in the state in 2014 were health care and social assistance, retail trade, accommodation and food services, construction, and educational services. Employment in these five industries is also projected to increase more than other industries in the state between 2012 and 2022. Based on a June 2015 monthly Job Service North Dakota report, total employment in North Dakota increased to 470,200, from 468,300 in June 2014. While mining and logging employment decreased, increases in construction, retail trade, and other services more than offset the reduction.

The Legislative Council staff presented the following proposed study plan for the committee's consideration:

1. Gather and review information regarding public assistance programs that limit hours worked or income, including limitations, whether the limitations are imposed by the state or federal government, and benefit levels.
2. Gather and review information regarding jobs available in the state, including monthly wage and whether the jobs require specific skills, education, or training.
3. Gather and review information regarding employed participants enrolled in assistance programs, including the state's work participation rate, a comparison of number of participants by county-to-county unemployment rates, and the number of employed participants sorted by earnings range.
4. Gather and review information regarding an update on the job opportunities and basic skills program, including number of participants, number of hours logged for various types of work activities, cost, and average number of months individuals participate in the program.
5. Gather and review information regarding possible public assistance program modifications that would allow recipients to increase employment hours without dramatic benefit reductions or that would incentivize recipients to accept increases in the number of hours worked, when available, including information regarding the feasibility of adopting variances to federal limitations, and the cost of modifications and variances to the state.
6. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.
7. Prepare a final report for submission to the Legislative Management.

Ms. Carol Cartledge, Economic Assistance Policy Division Director, Department of Human Services, provided information ([Appendix I](#)) regarding public assistance programs that limit hours worked or income, including limitations, whether the limitations are imposed by the state or federal government, and benefit levels. She provided a summary of income eligibility limits and work requirements for the child care assistance program low income home energy assistance program (LIHEAP), Medicaid, SNAP, and TANF. She said the child care assistance program and the LIHEAP programs do not include work requirements. She said Medicaid provisions do not include work requirements, except for the workers with disabilities coverage group. She said with some exceptions, the SNAP and TANF programs include certain work requirements. In addition, she provided information ([Appendix J](#)) regarding the impact of increased work hours on eligibility for various assistance programs. She said if a family becomes ineligible for TANF due to an increase in earnings, transition assistance of \$200 per month is available for six months to offset some of the "cliff effect." She said participants receive TANF supports and must continue to comply with TANF requirements during the transition period.

In response to a question from Senator Heckaman, Ms. Cartledge said the state's median income is \$55,759.

In response to a question from Representative Porter, Ms. Cartledge said changes to the benefits of one program may affect the benefits of another program. Representative Porter suggested the department provide a chart to demonstrate the effect programs have on one another.

In response to a question from Representative Porter, Ms. Cartledge said the state has more flexibility to make changes in the TANF program than other assistance programs. She said TANF benefits can be lost if the department becomes aware the participant is refusing additional work. She said there are also consequences in the SNAP program, however federal regulations determine work requirements.

Chairman Lee suggested the Department of Human Services provide a copy of the annually updated program limits to the committee.

Senator Anderson suggested the Department of Human Services provide more participant scenarios as part of the committee's study.

In response to a question from Senator Oelke, Ms. Cartledge said the Department of Human Services reviews programs internally and the State Auditor audits all of the department's programs. She said the department compares well with other states in its administration of the SNAP program. She said the state is also second in the nation for its work participation rate in the TANF program.

In response to a question from Representative Mooney, Ms. Cartledge said eligibility determinations include a review of what work the participant is able to perform and hours can be adjusted based on a physician's recommendations.

Chairman Lee suggested the committee include a study of various public assistance scenarios in the study plan.

It was moved by Representative Porter, seconded by Senator Axness, and carried on a voice vote that the committee proceed with this study as follows:

- 1. Gather and review information regarding public assistance programs that limit hours worked or income, including limitations, whether the limitations are imposed by the state or federal government, and benefit levels.**
- 2. Gather and review information regarding jobs available in the state, including monthly wage and whether the jobs require specific skills, education, or training.**
- 3. Gather and review information regarding employed participants enrolled in assistance programs, including the state's work participation rate, a comparison of number of participants by county-to-county unemployment rates, and the number of employed participants sorted by earnings range.**
- 4. Gather and review information regarding an update on the job opportunities and basic skills program, including number of participants, number of hours logged for various types of work activities, cost, and average number of months individuals participate in the program.**
- 5. Gather and review information regarding possible public assistance program modifications that would allow recipients to increase employment hours without dramatic benefit reductions or that would incentivize recipients to accept increases in the number of hours worked, when available, including information regarding the feasibility of adopting variances to federal limitations, and the cost of modifications and variances to the state.**
- 6. Gather and review information regarding various public assistance scenarios and the effects of changes in income and program eligibility requirements, including how changes in one program affect eligibility and benefits in other programs.**
- 7. Develop committee recommendations and prepare any legislation necessary to implement the committee recommendations.**
- 8. Prepare a final report for submission to the Legislative Management.**

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES THIRD BIENNIAL REPORT - HEALTH ISSUES FOR THE STATE OF NORTH DAKOTA 2015

Mr. Brad Gibbens, Deputy Director, Center for Rural Health, University of North Dakota School of Medicine and Health Sciences, provided information ([Appendix K](#)) regarding the *Third Biennial Report - Health Issues for the State of North Dakota 2015*, including an update on the construction of the new School of Medicine and Health Sciences building. He said the biennial report includes information regarding the state's population, health care needs, physician and other health care workforce, health care infrastructure, quality and value of health care, workforce development, and recommendations for health care planning in the state. He said the Center for Rural Health has begun to update information in anticipation of the fourth biennial report which will be available in December 2016. He said 13 counties in the state do not have a physician and seven counties have one physician providing care for 3,500 to 10,000 people. He said the ratio of physicians to 10,000 population is 24.1 in North Dakota, compared to 25.1 in the Midwest and 27.0 nationally. He provided information regarding the School of Medicine and Health Sciences workforce initiatives, including reducing the disease burden, training more physicians and health providers, retaining more graduates, and improving the efficiency of the health delivery system. He said the School of Medicine and Health Sciences has increased the medical school class size by 16 students per year, the number of residencies by

17 per year, and the number of other health sciences students by 15 percent. He said the School of Medicine and Health Sciences has revised the medical school admissions process to admit students more likely to stay in the state.

Mr. Gibbens said the new School of Medicine and Health Sciences building will be four floors with a fifth floor mechanical floor and no basement. He said the building, which will total 325,446 square feet, is on budget and will open on time in the Summer of 2016.

In response to a question from Chairman Lee, Mr. Gibbens said the biennial report will include information on dental workforce and oral health.

In response to a question from Chairman Lee, Mr. Gibbens said internal medicine residencies are staffed with more out-of-state graduates than other residencies. He said most other residents are from North Dakota and Minnesota. He said the school anticipates more closely tracking where graduates of the residency programs practice.

Chairman Lee suggested the committee receive information regarding the number of North Dakota residencies that are filled with students from the state's medical school and how many are from other states and countries.

Chairman Lee said the state has a need for licensed addiction counselors. She said because the state has fewer internships than graduates, many of the graduates must leave the state to complete their internship. She said funding is available for internships in science, technology, engineering, and math, but not behavioral health and some of the other health sciences.

Chairman Lee suggested the committee receive information regarding a plan for area health educational centers to administer behavioral health and other internships.

In response to a question from Representative Seibel, Mr. Gibbens said there will be approximately 78 doctors graduating from the School of Medicine and Health Sciences in 2020. He said historically approximately 45 percent stay in the state. He said between 1984 and 2014, approximately 22 percent of School of Medicine and Health Sciences graduates have gone into primary care. He said nationally 11 percent of medical school graduates enter primary care.

In response to a question from Representative Porter, Mr. Gibbens said the state provides funding for four years of medical school tuition for Rural Opportunities in Medical Education (ROME) students. He said participants must agree to serve five years in rural North Dakota. He said physicians in the ROME program may still be eligible for loan repayment program to reimburse them for their undergraduate education. He said if a physician were to leave a contract early, full tuition must be repaid within 60 days.

Chairman Lee suggested the committee receive an update on medical scholarships and loan repayment programs in the state.

OTHER COMMITTEE RESPONSIBILITIES

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

- Receive from the State Fire Marshal a report regarding findings and recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes;
- Receive a report from the Department of Human Services, the State Department of Health, the Indian Affairs Commission, and the Public Employees Retirement System (PERS) before June 1, 2016, on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes;
- Receive a report from the State Department of Health before June 1, 2016, regarding progress made toward the recommendations provided in Section 23-43-04 relating to continuous improvement of quality of care for individuals with stroke and any recommendations for future legislation;
- Recommend a private entity to contract with for preparing cost-benefit analyses of health insurance mandate legislation;
- Receive a report from the Tobacco Prevention and Control Advisory Committee and the State Department of Health by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of a \$500,000 grant provided to the State Department of Health by the advisory committee to assist in funding the department's Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs* during the 2015-17 biennium; and

- Receive periodic reports from the State Department of Health on the status of the health professional assistance program study. Before July 1, 2016, the State Department of Health must report to the Legislative Management on the outcome of the study, including recommended legislation.

Effectiveness of Legislation Related to Reduced Ignition Propensity Standards for Cigarettes

The Legislative Council staff said the Legislative Assembly in 2009 House Bill No. 1368 created Chapter 18-13 relating to reduced ignition propensity standards for cigarettes and penalties for wholesale and retail sale of cigarettes that violate the reduced propensity standards. The bill provides for enforcement of the standards by the State Fire Marshal, Tax Commissioner, and Attorney General and for monetary violations to be deposited in the fire prevention and public safety fund to be used by the State Fire Marshal to support fire safety and prevention programs. No funds were deposited into the fire prevention and public safety fund during the 2013-15 biennium, and the balance in the fund as of June 30, 2015, was \$0. In addition, fees collected for testing cigarettes are to be used by the State Fire Marshal for the purpose of processing, testing, enforcement, and oversight of ignition propensity standards. Cigarette manufacturers are required to pay the State Fire Marshal an initial \$250 fee for certification, which is deposited in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund. Deposits into the fund are estimated to total \$85,000 during the 2013-15 biennium and expenditures are estimated to total \$19,881. The balance in the Reduced Cigarette Ignition Propensity and Firefighter Protection Act enforcement fund is estimated to be \$379,079 as of June 30, 2015. Section 18-13-02(6) requires the State Fire Marshal to review the effectiveness of test methods and performance standards and report each interim to the Legislative Management the State Fire Marshal's findings and any recommendations for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes.

Report on Plans to Reduce the Incidence of Diabetes in the State, Improve Diabetes Care, and Control Complications Associated With Diabetes

The Legislative Council staff said the Legislative Assembly in 2013 House Bill No. 1443 created Section 23-01-40 which requires the Department of Human Services, the State Department of Health, the Indian Affairs Commission, and PERS collaborate to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes. Section 23-01-40(2) requires before June 1 of each even-numbered year, the Department of Human Services, the State Department of Health, the Indian Affairs Commission, and PERS submit a report to the Legislative Management on the following:

- The financial impact and reach diabetes is having on the agency, the state, and localities. Items included in this assessment must include the number of lives with diabetes impacted or covered by the agency, the number of lives with diabetes and family members impacted by prevention and diabetes control programs implemented by the agency, the financial toll or impact diabetes and diabetes complications places on the agency's programs, and the financial toll or impact diabetes and diabetes complications places on the agency's programs in comparison to other chronic diseases and conditions.
- An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease. This assessment must document the amount and source for any funding directed to the agency from the Legislative Assembly for programs and activities aimed at reaching those with diabetes.
- A description of the level of coordination existing between the agencies on activities, programmatic activities, and messaging on managing, treating, or preventing diabetes and diabetes complications.
- The development or revision of detailed action plans for battling diabetes with a range of actionable items for consideration by the Legislative Assembly. The plans must identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan must identify expected outcomes of the action steps proposed in the following biennium while also establishing benchmarks for controlling and preventing relevant forms of diabetes.
- The development of a detailed budget blueprint identifying needs, costs, and resources required to implement the plan identified in subdivision d. This blueprint must include a budget range for all options presented in the plan identified in subdivision d for consideration by the Legislative Assembly.

Report on the Improvement of Quality of Care for Individuals with Stroke

The Legislative Council staff said the Legislative Assembly approved 2015 House Bill No. 1323 relating to the creation and implementation of a stroke system and to provide for a report to the Legislative Management. The bill amended Section 23-43-04 to provide the State Department of Health establish and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke response and treatment, establish a data oversight process, and implement a plan for achieving continuous quality improvement in the quality of care provided under the state comprehensive stroke system for stroke

response and treatment. Section 23-43-04(4) requires before June 1 of each even-numbered year, the State Department of Health provide a report to the Legislative Management regarding progress made toward the recommendations provided in Section 23-43-04 and any recommendations for future legislation.

Health Insurance Coverage Mandates

The Legislative Council staff said Section 54-03-28 provides a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. The Health Services Committee has been assigned the responsibility of recommending a private entity, after receiving recommendations from the Insurance Commissioner, for the Legislative Council to contract with to perform the cost-benefit analysis for the 2017 legislative session. The Insurance Commissioner is to pay the costs of the contracted services, and each cost-benefit analysis must include:

1. The extent to which the proposed mandate would increase or decrease the cost of services.
2. The extent to which the proposed mandate would increase the use of services.
3. The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of the insured.
4. The impact of the proposed mandate on the total cost of health care.

The Legislative Council staff said a majority of the members of the standing committee to which the legislative measure is referred during a legislative session, acting through the chairman, determines whether a legislative measure mandates coverage of services. Any amendment to the legislative measure that mandates health insurance coverage may not be acted on by a committee of the Legislative Assembly unless the amendment has had a cost-benefit analysis prepared and attached.

The Legislative Council staff said the 2003-04 and 2005-06 interim Budget Committees on Health Care, the 2007-08 interim Human Services Committee, the 2009-10 interim Health and Human Services Committee, and the 2011-12 and 2013-14 interim Health Services Committees recommended the Insurance Department contract with Milliman USA for cost-benefit analysis services on health insurance mandates during the 2005, 2007, 2009, 2011, 2013, and 2015 legislative sessions. During the 2005 legislative session, two bills were referred for cost-benefit analysis at a total cost of \$8,323. In addition, the department paid \$5,606 to Milliman USA for general project work during the 2005 legislative session for total payments during the 2005 legislative session of \$13,929. During the 2007 legislative session, there were no health insurance mandates referred for cost-benefit analysis. The department paid a total of \$28,070 to Milliman USA for analyses conducted on three bills during the 2009 legislative session and \$14,982 to Milliman USA for analysis conducted on one bill during the 2011 legislative session. There were no health insurance mandates referred for cost-benefit analysis during the 2013 legislative session. During the 2015 legislative session, the Insurance Department paid a total of \$26,564 to Milliman USA for analyses conducted on three bills.

Report on Tobacco Prevention and Control Advisory Committee Grant to the State Department of Health

The Legislative Council staff said the Legislative Assembly approved 2015 House Bill No. 1024, the appropriations bill for the Tobacco Prevention and Control Advisory Committee, which includes \$500,000 from the tobacco prevention and control trust fund for a grant to the State Department of Health to be used for the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs* during the 2015-17 biennium. Section 2 of the bill requires the Tobacco Prevention and Control Advisory Committee and the State Department of Health report to the Legislative Management by September 1, 2016, regarding grant expenditures, the granting process, and reporting requirements of the grant. The Health Services Committee has been assigned the responsibility to receive this report.

The Legislative Council staff said the Legislative Assembly, in 2015 House Bill No. 1004, provided a total tobacco prevention appropriation of \$6,910,177 to the State Department of Health, of which \$3,440,864 is from the community health trust fund, \$2,969,313 is from federal funds, and \$500,000 is from a grant provided by the Tobacco Prevention and Control Advisory Committee from the tobacco prevention and control trust fund. Funding from the community health trust fund provides for community health tobacco programs, the Tobacco Quitline, and a tobacco prevention coordinator. Certain tobacco-related programs currently provided through the State Department of Health qualify as best practices as outlined by the Centers for Disease Control and Prevention. As a result, the funding for the Tobacco Prevention and Control Executive Committee is adjusted accordingly. However, because the State Department of Health anticipates reductions in federal funding available for tobacco prevention and control, the Legislative Assembly increased 2015-17 biennium authority for the Tobacco Prevention and Control Executive Committee and the State Department of Health to provide for a \$500,000 grant from the tobacco prevention and control trust fund to the State Department of Health. Funding for the comprehensive statewide tobacco prevention and control program is summarized as follows:

2015-17 Biennium	Community Health Trust Fund	Tobacco Prevention and Control Trust Fund	Federal Funds	Total
State Department of Health (SB 1004) Tobacco prevention and control	\$3,440,864	\$500,000 ¹	\$2,969,313	\$6,910,177 ¹
Tobacco Prevention and Control Executive Committee (SB 1024) Tobacco prevention and control	0	16,548,039 ¹	0	16,548,039 ¹
Total 2015-17 biennium funding	\$3,440,864	\$17,048,039 ¹	\$2,969,313	\$23,458,216 ¹

¹Includes \$500,000 provided as a grant from the Tobacco Prevention and Control Advisory Committee to the State Department of Health to be used for the Centers for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*.

State Department of Health Reports on the Status of the Health Professional Assistance Program Study

The Legislative Council staff said the Legislative Assembly approved 2015 House Bill No. 1036 which requires the State Department of Health to evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. The study must include:

- Identification of state programs to assist health professionals;
- Consideration of whether elements of the identified state programs could be standardized;
- Evaluation of funding and usage of the identified state programs;
- Evaluation of the effectiveness of these identified programs and how these programs could be revised to be more effective; and
- Consideration of whether there are gaps or duplication in programs designed to assist health professionals.

Section 1 of 2015 House Bill No. 1036 requires, during the 2015-16 interim, the State Department of Health make periodic reports to the Legislative Management on the status of the study. In addition, before July 1, 2016, the State Department of Health must report to the Legislative Management on the outcome of the study, including presentation of recommended legislation. The Legislative Management may introduce legislation recommended by the State Department of Health as part of the department's study report.

Chairman Lee asked the Legislative Council staff to prepare an updated memorandum regarding funds appropriated by the state as a result of risk associated behavior.

Chairman Lee suggested the committee receive information regarding collaboration between the University of North Dakota School of Law and the University of North Dakota School of Medicine and Health Sciences to provide behavioral health experiences for health sciences and law school students.

Senator Anderson suggested the committee receive information regarding funding for various health care internships. Chairman Lee suggested the committee receive information regarding funding for health care internships in Minnesota and South Dakota.

COMMITTEE DISCUSSION AND STAFF DIRECTIVES

Chairman Lee said because of similar membership, the Health Services Committee and the Human Services Committee will attempt to coordinate meeting dates. She said the Human Services committee anticipates meeting on November 3, 2015, and the Health Services Committee anticipates meeting on either November 2 or November 4.

It was moved by Senator Oelke, seconded by Representative Mooney, and carried on a voice vote that the meeting be adjourned. No further business appearing, Chairman Lee adjourned the meeting at 3:08 p.m.

Sheila M. Sandness
Senior Fiscal Analyst

ATTACH:11